 **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] Labile[ ] Expressing Loss of Pleasure[ ] Being Sad  | [ ] Suspicious[ ] Tearful[ ] Having Trouble Concentrating[ ] Withdrawn[ ] Expressing Worthlessness[ ] Expressing Worry[ ] Difficult or Unable to Assess |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