Pinnacle Behavioral Healthcare
Exceptional Care, Compassionate People!

MENTAL HEALTH PATIENT ASSESSMENT

Name: _____ Date: _____

Psychiatric Diagnosis:_____

ALLERGIES AND REACTIONS:(specify)_____

Referral Source: _____

Do you have adequate shelter with heat, power, and water? Yes ☐ No☐

If no, clarify: _____

PROVIDERS

Please fill out one Release to Communicate with Treatment Team for each of the following:

Physician Name:	**Psychiatrist Name:**	**Therapist Name:**	**Dietitian Name:**
Phone Number:	Phone Number:	Phone Number:	Phone Number:
Email Address:	Email Address:	Email Address:	Email Address:
Last Seen:	Last Seen:	Last Seen:	Last Seen:
Fax #:	Fax #:	Fax#:	Fax#:
Release signed Y N	Release signed Y N	Release signed Y N	Release signed Y N

Emergency Notification and Phone #: _____

MAJOR REASON(S) FOR SEEKING TREATMENT

_____

_____

_____

_____

_____

Current Medications

Medication	Dosage	Frequency	Date Started	Prescribing Doctor

How are you sleeping? _____

How is your appetite? _____

Do you feel isolated? Yes ☐ No ☐ Comments: _____

Have you been hearing voices, seeing unusual movements, or smelling unusual odors? Yes ☐ No ☐ If yes, clarify:

_____

_____

Have you ever been abused and/ or been the abuser:

☐ Emotionally ☐ Physically ☐ Sexually ☐ Denies

If so, what happened?

Comments: _____

_____

Do you have any problems from childhood you want to address? Yes ☐No ☐

(If yes, clarify):

_____

_____

Have you ever attempted suicide? Yes ☐No ☐. If so, what happened?

_____

_____

_____

Are you grieving any losses? ☐Yes ☐No. If yes, what are they?

_____

_____

RELATIONSHIPS

Are you: ☐Single ☐Engaged ☐Married ☐Divorced ☐Widowed ☐Living with someone

What is the name of your significant other (if applicable)? _____

Do you have any children? ☐Yes ☐No

If so, what are their names and ages? _____

Who lives with you and how are they related to you?

_____

Are there other people in your life that you're close to? ☐Yes ☐No. If so, who are they?

_____

_____

Is your family supportive of your treatment? ☐Yes ☐No

Are there family problems? ☐Yes ☐No. If yes, clarify:

_____

_____

EMPLOYMENT AND EDUCATION

Are you in school? ☐Yes ☐No Notes: _____

Are you working? ☐Yes ☐No Notes: _____

Do you like work and/or school? ☐Yes ☐No Notes: _____

What is your past work experience?_____

_____

What is your highest educational achievement? _____

Do you have any learning disabilities that you are aware of? ☐Yes ☐No

If yes, specify: _____

Do you have any difficulty reading? ☐Yes ☐No If yes, specify in what way:

_____

How do you learn best?

☐Listening ☐Reading ☐Visual ☐Hands-on

Do you have transportation? ☐Yes ☐No

Do you have any legal problems past or present? ☐Yes ☐No. If yes, specify:

_____

_____

Have you been in the military? ☐Yes ☐No. If yes, specify:

_____

_____

MENTAL HEALTH PATIENT ASSESSMENT

PERSONAL VALUES AND BELIEFS

How would you describe what is important to you in life?

_____

_____

_____

How would you describe your sense of self-worth?

_____

Do you feel a sense of purpose for your life? ☐Yes ☐No. Comments:

_____

_____

Do you feel a sense of hope? ☐Yes ☐No. Comments:

_____

_____

Do you have a religion or spirituality source that is meaningful and comforting to you?
☐Yes ☐No
Comments:_____

_____

Is there a cultural or ethnic heritage that you identify with? ☐Yes ☐No
Comments:_____

_____

Are there any cultural or ethnic characteristics that are important for us to know about that may affect your treatment? ☐Yes ☐No. If yes, clarify:

_____

_____

What is your preferred language? ☐English ☐Other (Specify):

_____

Are you a member of any clubs, organizations, or social groups? ☐Yes ☐No

If yes, specify:

_____

_____

What kind of recreation, exercise, or leisure activities do you enjoy or have you enjoyed in the past?

_____

_____

_____

If you are not engaged in these interests, what are the barriers?

_____

_____

HEALTH ISSUES

Do you have any unusual cravings or thirst? ☐Yes ☐No. If yes, clarify:

_____

_____

Do you binge or purge with food? ☐Yes ☐No. Notes:

_____

_____

Has your doctor recommended any special tests or treatment? ☐Yes ☐No. If yes, specify:

_____

_____

Do you have any chronic or acute medical conditions? ☐Yes ☐No. If yes, specify:

_____

_____

SUBSTANCE USE HISTORY – Caffeine, Tobacco, alcohol, marijuana, benzodiazepines, opiates, cocaine, pain medicine such as Vicodin, oxycodone, Tylenol #3, etc.

Substance	Age of first use	Pattern of use	Date last used	Amount Last Used
Caffeine				
Tobacco/nicotine				
Alcohol				
Marijuana				
Caffeine				

Do you feel that your use of any of these substances may be hurting you or your relationships?

☐Yes ☐No. Comments: _____

OTHER TYPES OF COMPULSIONOR ADDICTIONS

Do you feel that you may have a compulsion or addiction to any of the following? Comments if applicable

Compulsion or Addiction		Comments if applicable
Gambling	☐ Yes ☐ No	
Shopping	☐ Yes ☐ No	
Food	☐ Yes ☐ No	
Sex	☐ Yes ☐ No	
Exercise	☐ Yes ☐ No	
Work	☐ Yes ☐ No	
Perfectionism	☐ Yes ☐ No	
Cleaning	☐ Yes ☐ No	
Television	☐ Yes ☐ No	
Internet	☐ Yes ☐ No	
Computer games	☐ Yes ☐ No	
Social media	☐ Yes ☐ No	
Certain kinds of relationships	☐ Yes ☐ No	
Other	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

Do you feel that any of these addictions or compulsions may be hurting you or your relationships? ☐Yes ☐No. Comments: _____

If you use nicotine, please answer the following:

Would you like information about support and resources to quit smoking? ☐Yes ☐No

Would you like help to quit smoking? ☐Yes ☐No

If yes, would you like to make it a treatment goal? ☐Yes ☐No

☐Treat and add goal to treatment plan

☐Refer to: _____
☐Defer

What do you see as your strengths?

_____

_____

_____

What is going to stand in the way of your getting better?

_____

_____

_____

Treatment History

Psychiatric: _____ Substance Abuse: _____ Eating Disorder: _____

Name of Facility or Provider	**Was it Inpatient, Residential, PHP or Outpatient Treatment?**	**Admit Date**	**Length of Stay**	**Outcome of Treatment**

What goals would you like to work on while you're in this program?

_____

_____

_____

_____

_____

Start Date and/or Additional Comments:

_____

_____

_____

_____ _____

Patient Signature IOP Staff Signature with Credentials

Date/Time Date/Time