 **Missouri Mental Health Intake & Evaluation Form**

**Patient Name:**

**Medical Record #:** Click here to enter text.

**Date of Birth:** select month select day select year

**Current Age:** Click here to enter text.

**Date Service Provided:** Click here to enter a date.

**Primary Care Provider:** Click here to enter text.

**Reason for Referral:**

**Service(s) Provided:** select an option

**Evaluation Procedures:**

Interview withselect an option

Review of records

Psychological testing: select an option

Click here to enter text.

**Background Information**

**Medical History:**

|  |  |  |
| --- | --- | --- |
| see medical chart for details  addiction  cardiac illness  hypertension | diabetes  sleep disorder  fertility issues | per patient history is significant for chronic pain  nutrition/obesity/eating disorder  other |

**Additional Comments:**

**Current Medications per patient:** Click here to enter text.

**Current Functioning**

**Orientation:** select an option

**Appearance/Personal Hygiene:** select an option

**Eye Contact:** select an option

**Psychosis:** select an option

**Hallucinations:** None Auditory visual olfactory gustatory

**Delusions:** Bizarre Grandiose Jealousy Nihilistic Persecutory Reference Somatic

**Homicidal Ideation/Intentions:** select an option

**Duty to Protect process completed**

**Insight:** select an option

**Intelligence:** select an option

**Memory/Cognition:** select an option

**Mood/Affect:**

|  |  |  |
| --- | --- | --- |
| Angry  Anxious  Appropriate  Bright  Distressed  Fatigued  Flat | Expressing Guilt  Hopeful  Being Irritable  Labile  Expressing Loss of Pleasure  Being Sad | Suspicious  Tearful  Having Trouble Concentrating  Withdrawn  Expressing Worthlessness  Expressing Worry  Difficult or Unable to Assess |

**Suicidal Ideation/Intentions:** select an option

Frequency of occurrence: Click here to enter text.

How long does it last: Click here to enter text.

Intensity of suicidal thoughts: Click here to enter text.

Reasons individual would rather die than live: Click here to enter text.

**Detailed Plan:** select an option

Plan location: Click here to enter text.

How lethal is the method: Click here to enter text.

Access to lethal methods: Click here to enter text.

If firearms, are they being removed from patient access: select an option

**Steps taken to enact plan:** select an option

Rehearsal behaviors: Click here to enter text.

Obtained access: Click here to enter text.

Details: Click here to enter text.

**Thought Process:**

|  |  |  |
| --- | --- | --- |
| Blocking  Circumstantial  Clang Associations  Coherent  Egocentric | Evasive  Flight of ideas  Incoherent, Logical  Loose Associations  Magical thinking | Neologisms  Perseveration  Rational  Tangential  Word Salad |

**Test Results and Interpretation:**

*(add as needed)*

**Problem List:**

|  |  |  |  |
| --- | --- | --- | --- |
| No HTN  DM  Lipids  heart disease  smoking  mental illness | learning/cognitive impairment  compliance difficulties  Hypertension  Diabetes mellitus  Hyperlipidemia | Prior TIA / stroke  Coronary heart disease  Smoking history  Obesity  Sedentary lifestyle | Cognitive impairment  Seizure disorder  Compliance issues  Mood disorder  Personality disorder  Thought disorder |

**Additional Comments:**

**Diagnosis:** select an optionselect an option

select an option select an option

select an option select an option

select an option select an option

select an option select an option

select an option select an option

**Treatment Plan/Recommendations:**

Type you name here as a signature Click here to enter a date.

Insert Clinician’s Name Here Date