

Last, First Name: _____

ID # _____

State of Oklahoma Screening & Assessment Form

SCREENING PORTION:

Agency Name: _____ Agency # _____ Date (mm/dd/yyyy): _____

Name: Last _____ First _____ Middle Initial _____ Maiden _____

Source/Provider of Information: _____

Address/City/St/Zip/Co: _____

Phone # _____ SS # _____ Gender: _____ DOB (mm/dd/yyyy): _____ Age _____

Best way to contact you? _____ Confidentiality Issues? _____

What would you like help with (reason for seeking services)? _____

What are your immediate/urgent needs (including medical)? _____

Current thoughts of harming self and/or others? Yes No Not Provided

Currently receiving or past services? Yes No If yes, where? _____

Annual Household Income: \$ _____ # in Household: _____

Source of Income:

Employment SSI SSDI Food Stamps TANF Other: _____

Insurance:

Private Medicaid Medicare Private Pay Other: _____ ID# _____

Mental Health

Within the last 90 days (3 months) have you had a significant period in which you have experienced:

1. Serious depression (felt sadness, hopelessness, loss of interest, change of appetite or sleep pattern, difficulty going about your daily activities)? Yes No Not Provided
2. Serious anxiety or tension (felt uptight, worried, unable to relax)? Yes No Not Provided
3. Being prescribed medication for psychological/emotional problem? Yes No Not Provided
4. Thoughts of harming yourself? Yes No Not Provided
5. Hallucinations (heard/seen things others don't hear or see)? Yes No Not Provided
6. An Attempted suicide? Yes No Not Provided

Substance Abuse

During the past 12 months have you:

1. Been preoccupied with drinking alcohol and/or using other drugs? Yes No Not Provided
2. Tried to stop drinking alcohol and/or using other drugs, but couldn't? Yes No Not Provided
3. Had problems caused by drinking/using drugs, and you kept using? Yes No Not Provided
4. Need to drink and/or use more to get the same effect you used to? Yes No Not Provided
5. Drunk alcohol and/or used other drugs more than you intended? Yes No Not Provided
6. Experienced periods of time when your thinking speeds up and you have trouble keeping up with your thoughts? Yes No Not Provided

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7. Drunk alcohol and/or used other drugs to alter the way you feel? Yes No Not Provided

Trauma

During the past year (12 months) have you:

- 1. Experienced a traumatic event, natural disaster, war, accident, injury, loss of a loved one? Yes No NP
- 2. Had periods of time where you felt that you could not trust family or friends? Yes No NP
- 3. Ever been afraid of your partner and/or a family member? Yes No NP
- 4. Ever been hit, slapped, kicked, emotionally or sexually hurt, or threatened? Yes No NP

Gambling

During the past year (12 months) have you:

- 1. Felt the need to bet more and more money? Yes No NP
- 2. Had to lie to people important to you about how much you gamble? Yes No NP

Child/Adolescent Section

- 1. Are you feeling mad, sad, hopeless, nervous, or have you had a change in your sleeping, eating or school performance? Yes No NP
- 2. Are you spending less time with friends, care less about your appearance, or feel alone? Yes No NP
- 3. Get into trouble for acting up, fighting, setting fires, hurting animals or tearing up stuff? Yes No NP
- 4. Have you ever experienced a very bad thing or person (traumatic event) where you continued to feel scared, worried, or nervous or even had nightmares that bothered you after it was all over? Yes No NP
- 5. Are you using alcohol and/or illegal drugs including inhalants? Yes No NP
- 6. Are you misusing any prescription medication or over the counter products? Yes No NP

Are you currently taking any medication including over the counter? Yes No NP

If so, please list medications: _____

Referred by (Primary): _____ (Secondary): _____

Reason for referral: _____ If referred by court/criminal justice system, county where the legal proceedings held? _____

Are you currently Homeless? Yes No If yes, for how long? _____

Been homeless at any time during the past 3 years? Yes No, If yes, # times: _____

Race (check all that apply): American Indian Black/African American Asian Native Hawaiian/Pacific Islander White Other Ethnicity: Hispanic/Latino

Emergency Contact Name: _____ Relationship (Rel): _____

Phone #: _____ Address: _____

Guardian/Custodian: _____ Rel: _____ Willing to Participate

Anyone you would choose to come and participate in your services? Yes No NP

Preferred Language: _____ Other Languages Spoken: _____

Need any special help/equipment? Yes No, If yes, describe: _____

<p>Disposition (for staff only):</p> <p><input type="checkbox"/> Referred for Assessment: Date/Time/Agency/Clinician _____</p> <p><input type="checkbox"/> Referred for Medical Assessment: Date/Time/Agency/Physician _____</p> <p><input type="checkbox"/> Consumer was informed regarding reasons for ineligibility <input type="checkbox"/> In Person <input type="checkbox"/> By Phone <input type="checkbox"/> In Writing</p> <p><input type="checkbox"/> Referral Source contacted (w/written consent) regarding reasons for ineligibility <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p>

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<input type="checkbox"/> Referral to Community Resources <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Specify: _____ <input type="checkbox"/> Other Pertinent Info _____ Staff Signature/Credentials: _____ Date: _____
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ASSESSMENT PORTION:

Date (mm/dd/yyyy): _____ Start Time: _____ End Time: _____

Source of Information/Relationship: _____

Significant other to notify in case of emergency: _____

Are other people living in household receiving/seeking services? Yes No ____#

MH _____ SA/Integrated Request _____

Presenting Problem(s) Including History: _____

Does consumer have a representative payee/guardian/conservator/personal representative?

Yes No Not Provided If yes, which one and who, Phone # and Address: _____
 Person & Property Person Property

Urgent needs: Risk for Self Harm Harm to Others Other: _____

Are risk taking behaviors present? Yes No If YES, describe: _____

Family:

Currently resides with: biological family adoptive family foster family other: _____
Please describe: _____

Problem areas: parenting conflict abuse/violence neglect communication marital
 sibling parent/child other: _____

Specific example, frequency, duration, and intensity: _____

Current Social Support (need for & availability): _____

Family (history of relationships w/ family): _____

Marital/Significant Other (relationship history, separations, divorce, functional level of current relations):

Social/Interpersonal:

Please describe: _____

Problem areas: peers/friends social interaction withdrawal make/keep friends conflict

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Specific example, frequency, duration, and intensity: _____

Historical relationships w/friends, groups in life and include natural supports: _____

Recreational/Leisure (previous and current abilities and/or interest, activities for relaxation and pleasure and community involvement): _____

Sexual (history, problems in intimate relationships, other significant experiences): _____

Sexual Orientation: _____

HIV/AIDS/STD at risk behaviors? Yes No If YES, describe: _____

Referrals given/where (ROI needed)? _____

Community Integration:

Cultural Orientation/Background/Ethnicity (how this relates to treatment):

Spiritual Beliefs/Religious Orientation(denomination)/and Grief Practices:

Self-care/Basic Needs:

Please describe: _____

Problem areas: hygiene food clothing shelter medical/dental transportation
 personal mobility communication hearing vision

Specific example, frequency, duration, and intensity: _____

Is there a need for assistive technology in the provision of services? Yes No If YES, describe: _____

Caregiver Resources (ex: a person(s) who give physical and emotional support): _____

Education (chronological seq/adjustment/difficulties/special ed/current/future plan:

Highest grade completed: _____ Level of Educational Functioning: _____

Level of Intellectual Functioning: below average average above average

Occupational/Vocational (past and present job roles, stability):

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Military History (combat?): _____

Functional Role Performance:

employment/volunteer school/day care home management other: _____

Level/effectiveness of functioning: _____

Economic Resources (past and present annual income/means of support/type insurance):

Current Socio/Legal Issues:

Problem areas: ability to follow rules/laws authority issues legal issues aggression
 probation/parole abides by personal ethical/moral value system antisocial behaviors

Evidenced by (specific examples, frequency, duration and intensity): _____

Has consumer ever been arrested? 6 months 30 days please describe: _____

Past legal involvement: _____

Attorney Name and Phone: _____

Probation/Parole Officer: _____

Does consumer have a history and/or current issues with Verbal Physical Sexual Neglectful
 Emotional abusive behavior? Yes No If YES, describe: _____

Have consumer received perpetrator treatment services? Yes No If YES, describe: _____

Medical/Physical Health:

Historical Medical/physical conditions: _____

Current condition of health (including diagnoses): _____

Female only - Is consumer pregnant? please indicate month (0 for NO, 1-9 for YES):

Impact/limitations on day-to-day function: _____

Adjustments to disorders/disabilities: _____

Adherence to Medication or Treatment Recommendations: _____

Name of Primary Care Physician, address, phone: _____

Psychiatric & Medical Medications:				
Name/Strength/Dos/Freq	Effectiveness/ Side Effects	Prescribing Physician	Reason	Date Prescribed

List any medications previously prescribed for mental health issues:

Does consumer have any medication/food allergies or adverse reactions? Yes No If YES, list: _____

Does consumer have a medical advance directive? Yes No

Does consumer have a psychiatric advanced directive? Yes No

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Are parents and/or guardians able and willing to participate in services? Yes No

Comments: _____

Name of school child currently attends: _____ grade: _____

Has anyone ever told you your child's milestones were not in normal range? Yes No

If YES, describe (walking, talking, toilet training, self dressing, etc.): _____

Have any concerns or problems related to Child's learning ability been identified? Yes No

If YES, Please describe: _____

Does your child have an IEP/504 plan? Yes No If YES, Please describe: _____

Is your child receiving school based behavioral health services? Yes No If YES, Please describe: _____

Please rate Child's development (compared to others of the same age) in the following areas:

- | | | | |
|--------------|--|--|--|
| Visual | <input type="checkbox"/> Below Average | <input type="checkbox"/> About Average | <input type="checkbox"/> Above Average |
| Social | <input type="checkbox"/> Below Average | <input type="checkbox"/> About Average | <input type="checkbox"/> Above Average |
| Physical | <input type="checkbox"/> Below Average | <input type="checkbox"/> About Average | <input type="checkbox"/> Above Average |
| Speech | <input type="checkbox"/> Below Average | <input type="checkbox"/> About Average | <input type="checkbox"/> Above Average |
| Intellectual | <input type="checkbox"/> Below Average | <input type="checkbox"/> About Average | <input type="checkbox"/> Above Average |
| Emotional | <input type="checkbox"/> Below Average | <input type="checkbox"/> About Average | <input type="checkbox"/> Above Average |
| Hearing | <input type="checkbox"/> Below Average | <input type="checkbox"/> About Average | <input type="checkbox"/> Above Average |
| Motor | <input type="checkbox"/> Below Average | <input type="checkbox"/> About Average | <input type="checkbox"/> Above Average |

For each type of development that consumer rated above as below average, please describe current areas of concern: _____

List consumer expectations/goals for treatment:

1. _____
2. _____
3. _____
4. _____

List consumer strengths & abilities

1. _____
2. _____
3. _____

List consumer needs & preferences for treatments

1. _____
2. _____
3. _____

DSM-IV-TR DIAGNOSIS:

AXIS I:

- | | |
|-------------|--------------|
| Code: _____ | Title: _____ |
| Code: _____ | Title: _____ |
| Code: _____ | Title: _____ |
| Code: _____ | Title: _____ |

AXIS II:

- | | |
|-------------|--------------|
| Code: _____ | Title: _____ |
| Code: _____ | Title: _____ |

AXIS III:

AXIS IV:

- Problem areas: primary support group social environment education housing
 economic occupation access to healthcare services Interaction with Legal System/Crime
 other: _____

AXIS V:

Current GAF: _____ Highest GAF past year: _____

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Potential Barriers (optional): med adherence treatment adherence home environment activity changes behavioral changes attitudinal changes education/training cultural/religious beliefs transportation

SEVERITY LEVEL: NA/None MILD MODERATE SEVERE

CAR DOMAIN SCORES (give range 0-9, 10-19, etc):

	Past	Current
Feeling Mood/Affect	_____	_____
Thinking Mental Processes	_____	_____
Substance Abuse	_____	_____
Medical/Physical	_____	_____
Family	_____	_____
Interpersonal	_____	_____
Role Performance	_____	_____
Socio-Legal	_____	_____
Self Care/Basic Needs	_____	_____

COMMUNICATION (ICF/MR level of care) ___ ESL ___ Hearing impaired ___ Non-verbal ___ Uses interpreter ___ Signs ___ Uses mechanical device ___ Speech impaired ___ Fluency

ASI SCORES (18 and over):

Scoring system below:

- 0 - 1 No problem, treatment not necessary
- 2 - 3 Slight problem, treatment probably not necessary
- 4 - 5 Moderate problem, treatment probably necessary
- 6 - 7 Considerable problem, treatment necessary
- 8 - 9 Extreme problem, treatment absolutely necessary

Stages of Change:

- Pre-contemplation
- Contemplation
- Preparation
- Action
- Maintenance

___ Medical ___ Employment/Support ___ Alcohol Use
___ Drug Use ___ Legal Status ___ Family/Social Relations ___ Psychiatric Status

T-ASI Scores (under 18, scoring 0-4):

___ Chemical ___ School ___ Employment/Support
___ Family ___ Peer/Social ___ Legal ___ Psychiatric

Case Management Needs Assessment:

- | | | |
|--|--|--|
| <input type="checkbox"/> Rental Assistance | <input type="checkbox"/> Dental | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Clothing | <input type="checkbox"/> Food | <input type="checkbox"/> School Supplies |
| <input type="checkbox"/> Tutor | <input type="checkbox"/> GED | <input type="checkbox"/> Medical |
| <input type="checkbox"/> Childcare | <input type="checkbox"/> Eye Exam/Glasses | <input type="checkbox"/> Support Group |
| <input type="checkbox"/> Prescription | <input type="checkbox"/> Phone Service | <input type="checkbox"/> Household Needs |
| <input type="checkbox"/> Hearing Aids | <input type="checkbox"/> Hard of Hearing Equip | <input type="checkbox"/> Consumer Progs |
| <input type="checkbox"/> Utilities (heating/cooling programs, electric or water bills) | | |
| <input type="checkbox"/> Financial Assistance for School | | <input type="checkbox"/> Assistive Tech |
| <input type="checkbox"/> Home Improvement/Handicap Accessibility | | |
| <input type="checkbox"/> Medication Evaluation | <input type="checkbox"/> Other: _____ | |

If there is any additional information consumer would like to include, please list here: _____

Disposition:

Admit

