BEHAVIORAL HEALTH INTAKE -
PSYCHOSOCIAL HISTORY & ASSESSMENT

For use of this form, see MEDCOM Reg 40-XX (Pending assignment), the proponent agency is MCHO-CL-H

Welcome and thank you for your service to our Country. Please complete the following information so that we may conduct a thorough assessment and better serve you and your family. Place a check mark or "X" in the boxes, as applicable, and answer all questions as thoroughly as possible. ***Please feel free to ask for assistance, if needed.***

SECTION I - IDENTIFYING DATA

A. SPONSOR:

Name (Last, First, Middle Initial):

Social Security Number:

Today's Date:

Rank/Grade:

Date of Birth/Age:

Gender: ☐Male ☐Female

Relationship Status:
☐Single Single, Intimately Involved ☐Married
☐Divorced ☐Separated ☐Widowed

Cultural Affiliation *(Check all that apply)*:
☐African American ☐American Indian ☐Asian
☐Caucasian ☐Hispanic ☐Other:

Military Affiliation: ☐Active Duty ☐AD/Reserve or National Guard
☐Family Member ☐Reserve or National Guard
☐Retired ☐Family Member of Retired Military
☐Other:

Branch of Service:
☐Army ☐Air Force ☐Coast Guard
☐DoD ☐Marine Corps ☐Navy
☐Other:

Time In Service: _____ Years _____ Months

MOS/AOC:

Job Title:

Job Description:

Unit:

Commander & 1SGs Name:

Unit Phone:

Home Address:

Email Addresses:

Home Phone:

Work Phone:

Cell Phone:

May we leave a message? Home: ☐No ☐Yes Work: ☐No ☐Yes Cell: ☐No ☐Yes
Email: ☐No ☐Yes Other: _____

Emergency Contact Name/Relationship:

Phone Number(s):

B. SPOUSE / INTIMATE PARTNER / NEXT OF KIN:

For Provider Use Only

Name (Last, First, Middle Initial):

SSN:

Gender: ☐Male ☐Female

Rank/Grade:
☐N/A

Date of Birth/Age:

Relationship to Sponsor: ☐Spouse ☐Co-Parent
☐Intimate Partner ☐Next of Kin ☐Other:

Relationship Status:
☐Single ☐Single, Intimately Involved
☐Married ☐Divorced ☐Separated
☐Widowed ☐Not Applicable

Cultural Affiliation (Check all that apply):
☐African American ☐American Indian
☐Asian ☐Caucasian ☐Hispanic
☐Other:

Home Address:

Email:

Home Phone:
Work Phone:
Cell Phone:

Employed:
☐No ☐Yes

Employer Name and Location:

May we leave a message? Home: ☐No ☐Yes / Work: ☐No ☐Yes / Cell: ☐No ☐Yes / Email: ☐No ☐Yes

C. CHILDREN:

Name (Last, First, Middle Initial)	SSN	Sex	Age / Date of Birth	Race	Grade / School	Living with you?
		☐M ☐F	/		/	☐No ☐Yes
		☐M ☐F	/		/	☐No ☐Yes
		☐M ☐F	/		/	☐No ☐Yes
		☐M ☐F	/		/	☐No ☐Yes
Are you or partner pregnant?	☐No ☐Yes	☐M ☐F	Months Pregnant:	Anticipated Birth Date:		

D. OTHERS LIVING IN HOME:

Name (Last, First, Middle Initial)	SSN	Sex	Age / Date of Birth	Race	Relationship:
		☐M ☐F	/		Mother / Father / Other:
		☐M ☐F	/		Mother / Father / Other:

SECTION II - MEDICAL SUPPORT TEAM

Commander / First Sergeant / Platoon Sergeant:

Nurse Case Manager:

Physician:

Behavioral Health/**Social Work Care** Manager:

Other Providers:

Referral Source? ☐Self ☐Command ☐Medical / Provider
☐SRP ☐Reverse SRP ☐PHA/PDHRA ☐Other:

For Provider Use Only

SECTION III - MOBILIZATION & DEPLOYMENT

Mob / Deployment Location	Departure Date	Return Date	Combat Exposure	Combat Related Injuries
			☐No ☐Yes	☐No ☐Yes
			☐No ☐Yes	☐No ☐Yes
			☐No ☐Yes	☐No ☐Yes

Perceived level of threat during any deployment: High Medium Low
Explain if High or Medium:

Do you expect: ☐MEB ☐REFRAD ☐ETS ☐Remain on Active Duty

Additional comments:

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**FMP/SPONSOR SSN**:

SECTION IV - PRESENTING PROBLEM(S)

For Provider Use Only

A. ISSUES & GOALS

In order to help us determine the best treatment plan, please list the main issues or goals you would like assistance with:

1.

2.

3.

4.

B. STRESSORS *(Check all that apply)*

Marital/Relationships:

- ☐Recent or pending divorce
- ☐Separation
- ☐Infidelity
- ☐Abuse
- ☐Fighting/Disagreements
- ☐Alcohol/Drugs
- ☐Sexual
- ☐Death
- ☐Birth
- ☐Illness (EFMP)

Social:

- ☐Loss of friend(s)
- ☐Broken romance
- ☐Loneliness
- ☐Lack of Social Support
- ☐Transportation
- ☐Religious/Spiritual
- ☐Neighbor/Housing
- ☐Other (Describe)

Military:

- ☐Deployment
- ☐Recent Move
- ☐Pending Move
- ☐Job Related
- ☐ETS/Retirement
- ☐Chapter / Separation
- ☐Promotion issues
- ☐Weight/PT problems

Legal:

- ☐Letter of Reprimand
- ☐Article 15
- ☐Court Martial
- ☐Arrested
- ☐Probation/ Parole
- ☐Criminal
- ☐Family
- ☐Child Custody
- ☐Protective Order
- ☐DUI

Personal:

☐Financial ☐Mental Health ☐Illness ☐Injury
☐Physical Assault ☐Sexual Assault ☐Other: _____

Occupational:

☐Conflict with supervisor(s) ☐Discrimination ☐Other: _____
☐Excessive hours ☐Harassment
☐Fired/Relieved ☐Boring/Meaninglessness

SECTION V - BEHAVIORAL / MENTAL HEALTH

A. DEPRESSION

What is your current level of **emotional pain or distress**? Rating: _____

0--------1--------2--------3--------4--------5--------6--------7--------8--------9--------10
Pain Free Mild Moderate Severe Totally Disabling

F1-1

During the past month, have you often been bothered by feeling down, depressed, or hopeless?
… ☐No ☐Yes

During the past month, have you often been bothered by little interest or pleasure in doing things?
… ☐No ☐Yes

In the past have, you suffered any emotionally or physically traumatic event? ☐No ☐Yes
(If "Yes," please explain)

Have you experienced a recent loss (including separation / divorce)? ☐No ☐Yes
(If "Yes," please explain)

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**FMP/SPONSOR SSN**:

SECTION V - BEHAVIORAL / MENTAL HEALTH (Continued)

For Provider Use Only

B. SELF HARM

Are you having thoughts of **harming or killing yourself**? ☐No ☐Yes — F1-2

Do you have a **plan to harm yourself** (shoot self, overdose, cut self with knife, hang self, etc.)? ☐No ☐Yes — F1-3

Do you have access to a means to carry out a plan to hurt yourself (knives, rope, gun, drugs/medications, etc.)? ☐N/A ☐No ☐Yes — F1-4

Have you ever tried to harm yourself? ☐No ☐Yes
(If "Yes," please explain – include history of suicide thoughts, gestures, attempts, etc.) — F1-5

Are you hopeful about your future? ☐Yes ☐No — F1-6

How often do you perceive you have failures in your life?
☐Never ☐Rarely ☐Occasionally ☐Frequently — F1-7

Have you ever been diagnosed with a mental health condition/illness by a health care provider?
(If "Yes," please explain) ☐No ☐Yes — F1-8

IF YOU RESPONDED POSITIVELY TO ANY OF THE ABOVE BEHAVIORAL / MENTAL HEALTH QUESTIONS, COMPLETE THE DEPRESSION SCALE.

***DEPRESSION SCALE** ☐
***SUICIDE PREV PLAN** ☐

C. MENTAL STATUS

During the past week, have you had thoughts "racing" through your head? ☐No ☐Yes — F2-1

Do you believe you have special powers? ☐No ☐Yes — F2-2

Do you hear voices or are you "seeing things"? ☐No ☐Yes — F2-3

Do you believe that people are watching you [paranoia]? ☐No ☐Yes — F2-4

<u>POSITIVE</u> RESPONSES TO MENTAL STATUS QUESTIONS REQUIRE FULL ASSESSMENT------

FULL MSE ☐

D. ANXIETY / PANIC

Do you have any problems with anxiety, "nerves" or panic attacks? ☐No ☐Yes — F3-1

Have you ever experienced a sudden surge of overwhelming discomfort or extreme "anxiety" that came on without any warning or for no apparent reason? ☐No ☐Yes — F3-2

Do you avoid certain people, places, conversations, or other non-combat situations because you are concerned that you may experience a sudden surge of overwhelming discomfort or "anxiety"? ☐No ☐Yes — F3-3

***ANXIETY SCREEN** ☐

E. POST TRAUMATIC STRESS

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, <u>in the past month</u>, you…

1. Have had **nightmares** about it or thought about it when you did not want to? ☐No ☐Yes — F3-4
2. **Tried** hard not to think about it or went out of your way to avoid situations that reminded you of it? ☐No ☐Yes — F3-5
3. Were constantly on guard, watchful, or easily startled? ☐No ☐Yes — F3-6
4. Felt numb or detached from others, activities, or your surroundings? ☐No ☐Yes — F3-7

IF YOU RESPONDED "YES" TO ANY OF THE QUESTIONS IN THIS SECTION, COMPLETE THE PTSD CHECKLIST.

***PTSD CHECKLIST** ☐

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**FMP/SPONSOR SSN**:

F. ANGER / AGGRESSION INCLUDING DOMESTIC VIOLENCE

For Provider Use Only

Are you currently angry at anyone or about any situation? ☐No ☐Yes
(If "Yes," please explain) — F4-1

Do you have thoughts or plans to harm or kill another person? ☐No ☐Yes
(If "Yes," please explain) — F4-2

Have you recently broken objects or hurt yourself, others (emotionally, physically, sexually), or an animal due to your anger? ☐No ☐Yes — F4-3

Are you currently involved in physical, emotional or sexual abuse of anyone (including family members)? ☐No ☐Yes — F4-4

Do you currently have a restraining or protection order in place against you? ☐No ☐Yes — F4-5

Have you ever been charged or convicted of an offense of assault, battery or abuse? ☐No ☐Yes — F4-6

Do you have weapons in your home (firearms, switchblades, knife collections, etc.)? ☐No ☐Yes — F4-7

Have you recently had a relationship break-up, separation, or divorce due to you or your intimate partner's anger/aggressive behavior? ☐No ☐Yes — F4-8

(If "Yes," are you in agreement with the break-up / separation / divorce?) ☐N/A ☐Yes ☐No) — F4-9

DV RISK SCREEN ☐
SAFETY PLAN ☐
***VICTIM IMPACT STMT** ☐

G. SUBSTANCE USE

1. Have you ever felt you should cut down on your drinking? ☐No ☐Yes — F5-1
2. Have people annoyed you by criticizing your drinking? ☐No ☐Yes — F5-2
3. Have you ever felt bad or guilty about your drinking? ☐No ☐Yes — F5-3
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)? ☐No ☐Yes — F5-4
   Reference: Mayfield, D., McLeod, G. & Hall, P. (1974)
5. Do you drink alcohol or use drugs to cope with stress? ☐No ☐Yes — F5-5

Are you currently using any controlled or illegal substances (i.e., marijuana, cocaine, crack, stimulants, sedatives, tranquilizers, heroin, opiates, psychedelics)?
(If "Yes," please explain) ☐No ☐Yes — F5-6

***DRUG ABUSE / DEPENDENCE SCREEN** ☐

Are you currently misusing prescribed medications, herbal supplements/remedies, sports nutritional supplements? ☐No ☐Yes — F5-7

Have you been involved in any alcohol or drug treatment? ☐No ☐Yes — F5-8

Have you ever dropped out or failed any prior alcohol or drug treatment? ☐No ☐Yes

***ALCOHOL USE SCREEN** ☐

IF YOU RESPONDED "YES" TO ANY OF THE QUESTIONS IN THIS SECTION, COMPLETE THE AUDIT SCREEN.

H. BEHAVIORAL / MENTAL HEALTH HISTORY

Have you ever received counseling or mental health services? ☐No ☐Yes
(If "Yes," please explain)

Diagnosis	Location	Hospitalized?	Date Treatment Began	Date Treatment Ended
		☐No ☐Yes		
		☐No ☐Yes		
		☐No ☐Yes		

Have you ever been diagnosed with: Adjustment Disorder, Depression, Bi-Polar, Anxiety, PTSD, Acute Stress Reaction or Personality Disorder? *(Circle all applicable diagnoses)* ☐No ☐Yes

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**FMP/SPONSOR SSN**:

SECTION VI - PSYCHOSOCIAL HISTORY

For Provider Use Only

A. EARLY CHILDHOOD & FAMILY RELATIONSHIPS

Where were you born?

Current age of mother: _____ Occupation: _____
Current age of father: _____ Occupation: _____
Either parent deceased? _____

Are your parents still married to one another? ☐Yes ☐No

If they are divorced, how old were you when they divorced?

Who raised you?	Where were you raised?
How many biological brothers do you have?	How many biological sisters do you have?
How many step-brothers do you have?	How many step-sisters do you have?

What number child are you in the birth order?

What was it like in your childhood home? ☐Loving ☐Comfortable ☐Supportive ☐Chaotic ☐Abusive ☐Other (please describe):

Was your family: ☐Poor ☐Lower Middle Class ☐Middle Class ☐Upper Middle Class ☐Wealthy

Were you adopted? ☐No ☐Yes If yes, at what age?

Did your parents physically fight? ☐Never ☐Rarely ☐Sometimes ☐Often

Were you emotionally, physically or sexually abused, neglected or sexually assaulted as a child or an adult?
(If "Yes," please explain) ☐No ☐Yes

F6-1

Please identify any mental health issues that seem to "run in the family" or have occurred in family members in the past:
☐Alcoholism/Drug Addiction ☐Anxiety ☐Attention Deficit Hyperactivity Disorder
☐Depression ☐Hyperactivity ☐Manic-Depression/Bi-Polar Disorder
☐Schizophrenia ☐Sexual Abuse ☐Suicide ☐Other:
Please explain any identified issues:

B. MARRIAGE & RELATIONSHIPS

Are you currently married? ☐No ☐Yes
(If "No," skip to "If not married" below)

How long have you been married?
___ Years ___ Months

Are you currently living with your spouse? ☐Yes ☐No

How many times have you been married? _____ Your Partner? _____

Date of marriage	Date of divorce or death of spouse	Reason the relationship ended

If not married, are you currently in a relationship? ☐No ☐Yes
If "Yes," how long have you been involved with that person? _____ Years _____ Months

Please rate your satisfaction with your marriage/relationship: Rating: _____

0--------1--------2--------3--------4--------5--------6--------7--------8--------9--------10
Completely Satisfied Satisfied Dissatisfied

F6-2

Are you experiencing any problems with your spouse or in your relationship? ☐No ☐Yes
(If "Yes," please explain)

F6-3

Has past deployment(s) impacted your marriage, relationship, and family? ☐No ☐Yes
(If "Yes," please explain)

Do you and your children feel safe from domestic abuse at home? ☐Yes ☐No

***MARITAL SCREEN** ☐

CHILD ABUSE RISK SCREEN ☐

SAFETY PLAN ☐

F6-4

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**FMP/SPONSOR SSN**:

C. CHILDREN & HOME

For Provider Use Only

Are you currently having any problems with your children? ☐**N/A** ☐No ☐Yes
(If "Yes," please explain) **F6-5**

☐Abuse / Neglect ☐Behavior ☐Illness / Disability / EFMP
☐Child Care ☐School Problems ☐Special Issues
☐Parenting / Nurturing ☐Mental Health
☐Other: _____

Have you, your family or a person you are currently in a relationship with ever been to counseling or had involvement with any agency such as Child Protective Services or Family Advocacy due to physical, sexual, or emotional abuse or neglect? *(If "Yes," who participated in the counseling; please explain)* ☐No ☐Yes **F6-6**

Are you involved in the care of any family member for illness or otherwise? ☐No ☐Yes
(If "Yes," please explain)

D. EDUCATION

Highest level of education completed: ☐ Elementary ☐ Junior High ☐ High School
☐ Technical School ☐ Some college ☐ 2-Year college degree
☐ 4-Year college degree ☐ Graduate school ☐ Other:

If you did not graduate from high school, did you get your GED? ☐**N/A** ☐Yes ☐No

Did you repeat any grades? ☐No ☐Yes
(If "Yes," please explain)

Were you ever in special education classes or did you have a learning disability? ☐No ☐Yes **F7-1**
(If "Yes," please explain)

Did you have any disciplinary problems in school? ☐No ☐Yes

Were you ever suspended or expelled? ☐No ☐Yes
(If "Yes" to either question, please explain)

E. FINANCIAL

Do you currently have any financial problems? ☐No ☐Yes **F7-2**
(If "Yes," please explain)

Are you currently having any of the following problems? *(Select all that apply)*
☐Garnished wages ☐Filed bankruptcy ☐Bounced checks
☐No money for food ☐Late on payments or loans
☐Item repossession ☐Disciplined for debts or bad checks
☐Having "no pay due" ☐Pawning items to make ends meet
☐Other:

Do you need a referral to an agency for financial assistance/counseling? ☐No ☐Yes

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**FMP/SPONSOR SSN**:

F. ENVIRONMENT / SUPPORT SYSTEMS

For Provider Use Only

Do you have good social support systems (friends, family, neighbors, co-workers, organizations, etc.)? List your support systems: ☐Yes ☐No — F7-3

Are you having trouble in your relationships with family or friends? ☐No ☐Yes — F7-4

Do those surrounding you have sufficient knowledge about your condition? ☐Yes ☐No

Do you have adequate housing or a place to live? ☐Yes ☐No

Who do you rely on for help with problems? (e.g. family, friends, extended family)
Names:

Services you are currently receiving:

☐Alcohol and Drug ☐Army Community Services ☐Chaplains ☐Child Care/CYS
☐Child and Adolescent Counseling ☐Child Protective Services ☐Community Health Nurse
☐Community Mental Health ☐Court Mandated Counseling ☐English as a Second Language
☐Family Readiness Group ☐Family Member Employment Assistance Program
☐Legal Services ☐Marriage and Family Counseling ☐New Parent Support Program
☐Respite Care ☐School Counselor ☐Social Work Service
☐Special Needs Assistance Program (SNAP) ☐Tri-Care (Counseling/Psychiatric Care)
☐Use of Shelter ☐Victim Advocate ☐Others:

G. EMPLOYMENT

Are there any problems with your civilian or military job? ☐No ☐Yes — F7-5
(If "Yes," please explain)

Do you need a referral for civilian employment or vocational rehabilitation? ☐No ☐Yes

If Reservist or National Guard, what is your civilian occupation?

Are you returning to your job? ☐Yes ☐No
(If "No," please explain)

What are your plans:
☐Stay in and re-enlist ☐Stay in until my ETS
☐Get out ASAP with a good discharge ☐Get out ASAP with any discharge
☐I don't know right now ☐Other: _____

Partner's Occupation:
Length of Employment: _____ Years _____ Months
If unemployed, how long since last employment: _____ Years _____ Months

H. LEGAL

Do you presently have any legal problems? ☐No ☐Yes — F7-6
(If "Yes," please explain)

Have you ever had any administrative or legal action taken against you?
☐No ☐Yes *(If "Yes," please select all that apply)*
☐Letter of Reprimand ☐Article 15 ☐Court Martial ☐Chapter ☐Arrest ☐DUI
☐Other: _____ Reason for action:

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**FMP/SPONSOR SSN**:

I. LEISURE AND RECREATION

Please list activities which you enjoy or have enjoyed in the past, including hobbies, volunteer work, sports, etc.

J. SPIRITUAL AND CULTURAL

What is your religious or spiritual affiliation?

Are you an active participant with your religious/spiritual affiliation? ☐Yes ☐No

What is your cultural affiliation/heritage (i.e., American Indian, Asian, Irish, Hispanic, etc.)?

Do you have any religious or spiritual practices that the provider needs to be aware of during treatment? *(If "Yes," please explain)* ☐No ☐Yes

SECTION VII - HEALTH HISTORY

A. PHYSICAL HEALTH

How would you describe your physical health? ☐Excellent ☐Good ☐Fair ☐Poor F8-1

Current medical treatment: ☐None ☐Inpatient ☐Outpatient w/out Follow-up ☐Outpatient with Follow-up

MEDICAL HISTORY: List any medical conditions you have or have had:

Medical Diagnosis	Diagnosis Date	Treatment Completion Date	Provider

Were any of these illnesses/injuries combat or deployment related? ☐No ☐Yes
(If "Yes," where and when?)

What physical limitations do you have as a result of your illness/injury(s)?

B. MEDICATIONS

List ***ALL*** medications, over-the-counter or herbal supplements/remedies you are currently using, the dosage and the prescribing provider, if applicable: ☐**N/A**

Medication	Dosage	Prescribing Provider

Are you currently taking your prescribed medications as prescribed? ☐N/A ☐Yes ☐No F8-2
(In "No," please explain):_____

Are you satisfied with how your medications are working? ☐Yes ☐No
(If "No," please explain): _____

For Provider Use Only

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**FMP/SPONSOR SSN**:

C. TRAUMATIC BRAIN INJURY (TBI) & CONCUSSION

Did any injury received while you were deployed result in being dazed, confused or "seeing stars", not remembering the injury, losing consciousness (knocked out), having symptoms of concussion (headaches, dizziness, memory problems, balance problems, ringing in ears, irritability, sleep problems, etc.)? ☐No ☐Yes

Did you have any **concussions or open or closed head injuries** during deployment? ☐No ☐Yes

Have you had a **previous history of a TBI or concussion**? ☐No ☐Yes

D. PAIN

Are you experiencing physical pain today? (*If "Yes," please explain)* ☐No ☐Yes

Please rate the severity of your pain: Rating Injury/Illness #1:_____ Rating Injury/Illness #2:_____

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

Pain Free Mild Moderate Severe Totally Disabling

If you have physical pain, are you being treated for that pain? ☐N/A ☐Yes ☐No

(If "Yes," where or by whom?)

E. SLEEP

Are you experiencing difficulty sleeping? ☐No ☐Yes

(If "Yes," please explain) ☐Falling Asleep ☐Staying Asleep ☐Waking During Sleep

Are you taking medications (over-the-counter or prescribed) to help you sleep? ☐No ☐Yes

F. NUTRITION

Have you ever had problems with your weight or eating habits? ☐No ☐Yes

(If "Yes," please explain – include weight gain and loss and body image issues)

Have you ever had problems with binge eating or compulsive overeating, or purging (making yourself vomit or using laxatives to excess)? ☐No ☐Yes

(If "Yes," please explain)

SECTION VIII - ADDITIONAL INFORMATION

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

For Provider Use Only

F8-3
***TBI SCREEN** ☐

F8-4

F8-5

F8-6
If "**NO**," refer for pain management, if needed ☐

F8-7

***To be completed by patient, when indicated. All other screens completed by provider based on assessment/ intervention with patient.**

Person filling out this form:

☐ Sponsor ☐ Spouse ☐ Caregiver ☐ Other: _____

I have completed all information accurately and completely.

Signature of Patient/Family Member/Guardian or Caregiver:

Date:

Provider Signature & Stamp:

Installation Name:

Date:

THANK YOU -- PLEASE STOP HERE

The remainder of this form is for Provider Use Only

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**FMP/SPONSOR SSN**:

For Provider Use Only

CASE MANAGEMENT COMPLEXITY WORKSHEET FOR BEHAVIORAL HEALTH SOCIAL WORK CARE MANAGERS

	Rating 0 to 10*	Complexity Rating Scale Key* / Examples
Effort Scale**		
Injuries / Illnesses	Unk	
-Number of	0 1 2 3 4 5 6 7 8 9 10	PTSD, Back, Neck & Shoulder = 7 Rating
-Complexity of	0 1 2 3 4 5 6 7 8 9 10	Several Surgeries Required = 5 Rating
Medications	0 1 2 3 4 5 6 7 8 9 10	Pain & Behavioral Health Meds = 5 Rating
Requirements		
-Appointments	0 1 2 3 4 5 6 7 8 9 10	Medical/Mental Health/Dental/Support/Social
-Resources	0 1 2 3 4 5 6 7 8 9 10	Patient & Family
-Information / Education	0 1 2 3 4 5 6 7 8 9 10	Patient & Family
Functioning Scale		
Patient Functioning	0 1 2 3 4 5 6 7 8 9 10	Fair Functioning = 7
Patient As Own Advocate	0 1 2 3 4 5 6 7 8 9 10	Good Functioning = 3
Support System Strength	0 1 2 3 4 5 6 7 8 9 10	Good = 2
Provider Strength	0 1 2 3 4 5 6 7 8 9 10	Strong Skills & Knowledge = 0
Time Scale		
Care Coordination	0 1 2 3 4 5 6 7 8 9 10	Amount of Time (Patient & Family) (Team meetings, consultations, scheduling appointments, contacting collaterals)
Support Required	0 1 2 3 4 5 6 7 8 9 10	Length of Time (Patient & Family)
Add columns for Total _____ Divided by 12 = _____		
COMPLEXITY SCALE RATING: ☐ LOW ☐ MODERATE ☐ HIGH		
PROVIDER FINAL RATING: ☐ LOW ☐ MODERATE ☐ HIGH		

*Complexity Rating Scale Key

Effort**	Functioning	Rating & Rating Total	Amount of Time	Length of Time
None	Excellent	0	None	None
Low	Good	Low – 0-4	30-60 minutes/week	<30 days
Moderate	Fair / Limited	Mod – 5-7	60-180 minutes/week	30-120 days
High	Poor	High – 8-10	>180 minutes/week	>120 days

Based on effort to support patient including level of coordination and advocacy required. ***Score all "unknown" responses as 5.*

EXAMPLE: Patient with PTSD, back and neck pain, & shoulder injury; multiple medications (>5); requires multiple appointments; requires financial assistance, vocational rehabilitation referral and information on diagnosis and symptoms.

SCORING: Effort-7+5+4+4+5+4=29; Function-4+3+3+1=11; Time-6+9=15; Total-55/12=5 (MOD).

Items to consider: Appointments for medical, dental, behavioral health (depression, self-harm, anxiety, anger, grief, PTSD, alcohol & drugs, mental health, marital/relationship/family issues, domestic violence, child abuse, psychological assessments); rehabilitative care; home health supplies and assistance (TBI, prosthetics, blind, spinal cord injury); pain management; nutrition; lack of support (family, guardian, social); child issues (child care, exceptional needs); financial; employment; housing; legal (family, guardian, UCMJ, administrative); educational; leisure activities; spiritual; cultural; vocational rehabilitation; community resource referrals (local support groups); Veteran's Administration; Social Security Administration; family/guardian support; etc. MEDCOM BHD SWP 28 Jan 09

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**FMP/SPONSOR SSN**:

BEHAVIORAL HEALTH INTAKE-PSYCHOSOCIAL HISTORY & ASSESSMENT (BHI-PHA)

ASSESSMENT TOOLS

FOR BEHAVIORAL HEALTH SOCIAL WORK CARE MANAGERS IN MTFS, WTUs AND CBWTUs

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**FMP/SPONSOR SSN**:

To be completed by Patient

ALCOHOL USE

Date: _____

ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT)

Please circle the answer that is correct for you.

1. How often do you have a drink containing alcohol?

   Never | Monthly or less | Two to four times a month | Two to three times a week | Four or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

   1 or 2 | 3 or 4 | 5 or 6 | 7 to 9 | 10 or more

3. How often do you have six or more drinks on one occasion?

   Never | Less than monthly | Monthly | Weekly | Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

   Never | Less than monthly | Monthly | Weekly | Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

   Never | Less than monthly | Monthly | Weekly | Daily or almost daily

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?

   Never | Less than monthly | Monthly | Weekly | Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

   Never | Less than monthly | Monthly | Weekly | Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

   Never | Less than monthly | Monthly | Weekly | Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

   No | Yes, but not in the last year | Yes, during the last year

10. Has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

    No | Yes, but not in the last year | Yes, during the last year

SCORING: Questions 1-8 are scored 0, 1, 2, 3 or 4. Questions 9 and 10 are scored 0, 2 or 4 only. The response is as follows:

Question	0	1	2	3	4
1	Never	Monthly or less	Two to four times per month	Two to three times per week	Four or more times per week
2	1 or 2	3 or 4	5 to 6	7 to 9	10 or more
3-8	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
9-10	No		Yes, but not in the last year		Yes, during the last year

The minimum score (for non-drinkers) is 0 and the maximum possible score is 40.
A score of 8 or more indicates a strong likelihood of hazardous or harmful alcohol consumption.

REFERENCE: Saunders, J. B., Aasland, O. G., Babor, F., et al. (1993). Development of the alcohol use disorders screening test (AUDIT). WHO collaborative project on early detection of persons with harmful alcohol consumption, II. Addiction, 88, 791-804.

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**FMP/SPONSOR SSN**:

To be completed by Patient

ANXIETY SCREEN

OVERALL ANXIETY SEVERITY AND IMPAIRMENT SCALE (OASIS)

The following items ask about anxiety and fear. For each item, circle the number for the answer that best describes your experience over the past week.

1. In the past week, how often have you felt anxious?

0 = **No anxiety** in the past week.
1 = **Infrequent** anxiety. Felt anxious a few times.
2 = **Occasional** anxiety. Felt anxious as much of the time as not. It was hard to relax.
3 = **Frequent** anxiety. Felt anxious most of the time. It was very difficult to relax.
4 = **Constant** anxiety. Felt anxious all of the time and never really relaxed.

2. In the past week, when you have felt anxious, how intense or severe was your anxiety?

0 = **Little or None**: Anxiety was absent or barely noticeable.
1 = **Mild**: Anxiety was at a low level. It was possible to relax when I tried. Physical symptoms were only slightly uncomfortable.
2 = **Moderate**: Anxiety was distressing at times. It was hard to relax or concentrate, but I could do it if tried. Physical symptoms were uncomfortable.
3 = **Severe**: Anxiety was intense much of the time. It was very difficult to relax or focus on anything else. Physical symptoms were extremely uncomfortable.
4 = **Extreme**: Anxiety was overwhelming. It was impossible to relax at all. Physical symptoms were unbearable.

3. In the past week, how often did you avoid situations, places, objects, or activities because of anxiety or fear?

0 = **None**: I do not avoid places, situations, activities, or things because of fear.
1 = **Infrequent**: I avoid something once in a while, but will usually face the situation or confront the object. My lifestyle is not affected.
2 = **Occasional**: I have some fear of certain situations, places, or objects, but it is still manageable. My lifestyle has only changed in minor ways. I always or almost always avoid the things I fear when I'm alone, but can handle them if someone comes with me.
3 = **Frequent**: I have considerable fear and really try to avoid the things that frighten me. I have made significant changes in my life style to avoid the object, situation, activity, or place.
4 = **All the Time**: Avoiding objects, situations, activities, or places has taken over my life. My lifestyle has been extensively affected and I no longer do things that I used to enjoy.

4. In the past week, how much did your anxiety interfere with your ability to do the things you needed to do at work, at school, or at home?

0 = **None**: No interference at work/home/school from anxiety.
1 = **Mild**: My anxiety has caused some interference at work/home/school. Things are more difficult, but everything that needs to be done is still getting done.
2 = **Moderate**: My anxiety definitely interferes with tasks. Most things are still getting done, but few things are being done as well as in the past.
3 = **Severe**: My anxiety has really changed my ability to get things done. Some tasks are still being done, but many things are not. My performance has definitely suffered.
4 = **Extreme**: My anxiety has become incapacitating. I am unable to complete tasks and have had to leave school, have quit or been fired from my job, or have been unable to complete tasks at home and have faced consequences like bill collectors, eviction, etc.

5. In the past week, how much has anxiety interfered with your social life and relationships?

0 = **None**: My anxiety doesn't affect my relationships.
1 = **Mild**: My anxiety slightly interferes with my relationships. Some of my friendships and other relationships have suffered, but, overall, my social life is still fulfilling.
2 = **Moderate**: I have experienced some interference with my social life, but I still have a few close relationships I don't spend as much time with others as in the past, but I still socialize sometimes.
3 = **Severe**: My friendships and other relationships have suffered a lot because of anxiety. I do not enjoy social activities. I socialize very little.
4 = **Extreme**: My anxiety has completely disrupted my social activities. All of my relationships have suffered or ended. My family life is extremely strained.

SCORING: Add the numbers of the 5 items circled. Score of 8 and above indicates probable anxiety disorder; pending further evaluation by Dr. Norman, et al. in 2007.
REFERENCE: Norman, Sonya B., Ph.D., et al. (2006) and Laura Campbell-Sills, Ph.D.

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**FMP/SPONSOR SSN**:

CHILD ABUSE/NEGLECT RISK SCREEN

CHILD ABUSE/NEGLECT
RISK LEVEL - QUICK SCREEN

Patient/Child's Name: _____ **Date:** _____
Interviewed: Mother / Father / Children: _____ /
Other: _____ (May include provider/screener observations)

Instructions: Check applicable boxes to indicate "yes" as to the presence of the risk factors below:

	Mother	Father	Children	Other
1. Child(ren) is under 36 months old.	☐	☐	☐	☐
2. Poor parent-child bonding / attachment/nurturing skills.	☐	☐	☐	☐
3. Parent(s) is experiencing moderate to severe anxiety or depression.*	☐	☐	☐	☐
4. Parent(s) is suicidal / homicidal.*	☐	☐	☐	☐
5. Parent(s) is suffering from post-partum depression or psychosis.*	☐	☐	☐	☐
6. Parent(s) abuses alcohol and/or other substances.*	☐	☐	☐	☐
7. Parent(s) reports feeling overwhelmed / stressed.	☐	☐	☐	☐
8. Parent(s) displays anger/hostility during visit / assessment.	☐	☐	☐	☐
9. Parent(s) is socially isolated / lonely or lacks support systems.	☐	☐	☐	☐
10. Parent(s) has thoughts of harming child.	☐	☐	☐	☐

ESTIMATED RISK (Circle one): LOW / MODERATE / HIGH RISK /

UNABLE TO DETERMINE

This checklist is provided for use as a guide to identify factors which place a victim at "high risk" of abuse and is not inclusive of all risk factors. All suspected child abuse including cases estimated to be at high risk requires referral to Social Work Service. Consult with Social Work Service for further guidance, if needed.

***Requires referral to Behavioral Health Service and/or Substance Abuse Services, as applicable.**

MEDCOM FAP Update: 28 Jan 09

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**FMP/SPONSOR SSN**:

DEPRESSION SCALE - PHQ-9

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ **DATE:** _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
add columns:		+	+	
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) **TOTAL:**				

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	**Not difficult at all** _____ **Somewhat difficult** _____ **Very difficult** _____ **Extremely difficult** _____

ZT274388

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**FMP/SPONSOR SSN**:

DEPRESSION SCALE - PHQ-9
SCORING

INSTRUCTIONS FOR USE

for doctor or healthcare professional use only

PHQ-9 QUICK DEPRESSION ASSESSMENT

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment on accompanying tear-off pad.
2. If there are at least 4 ✓s in the blue highlighted section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.
3. ***Consider Major Depressive Disorder***
   —if there are at least 5 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)

   Consider Other Depressive Disorder
   —if there are 2 to 4 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician and a definitive diagnosis made on clinical grounds, taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying PHQ-9 Scoring Card to interpret the TOTAL score.
5. Results may be included in patients' files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

PHQ-9 SCORING CARD FOR SEVERITY DETERMINATION

for healthcare professional use only

Scoring—add up all checked boxes on PHQ-9

For every ✓: Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
0-4	None
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**FMP/SPONSOR SSN**:

For Provider Use Only

DOMESTIC VIOLENCE SCREEN

DOMESTIC VIOLENCE
RISK LEVEL - QUICK SCREEN

Date:_____

Patient's Name: _____ **Victim or Alleged Offender** (Circle One)
Interviewed: Victim / Alleged Offender / Other: _____

Instructions: Check applicable boxes to indicate the presence of the risk factors below. All questions apply to both victim and alleged offender, unless otherwise specified.

	Yes	No	Unk	N/A
1. Recent separation/divorce from partner against partner's wishes.	☐	☐	☐	☐
2. Perceived infidelity.	☐	☐	☐	☐
3. Victim has imminent fear of their partner.	☐	☐	☐	☐
4. Any threat to kill self or others.*	☐	☐	☐	☐
5. High/intense family conflict.	☐	☐	☐	☐
6. Harassing or stalking victim.	☐	☐	☐	☐
7. Escalation in severity, frequency and intensity of abuse by partner.	☐	☐	☐	☐
8. Strangled or attempted to strangle partner in the past.	☐	☐	☐	☐
9. Access to or threatened use of a weapon.	☐	☐	☐	☐
10. Destroyed property in any relationship conflict.	☐	☐	☐	☐
11. Current injuries to the victim.	☐	☐	☐	☐
12. High levels of anger/hostility.*	☐	☐	☐	☐
13. Experiencing moderate to severe anxiety or depression.*	☐	☐	☐	☐
14. Abuse of alcohol and/or other substances.*	☐	☐	☐	☐

ESTIMATED RISK (Circle one): LOW / MODERATE / HIGH RISK / UNABLE TO DETERMINE

This checklist is provided for use as a guide to identify factors which place a victim at "high risk" of abuse and is not inclusive of all risk factors. All intimate partner abuse including cases estimated to be at high risk requires referral to Social Work Service. Consult with Social Work Service for further guidance, if needed.

***Requires referral to Behavioral Health Service and/or Substance Abuse Services, as applicable.**

MEDCOM FAP Update: 28 Jan 09

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**FMP/SPONSOR SSN**:

To be completed by Patient

DRUG ABUSE / DEPENDENCE SCREEN

DRUG ABUSE / DEPENDENCE SCREENER

Here is a list of drugs:

- Marijuana, hashish, pot, grass
- Amphetamines, stimulants, uppers, speed
- Barbiturates, sedatives, downers, sleeping pills, seconal, quaaludes
- Tranquilizers, Valium, Librium
- Cocaine, coke, crack
- Heroin
- Opiates, codeine, Demerol, morphine, methadone, Darvon, opium
- Psychedelics, LSD, Mescaline, peyote, psilocybin, DMT, PCP

1. Have you ever used one of these drugs on your own more than 5 times in your life? By "on your own," I mean to get high or without a prescription or more than was prescribed.

☐ Yes = 1; ☐ No = 0

2. Did you ever find you needed larger amounts of these drugs to get an effect or that you could no longer get high on the amount you used to use?

☐ Yes = 1; ☐ No = 0

3. Did you ever have emotional or psychological problems from using drugs - such as feeling crazy or paranoid or depressed or uninterested in things?

☐ Yes = 1; ☐ No = 0

Scoring: *Consider screen positive for lifetime drug abuse/dependence if item 1 = Yes and either item 2 or 3 = Yes*

REFERENCES

Rost, K., Burnam, A., & Smith, G. R. (1993). Development of screeners for depressive disorders and substance disorder history. Medical Care, 31, 189-200.

Schorling, J. B., & Buchsbaum, D. G. (1997). Screening for alcohol and drug abuse. Medical Clinics of North America, 81, 845-65.

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**FMP/SPONSOR SSN**:

MARITAL QUALITY SCREEN

Quality of Marriage Index (QMI)

Please rate the following statements about your spouse or significant other by circling the appropriate number:

	Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
1. We have a good relationship.	1	2	3	4	5
2. My relationship with my partner is very stable.	1	2	3	4	5
3. Our relationship is strong.	1	2	3	4	5
4. My relationship with my partner makes me happy.	1	2	3	4	5
5. I really feel like a part of a team with my partner.	1	2	3	4	5
6. Everything considered, I am happy in my relationship.	1	2	3	4	5

REFERENCE

Norton, R. (1983). Measuring marital quality. A critical look at the dependent variable. *Journal of Marriage and the Family.*

SCORING: There is no scoring mechanism for this assessment tool.

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**FMP/SPONSOR SSN**:

For Provider Use Only

MENTAL STATUS EVALUATION

Date: _____

APPEARANCE:

Build: ☐Well-Developed ☐Undernourished/Slight ☐Overweight/Obese

Dress: ☐Neat ☐Meticulous ☐Appropriate ☐Inappropriate (describe): _____

Grooming: ☐Neat ☐Meticulous ☐Poor

BEHAVIOR:

Motor: ☐WNL ☐Agitation/Restlessness ☐Retardation

☐Unusual Mannerisms ☐Other (describe): _____

Verbal: ☐WNL ☐Hyper-verbal ☐Pressured ☐Loud ☐Interjects/Interrupts

☐Mumbling ☐Quiet ☐Slow to Respond

☐Other: _____

ATTITUDE: ☐Cooperative ☐Uncooperative ☐Demanding ☐Hostile ☐Frank

☐Dramatic ☐Guarded ☐Entitled

☐Other: _____

SENSORIUM AND COGNITION:

Level of Consciousness: ☐Alert ☐Clouding of Consciousness ☐Stuporous

☐Delirious ☐Psychotic ☐Intoxicated

☐Other: _____

Orientation: ☐Fully Oriented Oriented to: ☐Person ☐Time ☐Place ☐Purpose

☐Not Oriented

Receptive and expressive speech: ☐Appeared intact ☐Deficits in Receptive Speech (describe): _____

☐Deficits in Expressive Speech (describe): _____

Memory: Short-term: ☐Good ☐Fair ☐Impaired Long-term: ☐Good ☐Fair ☐Impaired

☐Impaired Recent ☐Impaired Remote

Attention: ☐Good ☐Fair ☐Impaired Concentration: ☐Good ☐Fair ☐Impaired

Fund of knowledge: ☐Above Average ☐Average ☐Below Average Abstraction: ☐Good ☐Fair ☐Poor

Intelligence: ☐Above average ☐Average ☐Below Average

Thought processes: ☐WNL ☐Flight of ideas ☐Slowed ☐Loose Associations

☐Circumstantial ☐Tangential ☐Incoherent ☐Other: _____

Thought content: ☐Unremarkable ☐Delusions ☐Hallucinations ☐Preoccupations

☐Obsessions ☐Compulsions ☐Phobias

☐Antisocial urges ☐Other formal disturbances of thought (describe): _____

INSIGHT AND JUDGMENT:

Insight: ☐Good ☐Fair ☐Impaired Judgment: ☐Good ☐Fair ☐Impaired

MOOD AND AFFECT:

Mood: ☐Euthymic ☐Depressed ☐Anxious ☐Angry/Irritable

☐Euphoric ☐Resigned ☐Hopeless ☐Other: _____

Affect: ☐Congruent with Mood ☐Depressed ☐Anxious

☐Angry/Irritable ☐Euphoric ☐Resigned ☐Hopeless

☐ Other: _____

SAFETY ASSESSMENT:

SI: ☐Thoughts ☐Intent ☐Plan Self-Harm: ☐Thoughts ☐Intent ☐Plan Weapons: ☐No ☐Yes

HI: ☐Thoughts ☐Intent ☐Plan Harm to Others: ☐Thoughts ☐Intent ☐Plan

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**FMP/SPONSOR SSN**:

To be completed by Patient

POST TRAUMATIC STRESS

Date: _____

PTSD CheckList (PCL-17)

Instruction to Patient: Below is a list of problems and complaints that veterans sometimes have in response to stressful life experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem ***in the last month.***

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing *memories, thoughts,* or *images* of a stressful experience from the past?					
2.	Repeated, disturbing *dreams* of a stressful experience from the past?					
3.	Suddenly *acting* or *feeling* as if a stressful experience *were happening again* (as if you were reliving it)?					
4.	Feeling *very upset* when *something reminded* you of a stressful experience from the past?					
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past?					
6.	Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?					
7.	Avoid *activities* or *situations* because *they remind you* of a stressful experience from the past?					
8.	Trouble *remembering important parts* of a stressful experience from the past?					
9.	Loss of *interest in things that you used to enjoy?*					
10.	Feeling *distant* or *cut off* from other people?					
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?					
12.	Feeling as if your *future* will somehow be *cut short*?					
13.	Trouble *falling* or *staying asleep*?					
14.	Feeling *irritable* or having *angry outbursts*?					
15.	Having *difficulty concentrating*?					
16.	Being *"super alert"* or watchful on guard?					
17.	Feeling *jumpy* or easily startled?					

PCL for DSM-IV (11/1/94). Weathers, Litz, Huska, & Keane, National Center for PTSD – Behavioral Science Division. Correlates highly with PTSD if at least 1 symptom from q. 1-5; 3 symptoms from q. 6-12; and 2 symptoms from q. 13-17 are endorsed "moderately" or above.

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**FMP/SPONSOR SSN**:

For Provider Use Only

PTSD CHECKLIST
SCORING

PCL: Post-Traumatic Stress Disorder (PTSD) Checklist

The PCL is a standardized self-report rating scale for PTSD comprising 17 items that correspond to the key symptoms of PTSD. Two versions of the PCL exist:

1) PCL-M is specific to PTSD caused by military experiences
2) PCL-C is applied generally to any traumatic event

The PCL can be easily modified to fit specific time frames or events. For example, instead of asking about "the past month," questions may ask about "the past week" or be modified to focus on events specific to a deployment.

How is the PCL completed?

- The PCL is self-administered
- Respondents indicate how much they have been bothered by a symptom over the past month using a 5-point (1–5) scale, circling their responses. Responses range from **1** *Not at All* – **5** *Extremely*

How is the PCL Scored?

1) Add up all items for a total severity score

or

2) Treat response categories **3–5** (*Moderately* or above) as symptomatic and responses **1–2** (below *Moderately*) as non-symptomatic, then use the following DSM criteria for a diagnosis:
   - Symptomatic response to at least 1 "B" item (Questions 1–5),
   - Symptomatic response to at least 3 "C" items (Questions 6–12), and
   - Symptomatic response to at least 2 "D" items (Questions 13–17)

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**FMP/SPONSOR SSN**:

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SAFETY PLAN for ANGER / AGGRESSION / DOMESTIC VIOLENCE

Date: _____

Patient informed of level of risk and/or potential lethality? ☐No ☐Yes

Patient informed of safety alternatives available (911, Shelter, etc.)? ☐No ☐Yes

Victim Advocate/counselor involved? ☐No ☐Yes

Arrangements made for safety of children? ☐No ☐Yes ☐N/A

Child Protective Services notified? ☐No ☐Yes ☐N/A

Commander notified: ☐No ☐Yes

Protective measures discussed and in place (i.e., protective orders, no contact order, restricted to barracks, restricted to post, escort assigned, removal of weapons, and removal of children)? ☐No ☐Yes *(If yes, describe measures)*

Law enforcement notified? ☐No ☐Yes ☐N/A

Offender compliant with Protective Orders? ☐No ☐Yes ☐N/A

Weapons Secured? ☐N/A ☐No ☐Yes, Where:

Victim referred to additional resources? ☐No ☐Yes, list referrals:

Additional Considerations:

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**FMP/SPONSOR SSN**:

To be completed by Patient

SUICIDE PREVENTION PLAN

I will take the following actions if I am ever suicidal:

1) CALL 911 if I believe that I am in immediate danger of harming myself.

2) CALL FAMILY MEMBER OR FRIENDS:

_____ **Name and Phone Number**

_____ **Name and Phone Number**

_____ **Name and Phone Number**

3) GO TO my local Emergency Room for immediate care needed.

4) CALL MY COUNSELOR:

_____ **Name and Phone Number**

5) CALL 1-800-SUICIDE (24-hour suicide prevention line), if having suicidal thoughts or need to speak with someone to prevent me from harming myself.

6) I will continue talking on the phone with as many people as necessary for as long as necessary until the suicidal thoughts have subsided.

7) Other coping strategies: _____

_____

_____

My Signature: _____ **Date:** _____

Buddy Support Signature: _____ **Date:** _____

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**FMP/SPONSOR SSN**:

To be completed by Patient

TRAUMATIC BRAIN INJURY (TBI) SCREEN

3 Question DVBIC TBI Screening Tool

1. Did you have any injury(ies) during your deployment from any of the following? (check all that apply):

A. ☐ Fragment
B. ☐ Bullet
C. ☐ Vehicular (any type of vehicle, including airplane)
D. ☐ Fall
E. ☐ Blast (Improvised Explosive Device, RPG, Land mine, Grenade, etc.)
F. ☐ Other specify: _____

2. Did any injury received while you were deployed result in any of the following? (check all that apply):

A. ☐ Being dazed, confused or "seeing stars"
B. ☐ Not remembering the injury
C. ☐ Losing consciousness (knocked out) for less than a minute
D. ☐ Losing consciousness for 1-20 minutes
E. ☐ Losing consciousness for longer than 20 minutes

NOTE: Endorsement of A-E meets criteria for positive TBI Screen

F. ☐ Having any symptoms of concussion afterward (such as headache, dizziness, irritability, etc.)
G. ☐ Head Injury

NOTE: Confirm F and G through clinical interview

H. ☐ None of the above

3. Are you currently experiencing any of the following problems that you think might be related to a possible head injury or concussion? (check all that apply):

A. ☐ Headaches
B. ☐ Dizziness
C. ☐ Memory problems
D. ☐ Balance problems
E. ☐ Ringing in the ears
F. ☐ Irritability
G. ☐ Sleep problems
H. ☐ Other specify:_____

Schwab, K. A., Baker, G., Ivins, B., Sluss-Tiller, M., Lux, W., & Warden, D. (2006). The Brief Traumatic Brain Injury Screen (BTBIS): Investigating the validity of a self-report instrument for detecting traumatic brain injury (TBI) in troops returning from deployment in Afghanistan and Iraq. *Neurology, 66*(5)(Supp. 2), A235.

For more information contact:
Telephone: 1-800-870-9244 Email: info@DVBIC.org Web: www.DVBIC.org

PATIENT IDENTIFICATION (Last, First, Middle Initial):	**FMP/SPONSOR SSN**:

3 Question DVBIC TBI Screening Tool Instruction Sheet

Purpose and Use of the DVBIC 3 Question TBI Screen

The purpose of this screen is to identify service members who may need further evaluation for mild traumatic brain injury (MTBI).

Tool Development

The 3 Question DVBIC TBI Screening Tool, also called The Brief Traumatic Brain Injury Screen (BTBIS), was validated in a small, initial study conducted with active duty service members who served in Iraq/Afghanistan between January 2004 and January 2005.

Schwab, K. A., Baker, G., Ivins, B., Sluss-Tiller, M., Lux, W., & Warden, D. (2006). The Brief Traumatic Brain Injury Screen (BTBIS): Investigating the validity of a self-report instrument for detecting traumatic brain injury (TBI) in troops returning from deployment in Afghanistan and Iraq. *Neurology, 66*(5)(Supp. 2), A235.

Who to Screen

Screen should be used with service members who were injured during combat operations, training missions or other activities.

Screening Instructions

Question 1: A checked **[√]** response to any item A through F verifies injury.

Question 2: A checked **[√]** response to A-E meets criteria for a positive (+) screen. Further interview is indicated. A positive response to F or G does not indicate a positive screen, but should be further evaluated in a clinical interview.

Question 3: Endorsement of any item A-H verifies current symptoms which may be related to an MTBI if the screening and interview process determines a MTBI occurred.

Significance of Positive Screen

A service member who endorses an injury [Question 1], as well as an alteration of consciousness [Question 2 A-E], should be further evaluated via clinical interview because he/she is more highly suspect for having sustained an MTBI or concussion. The MTBI screen alone does not provide diagnosis of MTBI. A clinical interview is required.

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To be completed by Patient

VICTIM IMPACT STATEMENT

VICTIM NAME (Last, First):	Example*:	DTA Summary
ACT — **DESCRIBE THE INCIDENT and identify the level of force (LOF) used on a scale of 1 to 10 (1=lowest; 10=highest):**	Twisted my left arm (LOF: 4) and pushed me into the car (LOF: 8) causing my head to hit the car.	YES / NO FORCE #1:
	(e.g., Yelling, Name Calling, Threatening, Throwing Objects, Pushing, Grabbing, Shaking, Throwing, Scratching, Pinching, Biting, Slapping, Hitting, Stabbing, Kicking, Cutting Off Air Supply, Choking; Applying Force to the Throat, Holding Under Water, Using a Weapon, Sexual Abuse/Assault/Grooming, Stalking, Neglect)	FORCE #2:
IMPACT — **DESCRIBE PHYSICAL INJURIES, duration of injuries, and duration of pain from the injuries:**	Red marks which remained on my arm for two days and a bruise to my left arm which lasted a week; the pain lasted at least four hours.	YES / NO
	Red mark and bump on my head which lasted for a week; the pain lasted over four hours	
If no injuries, do you believe there was **potential for injury or harm**? Yes or No		YES / NO
DESCRIBE PSYCHOLOGICAL IMPACT:	I was scared and anxious and could not sleep that night because I was afraid and kept thinking about the incident. I had to go to the doctor because I was depressed and anxious and keep thinking that the incident might happen again. I cannot sleep at night sometimes and am frequently late to work because I cannot get up in the morning. My doctor diagnosed me with Adjustment Disorder and I'm on medication	YES / NO
Scale: 0=No Fear and 10=Very Fearful. (Circle appropriate number.)		
DURING THE INCIDENT, what was your LEVEL OF FEAR? **0----1----2----3----4----5----6----7----8----9----10**	Level of Fear (During): 8 Fear of harm to self or others	LEVEL OF FEAR:
48 HOURS *after* the INCIDENT, what was your LEVEL OF FEAR? **0----1----2----3----4----5----6----7----8----9----10**	Level of Fear (48 hours after): 6 (e.g., Persistent recollections of the incident, avoidance of cues or the abuser, hyper-arousal, anxiety, anger, exaggerated startle response, etc.)	LEVEL OF FEAR:
DESCRIBE PHYSICAL COMPLAINTS (somatic) due to the incident:	My stomach has been hurting and I have a lot of back pain now; I have been having headaches	YES / NO
	(Stress-related physical ailments, i.e., aches and pains, migraines, stomach problems, etc.)	
DESCRIBE IMPACT OF ACT/INCIDENT(S) on your lifestyle (social - family/friends, employment, education, community activities, etc.).	Yes, I am afraid to ask for money and to use the car. I feel afraid to tell my family what is going on because my spouse will get angry; therefore, I have isolated myself from my friends and family. I lost my job because my spouse kept calling or interfering with my work.	YES / NO
***Child Incidents Only*: Has the act/incident(s) or failure to act interfered with child's physical or mental health, development, socialization, education/school, ability to relate to others, etc.?**	Yes, my child had multiple medical appointments due to his injury and was failing school due to the emotional stress caused by the abuser.	YES / NO
	*Applies to either male or female victim.	

FAP VICTIM IMPACT STATEMENT INSTRUCTIONS:

Victim completes the left side of the form, the Assigned Worker completes the right side. The right side of the form has to do with the Decision Tree response. A "yes" response means that the Act or Impact met criteria for the act or impact. A "no" response means that the Act or Impact did not meet criteria for act or impact.

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