

## BEHAVIORAL HEALTH ASSESSMENT

(Please provide the following information to assist your provider in making a complete evaluation)

<b>Part 1 – IDENTIFYING DATA</b>					
Name ( <i>Last, First, MI</i> )		Your SSN		Sponsor's SSN	
Age:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Race: <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Other (Please specify):			
Home Phone:		Work Phone:			
Cell phone/Pager:		E-mail address:			
Address:					
Who referred you to the clinic? <input type="checkbox"/> Self <input type="checkbox"/> Health Care Provider <input type="checkbox"/> Command-Directed <input type="checkbox"/> Other:					
Is English your primary Language? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, what is your primary language? _____ (Please inform the receptionist if you need assistance completing this form due to language difficulties.)					
<b>Part 1A – MILITARY INFORMATION (Active Duty Only)</b>					
Rank/Grade:	Branch of service: <input type="checkbox"/> USA <input type="checkbox"/> USN <input type="checkbox"/> USMC <input type="checkbox"/> USAF <input type="checkbox"/> USCG <input type="checkbox"/> Other		<input type="checkbox"/> Active <input type="checkbox"/> Guard <input type="checkbox"/> Reserve		Military occupational specialty:
Unit name, address and phone number:					
Commander / First Sergeant name and phone number:					
Time in service:	Time in current unit:		Work phone:		
List any deployments and combat experience: <input type="checkbox"/> OIF <input type="checkbox"/> OEF <input type="checkbox"/> Bosnia <input type="checkbox"/> Somalia <input type="checkbox"/> Desert Shield/Desert Storm <input type="checkbox"/> Panama <input type="checkbox"/> Grenada <input type="checkbox"/> Viet Nam <input type="checkbox"/> Other:					
<b>Part 2 – PRESENTING PROBLEM</b>					
What is (are) your reason(s) for coming in today?					
How long have you been experiencing these problems?					
Have you had difficulties like this before? <input type="checkbox"/> Yes <input type="checkbox"/> No ( <i>If yes, please explain</i> )					
Are you having any self-destructive or suicidal thoughts? <input type="checkbox"/> Yes <input type="checkbox"/> No ( <i>If yes, please explain</i> )					

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### Part 3 – PAST PSYCHIATRIC HISTORY

List any previous psychiatric or substance abuse evaluations, counseling or hospitalizations:

Reason	Location	Dates	Diagnosis (if known)

**Military Only** – Were any of the above evaluations, counseling or hospitalizations command directed?  Yes  No

List any previous psychiatric medication therapy:

Medication	Dates	Effectiveness	Side Effects	Reason for Discontinuation

Have you ever attempted suicide in the past?  Yes  No *(If yes, please explain)*

### Part 4 – MEDICAL HISTORY

Name and Location of Primary Care Provider:

Office Phone of Primary Care Provider:

List all allergies and reactions to medications:

List all medications that you are currently taking (please continue in Part 18 if more space required):

Name of Drug	Amount taken (dose)	Name of Drug	Amount taken (dose)

List all current and past medical or physical problems, including hospitalizations and traumatic injuries:

Are you currently experiencing severe pain, fever, dizziness, or lightheadedness?  Yes  No

If so, do you desire to see a physician for these problems?  Yes  No

List any over the counter medications

Herbal products

Supplements/Vitamins

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**Part 4A - PAIN ASSESSMENT**

Are you currently experiencing any physical pain?  Yes  No (If yes, please explain below)

**For provider only**

**Is Further evaluation or referral required?**

(If experiencing pain, please score your pain on a 10 point scale where 0 = no pain and 10 = worst pain imaginable)

Please score your pain: 0 1 2 3 4 5 6 7 8 9 10

YES  NO  
Use Initials

**Part 5 – SUBSTANCE USE ASSESSMENT**

In the past year, have you ever drunk alcohol or used drugs more than you intended?  Yes  No

In the past year, have you felt you wanted or needed to cut down on your alcohol or drug use?  Yes  No

What, if any, recreational or illicit drugs or medications have you used recently or in the past?

Did you ever find that you needed to drink a lot more or use more drugs in order to get an effect, or that you could no longer get high on the amount that you were using?  N/A  Yes  No

**For provider only**

**Is Further evaluation or referral required?**

YES  NO  
Use Initials

<b>AUDIT Screening Tool</b>	0	1	2	3	4
<b>Instructions: Please check the box that most applies to you.</b>	Never	Monthly or less	2-4 times monthly	2-3 times weekly	4 + times weekly
1. How often do you have a drink containing alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Never	Monthly or less	Monthly	Weekly	Daily or almost daily
3. How often do you have six or more drinks on one occasion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. How often during the last year have you found that you were not able to stop drinking once you had started?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. How often during the last year have you been unable to remember what happened the night before because of drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Never		Yes, but not in last year		Yes, during the last year
9. Have you or someone else been injured as a result of your drinking?	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
10. Has anyone been concerned about your drinking or suggested that you should cut down	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Total AUDIT Score					
	←				

**TOBACCO USE**

**CAFFEINE USE**

Do you smoke or use tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no please go to next section)	How many caffeinated beverages do you consume per day on average?
What do you smoke or use? <input type="checkbox"/> Cigarettes <input type="checkbox"/> Snuff <input type="checkbox"/> Cigars <input type="checkbox"/> Pipe	
How much do you use in a day?	Do you ever feel irritable, jumpy or nervous because of your caffeine use? <input type="checkbox"/> Yes <input type="checkbox"/> No
How long have you been using tobacco products?	
Do you wish to quit? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does caffeine use impair your sleep? <input type="checkbox"/> Yes <input type="checkbox"/> No

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**Part 6 – FAMILY PSYCHIATRIC HISTORY**

List any family members who have been diagnosed or treated for any of the mental health problems?

Relationship	Problem/Diagnosis	Hospitalized	Medications prescribed?
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Have there been any unnatural deaths or suicidal behavior in your family?  Yes  No (If yes, please explain)

**PART 7 – PSYCHOSOCIAL / DEVELOPMENTAL HISTORY**

Where were you born? Who raised you?  Both Parents  Mother  Father  
 Other Family  
 Foster Parent(s)  Adoptive Parent(s)  Other:

Were there any complications at birth?  Yes  No (If yes, please explain below)

How many siblings do you have and what number child were you?

What was it like in your childhood home?  Loving  Comfortable  Supportive  Chaotic  Abusive  Other:

What type of discipline was used in your childhood home?

Did you have any developmental delays or problems?  Yes  No (If yes, please explain below)

Have you ever been physically, sexually or emotionally abused? :  Yes  No (If yes, please explain)

**Part 8 - CURRENT FAMILY RELATIONSHIP ASSESSMENT**

Marital Status? If married, how long have you been married?  
 Single  Married  Divorced  Separated  Widowed

If married, are you currently having any stressors or problems in your marriage?  Yes  No  N/A (If yes, please explain)

Have you been married previously?  Yes  No  N/A (If yes, please explain)

Do you have any concerns about domestic violence or abuse?  Yes  No (If yes, please explain)

**For provider only**  
**Is Further evaluation  
or referral required?**  
 YES  NO  
Use Initials

Have you or any of your spouses ever been referred to any agency such as Child Protective Services or Family Advocacy?  
 Yes  No (If yes, please explain)

Please list all your children:  N/A (continue below, if needed)

Child's name	Child's age	Child's Gender	Biological or stepchild	Does this child currently reside with you?
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

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Does anyone else reside in your household?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>(If yes, please explain below)</i>
Are you having any problems with your children?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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**Part 9 – RISK ASSESSMENT**

Are there any firearms in your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>For provider only</b>  <b>Is Further evaluation or referral required?</b>  <input type="checkbox"/> YES <input type="checkbox"/> NO Use Initials
Is there any history of domestic violence in your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a history of suicidal or self-destructive thoughts or behaviors?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a history of homicidal (harm to others) thoughts or behaviors?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have any other safety concerns at this time?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Part 10 - SOCIAL SUPPORT ASSESSMENT**

Do you have someone to talk to when you have a problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there someone you would ask for help if you needed it?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you geographically separated from family and friends?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you having trouble with your relationships with family, friends or coworkers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you recently withdrawn from family or friends?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you belong to any groups or organizations that are supportive and helpful to you? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, please explain)</i>	

**Active Duty Only:** Do you feel supported and/or accepted by your unit?  Yes  No *(If NO, please explain)*

**Part 11 – SPIRITUAL/ CULTURAL ASSESSMENT**

What is your religious or spiritual affiliation?	<b>For provider only</b>  <b>Is Further evaluation or referral required?</b>  <input type="checkbox"/> YES <input type="checkbox"/> NO Use Initials
How much is your religion or spirituality a source of strength or comfort to you? <input type="checkbox"/> Not at all <input type="checkbox"/> Not very much <input type="checkbox"/> Somewhat <input type="checkbox"/> Quite a bit <input type="checkbox"/> A great deal	
How much is your spiritual community a source of support to you? <input type="checkbox"/> Not at all <input type="checkbox"/> Not very much <input type="checkbox"/> Somewhat <input type="checkbox"/> Quite a bit <input type="checkbox"/> A great deal	
Do you have any religious, spiritual or cultural practices that your provider needs to be aware of during treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, please explain)</i>	

**Part 12 - EDUCATIONAL ASSESSMENT**

Highest level of education completed? <input type="checkbox"/> GED <input type="checkbox"/> HS <input type="checkbox"/> Some College <input type="checkbox"/> 4yr College <input type="checkbox"/> Masters <input type="checkbox"/> Doctoral	
Are you currently in school or training?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did you repeat or skip any grades?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did you attend any special education or gifted classes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did you have any learning disabilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did you have any disciplinary problems in school?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, were you ever suspended or expelled?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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**PART 13 - LEGAL ASSESSMENT**

Have you ever been arrested?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>(If yes, please explain below)</i>
Are you currently on probation or parole?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you presently have any other legal problems ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**(Military only)** Have you ever had any administrative actions taken against you?  No  Yes *(If yes, please explain)*

- Negative counseling statement
- Letter of reprimand
- Article 15
- Court-martial
- Chapter

**Part 14 – SEXUAL ASSESSMENT**

Are you experiencing any sexual concerns?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>(If yes, please explain below)</i>
Have you ever been sexually abused, assaulted or harassed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Part 15 – LEISURE, RECREATIONAL AND VOCATIONAL ACTIVITIES**

What is your present job?

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Are there any problems with your present job?

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What do you like to do in your free time?

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What limits your ability or desire to participate in leisure and recreational activities?

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**Part 16 – NUTRITIONAL ASSESSMENT**

Height	Weight	How many pounds have you gained or lost in the last month? _____
		How many pounds have you gained or lost in the last 6 months? _____

How many meals do you eat per day?

Are you currently or have you ever had problems with: *(If checked, please explain)*

- Binge eating. Past or Current (circle one)
- Compulsive overeating. Past or Current (circle one)
- Self-induced vomiting. Past or Current (circle one)
- Laxative Abuse. Past or Current (circle one)
- Excessive dieting. Past or Current (circle one)
- Diuretic (Water pill) Abuse. Past or Current (circle one)
- Other eating disorders/problems (Please specify) \_\_\_\_\_ Past or Current (circle one)
- Currently enrolled in a Weight Control Program
- Do you have or have you ever been diagnosed with Diabetes, Hypertension, Crohn's Disease, Renal Disease or Coronary heart disease (Please circle all that apply).

**For provider only**

**Patient's BMI:** \_\_\_\_\_  
**BMI < 18.5\***  
**BMI > 30\***  
**5% loss/gain within 30 days**  
**or 10% loss/gain within 6**  
**months=\*\***  
**All other current items=\***

**Patient's nutritional risk is:**  
**(check one)**  
**Low=no \*** \_\_\_\_\_  
**Moderate=One \*** \_\_\_\_\_  
**High =Two\*** \_\_\_\_\_

**Referral to Primary Care or**  
**Nutritional Care (if**  
**available) is required for**  
**Moderate or High risk.**

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**Part 17 - FINANCIAL ASSESSMENT**

Do you currently have any financial problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>(If yes, please explain below)</i>
Do you think you need financial counseling?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<b><u>For provider only</u></b>  <b>Is Further evaluation or referral required?</b>  <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b> Use Initials

**Part 18 – PATIENT DISCLOSURE**

Please use this space to tell us anything additional that you may feel is relevant or may be important for your provider to know.

**Patient Signature and Date:** \_\_\_\_\_

Please list any individuals that you consent to have contacted regarding your care:

<input type="checkbox"/> Spouse	<input type="checkbox"/> Gather further information	<input type="checkbox"/> Release information	<input type="checkbox"/> Make recommendations
<input type="checkbox"/> Supervisor	<input type="checkbox"/> Gather further information	<input type="checkbox"/> Release information	<input type="checkbox"/> Make recommendations
<input type="checkbox"/> First Sergeant	<input type="checkbox"/> Gather further information	<input type="checkbox"/> Release information	<input type="checkbox"/> Make recommendations
<input type="checkbox"/> Commander	<input type="checkbox"/> Gather further information	<input type="checkbox"/> Release information	<input type="checkbox"/> Make recommendations
<input type="checkbox"/> Doctor	<input type="checkbox"/> Gather further information	<input type="checkbox"/> Release information	<input type="checkbox"/> Make recommendations
<input type="checkbox"/> Other Person or Agency	<input type="checkbox"/> Gather further information	<input type="checkbox"/> Release information	<input type="checkbox"/> Make recommendations

**(PATIENTS, DO NOT COMPLETE THE SECTION BELOW)**  
**PROVIDER REVIEW**

*I have reviewed this form for clinically relevant information.*

Additional Assessments:		Score:
OQ- 45	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Symptom Check List	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Beck Depression Inventory – II	<input type="checkbox"/> Yes <input type="checkbox"/> No	
PTSD Check List	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Post Deployment Health Assessment Tool	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Yale Brown Obsessive Compulsive Scale	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Folstein Mini Mental State	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Referrals made for further assessment:</b> <input type="checkbox"/> PCM (for medical issue or Pain > 4 / 10) <input type="checkbox"/> ASAP (for additional substance screening) <input type="checkbox"/> Family Advocacy (for suspected domestic abuse) <input type="checkbox"/> Psychiatrist/Psychologist (for Safety Assessment) <input type="checkbox"/> Chaplain <input type="checkbox"/> Nutrition <input type="checkbox"/> Army Community Service (for financial services)	<b>Comments:</b>	
Signature:		Date:

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