St. Clair County Community Mental Health Authority

Intake Packet - CIU Department Use Only

Name:	
Preferred Name:	
Date:	
Social Security #:	

Address:_____

Phone Number(s):_____

Automatic appointment reminders via text? ☐ Yes ☐No

E-mail Address:_____

Gender: ☐Male ☐Female ☐Other (please specify):_____

Parent/Guardian (if applicable):_____

Emergency Contact (Name/Phone):_____

Please check all mental health symptoms you are currently experiencing:

☐Suicidal or Homicidal thoughts ☐Depression ☐Anxiety
☐Panic Attacks ☐Aggression ☐Anger
☐Seeing or hearing thing others do not ☐Appetite changes ☐Sleep Changes

Please check all area you are currently experiencing difficulty function in:

☐Home Environment ☐Work ☐School
☐Legal issues ☐Personal relationships ☐Housing
☐Substance use

INSURANCE INFORMAITON:

Name of PRIMARY insurance:_____

- ID Number:_____
- Group Number: _____
- Phone Number: _____
- Subscriber Name:_____

Name of SECONDARY insurance:_____

- ID Number:_____
- Group Number: _____
- Phone Number: _____
- Subscriber Name:_____

FINANCIAL INFORMATION

Annual income (approximate): $_____ Dependents (including yourself): _____

PLEASE COMPLETE MEDICAL INFORMATION AND MEDICATION CHART ON THE NEXT PAGE

MEDICAL INFORMATION:

Primary Care Doctor: _____

Address: _____

Phone: _____

Date of last appointment: _____

Pharmacy (Name and Phone): _____

NAME OF MEDICAITON	DOSE (i.e., 10mg)	HOW OFTEN DO YOU TAKE IT?	PRESCRIBER	REASON FOR USE

PATIENT HEALTH QUESTIONNAIRE (PHQ-(9)

NAME:_____ DATE:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
2. Feeling down, depressed or hopeless	☐ 0	☐ 1	☐ 2	☐ 3
3. Trouble falling or staying asleep, or sleeping too much	☐ 0	☐ 1	☐ 2	☐ 3
4. Feeling tired or having little energy	☐ 0	☐ 1	☐ 2	☐ 3
5. Poor appetite or overeating	☐ 0	☐ 1	☐ 2	☐ 3
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down.	☐ 0	☐ 1	☐ 2	☐ 3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	☐ 0	☐ 1	☐ 2	☐ 3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual.	☐ 0	☐ 1	☐ 2	☐ 3
9. Thoughts that you would be better off dead, or of hurting yourself.	☐ 0	☐ 1	☐ 2	☐ 3

Add columns _____ + _____ + _____

TOTAL: _____

10. If you checked off any problems, how difficult have these problems mad it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult ☐

LEC-5 Standard

Instructions: Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); (e) you're not sure if it fits; or (f) it doesn't apply to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Part of my job	Not sure	Doesn't apply
1. Natural disaster (for example, flood hurricane, tornado, earthquake)						
2. Fire or explosion						
3. Transportation accident (for example, car accident, boat accident, train wreck, plan crash)						
4. Serious accident at work, home, or during recreational activity.						
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)						
6. Physical assault (for example being attacked, hit, slapped, kicked, beaten up)						
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)						
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)						
9. Other unwanted or uncomfortable sexual experience						
10. Combat or exposure to a war-zone (in the military or as a civilian)						
11. Captivity (for example being kidnapped, abducted, held hostage, prisoner of war)						
12. Life-threatening illness or injury						
13. Severe human suffering						
14. Sudden violent death (for example homicide, suicide)						
15. Sudden accidental death						
16. Serious injury, harm, or death you caused to someone else						
17. Any other very stressful event or experience						

Name: _____

Date of Birth: _____

Alcohol screening questionnaire (AUDIT)

Drinking alcohol can affect your health and some medications you make take. Please help us provide you with the best medical care by answering the questions below.

One Drink Equals:  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	☐ 0-2	☐ 3 or 4	☐ 5 or 6	☐ 7-9	☐ 10 or more
3. How often do you have five or more drinks on one occasion?	☐ Never	☐ Less than monthly	☐ Monthly	☐ Weekly	☐ Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	☐ Never	☐ Less than monthly	☐ Monthly	☐ Weekly	☐ Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	☐ Never	☐ Less than monthly	☐ Monthly	☐ Weekly	☐ Daily or almost daily
6. How often during the last year have you needed a first drinking the morning to get yourself going after a heavy drinking session?	☐ Never	☐ Less than monthly	☐ Monthly	☐ Weekly	☐ Daily or almost daily
7. How often during the last year have you had a feeling of guild or remorse after drinking?	☐ Never	☐ Less than monthly	☐ Monthly	☐ Weekly	☐ Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	☐ Never	☐ Less than monthly	☐ Monthly	☐ Weekly	☐ Daily or almost daily
9. Have you or someone else been injured because of your drinking?	☐ No		☐ Yes, but not in the last year		☐ Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	☐ No		☐ Yes, but not in the last year		☐ Yes, in the last year
	0	1	2	3	4

Have you ever been in treatment for an alcohol problem? ☐ Never ☐ Currently ☐ In the past

I	II	III	IV
0-3	4-9	10-13	14+

Drug Abuse Screening Test (DAST- 10)

General Instructions:

"Drug use" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD), or narcotics (e.g., heroin). The questions do not include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

Date of Assessment: _____

These questions refer to drug use in the past 12 months. Please answer No or Yes.

1. Have you used drugs other than those required for medical reasons?
   ☐ No ☐ Yes
2. Do you use more than one drug at a time?
   ☐ No ☐ Yes
3. Are you always able to stop using drugs when you want to?
   ☐ No ☐ Yes
4. Have you had "blackouts" or "flashbacks" as a result of drug use?
   ☐ No ☐ Yes
5. Do you ever feel bad or guilty about your drug use?
   ☐ No ☐ Yes
6. Does your spouse (or family) ever complain about your involvement with drugs?
   ☐ No ☐ Yes
7. Have you neglected your family because of your use of drugs?
   ☐ No ☐ Yes
8. Have you engaged in illegal activities in order to obtain drugs?
   ☐ No ☐ Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?
   ☐ No ☐ Yes

10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding etc.)?

☐ No ☐ Yes

Comments:

Scoring:

Score 1 point for each question answered "Yes", **except for question** 3 for which a "No" receives 1 point.

DAST Score: _____

Interpretation of Score:

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	None at this time
1-2	Low level	Monitor, reassess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment