INTAKE ASSESSMENT

I. Identifying Information and Presenting Problem
    A. Name, Age, Marital status, Ethnicity, Gender
    B. Brief physical description of patient and presentation
    C. Mode of presentation (emergent walk-in versus scheduled, etc)
    D. Brief description of problem as presented (include patient's own words, symptoms, and complaints to describe the problem in detail, and "why now?")
    E. Source of information and reliability
II. History of the Problem
    A. Onset and precipitants of problem
    B. Detailed description of history of problem, including history of psychiatric symptoms (e.g., past suicidal ideation, history of mania, first panic attack, etc)
III. Current/Past Psychiatric History
    A. First contact
    B. Diagnosis and symptoms
    C. Type of treatment (hospitalizations, outpatient, medications, effects of treatment)
IV. Current/Past Alcohol, Tobacco, and/or Drug Use
    A. Name of substance(s)
    B. Frequency and amount
    C. Last time of use
    D. Presence of tolerance, withdrawal, black-outs
    E. Longest and most recent periods of abstinence
    F. Mode of use (smoke, snort, IV, etc)
    G. Treatment history (including AA, NA, etc)
        1. First contact
        2. Diagnosis and symptoms
        3. Type of treatment (hospitalizations, outpatient, medications, effects of treatment)
V. Family and Marital History
    A. Parents
        1. Marital history, description of their relationship
        2. Description of relationship with parents
        3. Age, health, work history
    B. Description of sibship
    C. Description of quality of family relationships
    D. Location of family members
    E. Family psychiatric and/or substance abuse history(whether formally diagnosed or not) and treatment including medications and hospitalizations
    F. Current and past relationship history (marital, sexual, dating, etc)
        1. Ages and functioning of children
        2. Description of relationship with current and former partners/spouses
VI. Social History
    A. Development/Early childhood environment

1. Birth and development (pregnancy/delivery, timing of developmental milestones, etc)
2. Developmental problems/medical abnormalities
3. Atmosphere (living conditions at home, school/peer relationships, etc)
4. History of childhood trauma, abuse, neglect, or isolation
5. Aggressive triad (fire-setting, bed-wetting, cruelty to animals)

B. Education
1. Highest level completed
2. Delays, learning disabilities, behavioral problems at school
a. Grades received (A's, B's, C's, etc)
b. Failures/Repeated grades or classes

C. Work history
1. Current position
a. Satisfaction, performance, productivity, discipline, status
2. Past work history
a. Types of jobs
b. Duration of jobs
c. Reasons for leaving previous jobs
3. Military history
a. Discharge status ("what would I find if I checked your military record?")
b. Involvement in combat

D. Social support system

E. Current home environment (who living with, quality of home relationships, etc)

F. History of arrests and other legal involvement or antisocial behavior

G. History of assault or abuse against or from others (family of origin, domestic partners, others)

H. Ownership or access to weapons (reasons for weapon use)

I. Financial status and financial history

J. Hobbies, interests, religion
1. Socialized or isolated
2. High-risk activities/hobbies

K. Self-description of personality

VII. Medical History/Status

A. Date of last physical exam, and name of primary care physician

B. Current use of medication (prescription, over-the-counter, herbal, other)

C. Current or past medical problems and/or illnesses/diseases, including chronic pain
1. Review of systems
2. History of trauma
a. Loss of consciousness
b. Head injury, motor vehicle accidents, fights, etc
c. Developmental delays, birth traumas/defects

D. History of surgeries

E. Drug/medication allergies

VIII. Mental Status

A. General appearance, orientation, and behavior

1. Orientation to place, time, and person
2. Speech
    a. Rate, rhythm, volume
    b. Pressure, hesitance, spontaneity, coherence
3. Motoric behaviors (tics, tremor, agitation, retardation)
4. Attitude and interpersonal posture (imposing, cowering, self-assured, pleasant, cooperative, etc)
5. Appearance (grooming, appropriately dressed, etc)

B. Thought Process

1. Loose associations, tangential or circumstantial thought process, derailment
2. Goal oriented, reality based, logically flows

C. Thought content

1. Hallucinations or illusions
    a. Auditory, visual, tactile, olfactory (smell), gustatory (taste)
2. Delusions
    a. Paranoia, persecutory, grandiosity, referential, body control, thought insertion/broadcasting/withdraw, peculiarities of thoughts
3. Other signs of psychosis

D. Vegetative symptoms

1. Sleep disturbance (delayed sleep onset, fitful/non-restful sleep, early morning awakenings, hypersomnia, nightmares/night terrors, sleep walking)
2. Appetite disturbance (increase or decrease in appetite, eating behavior, weight, tolerance of food, etc)
3. Energy level disturbance (increase or decrease in energy level, motivation, passivity, goal-directed behavior, etc)
4. Slowness/retardation of thoughts and cognitive functioning
5. Crying episodes (frequency, duration, sense of control over, appropriateness of)

E. Stated mood (use patient's own words), observed mood, and range of affect [note: there is considerable overlap from other sections to assist with diagnostic conceptualization]

1. Presence or absence of manic/hypomanic symptoms
    a. Rapid/pressured speech, flight of ideas/racing thoughts
    b. Increased energy, psychomotor agitation, increased sexuality, impulsive spending, etc
    c. Expansiveness, irritability, grandiosity, elevated self-attitude
    d. Decreased need for sleep
2. Presence or absence of depressive symptoms
    a. Low mood
    b. Decreased energy, psychomotor retardation or agitation
    c. Anhedonia (lack of interest/pleasure in activities that were previously interesting/pleasurable), decreased interest in sex

d. Feelings of hopelessness and helplessness, decreased future orientation, poor self-attitude/self-regard
e. Isolative/avoidant behavior
f. Impaired concentration/attention/memory
g. Passive death wish/Suicidal thoughts, intentions, or gestures/behaviors
h. Drastic change (increase or decrease) in sleep and/or appetite

3. Presence or absence of anxiety symptoms
a. Anxiousness, anxiety, irritability, agitation, excessive worry
b. Panic attacks, agoraphobia, social phobia, simple phobias
c. Obsessive thoughts and/or compulsive behaviors
d. Re-experiencing phenomena (flashbacks, nightmares, intrusive thoughts/images)
e. Avoidance behaviors

F. Appropriateness, congruence, and range of affect

G. Assessment of suicidal risk and homicidal risk
1. Presence of suicidal/homicidal ideations and/or passive death wish
2. History of suicidal/homicidal ideations/behavior (describe in detail)
3. Presence of suicide/homicide plan (describe in detail)
a. Intention, access to means, lethality of plan
4. Ratings on Suicide Status Form (brief summary of self-description and/or results from administration of the SSF)
a. Degree of "Psychological Pain" (low pain - intolerable pain)
b. Degree of "External Pressures/Stressors" (low external pressures - high external pressures)
c. Degree of "Agitation/Perturbation" (low agitation - high agitation)
5. Protective factors against carrying out plan (e.g., family and friends, religious beliefs, future plans/goals, enjoyable things, etc)

H. Cognitive functioning
1. Attention, concentration, memory
2. Estimated intelligence level, fund of knowledge, use of language

I. Ego functions
1. Judgment, insight, impulse control

IX. Diagnostic Formulation

A. Initial diagnostic impression (Axes I, II, and III), including rule-out and previous diagnoses received

B. Formulation and description of the dynamics of the problem(s)
1. General summary of pertinent points above to justify/explain diagnosis and lead up to a logical explanation of your reasoning regarding the recommended disposition
2. General impressions regarding precipitating factors, stressors, patient's level of insight/understanding, "at-risk" factors, and overall assessment of risk
3. Defense mechanisms employed and their adaptability at this point, patient's strengths

4. Psychological testing data (e.g., MMPI-2, NEO, SCL-90, etc)

X. Disposition

A. Immediate plan

1. Date and time of next appointment

2. Names and phone numbers of others consulted with (e.g., Psychiatry resident in the ER, primary care physician, supervisor, spouse, etc)

3. Description of other actions taken (provided supportive session, referred to an outpatient therapist, escorted to the Psychiatric ER, inpatient bed held at treatment facility, etc)

4. Rationale for not taking more extreme or more conservative actions which demonstrates and documents that you have considered and ruled out these courses of action (e.g., "inpatient psychiatric admission not deemed necessary at this time because Pt's suicidal ideations are of a passive nature, she denied intention, reported no history of previous attempt/gestures, and her husband has agreed to closely monitor and support Pt until she is to be re-evaluated by Dr Smith in two days from now")

B. Patient's reaction to disposition

C. Follow-up tasks for therapists/others involved in case

Intake Note Outline. Revised: January 29, 2001