Name: DOB: SS#:

care resource
Your One Source

GROUP INTAKE QUESTIONNAIRE, BRIEF MENTAL HEALTH ASSESSMENT & GROUP TREATMENT PLAN

I. My services are funded by:

☐ Private Insurance Carrier: ______________________ ☐ Other: ______________________

☐ Medicaid Number: ______________________ ☐ Medicare Number: ______________________

☐ Ryan White Program Case Manager: ______________

II. *If other than Ryan White (RW) Program, please complete the following (RW already records this data), if Ryan White Skip to Section III:* ☐ Male ☐ Female ☐ Transgender

Race: ☐ Black ☐ White ☐ Asian/Pacific Islander ☐ American Indian/Alaska Native

Ethnicity: ☐ Hispanic or Latino ☐ Haitian/Creole

III. Brief Questionnaire:

A. How would you describe your quality of life right now? ______________________

B. Have you disclosed your HIV status to members of your household? ☐ Yes ☐ No

a. If no, do you wish to tell them? ☐ Yes ☐ No

b. If yes to a, do you need help telling them? ☐ Yes ☐ No

C. Do you have a support system you can depend upon? ☐ Yes ☐ No

a. If yes, do they know your HIV status? ☐ Yes ☐ No

D. During the past month, how have you been feeling?

____

____

E. In the past two weeks have you experienced any of the following feelings?

☐ Anger ☐ Depression ☐ Anxiety ☐ Loneliness ☐ Pain

☐ Happiness ☐ Sadness ☐ Joy ☐ Hyper ☐ Paranoia ☐ Others: ______________

F. Have you ever had a Mental Health Diagnosis? ☐ Yes ☐ No

a. If yes, which ones? ______________________

b. Where and when were you diagnosed? ______________________

c. Who diagnosed you? ______________________

G. Have you ever had what you consider to be problems with drugs or alcohol? ☐ Yes ☐ No

a. If yes, can you describe?______________________

____

H. Have you ever been in a violent or abusive relationship? ☐ Yes ☐ No

I. Are there any life crises that have an impact on you? ☐ Yes ☐ No

a. if yes, describe: ______________________

____

J. Have you thought about committing suicide during the past 30 days? ☐ Yes ☐ No

a. If yes, describe: ______________________

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IV. Brief Assessment

A. Mental Status Exam

Appearance: ☐ Neat ☐ Appropriate ☐ Unkempt ☐ Other: _____
Hygiene: ☐ Clean ☐ Adequate ☐ Inadequate ☐ Other: _____
Posture: ☐ Appropriate ☐ stooped ☐ stiff ☐ Other: _____
Mood: ☐ Sad☐ Cheerful ☐ Anxious ☐ Curious ☐ Restless ☐ Irritable ☐ Elevated ☐ Serious ☐ Indifferent ☐ Euphoric ☐ Hostile ☐ Hopeful ☐ Fearful☐ Unable to Assess Other: _____
Affect: ☐ Appropriate ☐ Labile ☐ Flat ☐ Dull ☐ Angry ☐ Suspicious ☐ Sad ☐ Euphoric ☐ Dysphoric ☐ Anxious ☐ Agitated ☐ Anhedonic ☐ Discouraged ☐ Other: _____
Speech: ☐ Appropriate ☐ Coherent ☐ Slow ☐ Loud ☐ Pressured ☐ Slurred ☐ Mumbled ☐ Stutter ☐ Elective Mutism ☐ Unable to Understand ☐ Other: _____
Thought: ☐ Appropriate ☐ Organized ☐ Logical ☐ Insight ☐ Illogical ☐ Irrelevant ☐ Rambles ☐ Tangential ☐ Blocking ☐ Evasive ☐ Flight of Ideas ☐ Blaming ☐ Loose Associations ☐ Circumstantial ☐ Phobic☐ Grandiose ☐ Denial ☐ Worthlessness ☐ Loss ☐ Death ☐ Helpless ☐ Obsessive ☐ Paranoid ☐ Bizzarre ☐ Alienation ☐ Ideas of Reference ☐ Self Pity ☐ Compulsive ☐ Suicidal ☐ Homicidal ☐ Ambivalent ☐ Inadequacy ☐ Isolation ☐ Confused ☐ Other: _____
Delusions: ☐ Persecution ☐ Somatic ☐ Religious ☐ Grandiose ☐ Blocking ☐ No Evidence of Delusions ☐ Denies ☐ Other: _____
Hallucinations:☐ Audio ☐ Visual ☐ Tactile ☐ Olfactory ☐ Gustatory ☐ Reported ☐ Observed ☐ None Observed ☐ Denies ☐ Other: _____
Judgment: ☐ Intact ☐ Impaired ☐ Unable to Assess or Other: _____
Knowledge of Illness: ☐ Recognition of Problem ☐ Recognizes Contribution ☐ Motivated to Resolve Problem ☐ Little or no Insight ☐ Other: _____
Motor Behavior: ☐ Appropriate ☐ Retarded ☐ Hyperactivity ☐ Tics ☐ Tremors ☐ Pacing ☐ unsteady ☐ fidgety ☐Other: _____
Attitude/Behavior: ☐ Cooperative ☐ Uncooperative ☐ Angry ☐ Withdrawn ☐ Fearful ☐ suspicious ☐ despondent ☐ Complaining ☐ Sexually Inappropriate ☐Other: _____

B. Symptoms: ____

____

____

____

____

C. Multi-Axial Diagnosis:

Axis I:

Axis II:

Axis III: _____

Axis IV:

Axis V: 78-80 Either mild symptoms or mild impairment (Current)
90 Absent or Minimal Symptoms No Functional Imp. (Previous, if documented)

Name: DOB: SS#:

V. Group Treatment Plan

A. **What is the reason you're coming to the group? ____________________**
B. **What do you want to accomplish through participation in the group?**

____

C. **Objectives:**
  a. 1 ____________________
  b. 2____________________
  c. 3____________________

D. **Target Date:**
  a. 1____________________
  b. 2____________________
  c. 3____________________

E. **Date Achieved:**
  a. 1____________________
  b. 2____________________
  c. 3____________________

VI. HIV Knowledge :

A. **Please define in your own words the following words:**
  a. **HIV**____________________
  b. **AIDS**____________________
  c. **Viral Load**____________________
  d. **CD4**____________________
  e. **Treatment Adherence**____________________
  f. **Drug Classes** ____________________

B. **Please list your medications:**

Drug Name	**Why are you taking this medication**	**Number pills each time**	**Number times each day**	**Please describe restrictions with this drug, (with/ without food)**	**When is the next refill date?**
Supplements	**Why are you taking this Supplement**	**Number pills each time**	**Number times each day**	**Please describe restrictions with this Supplement**	

C. Do you have everything you need to be able to follow the instruction for these medications?

Name: DOB: SS#:

(Please check)	Yes	No	N/A
A good place to store your medications at home	☐	☐	☐
A good place to store your medications away from home	☐	☐	☐
Food to eat with the medications, when needed	☐	☐	☐
Enough drinking water	☐	☐	☐
Reminders (alarm clocks, watch, etc.)	☐	☐	☐

D. Is there anything that you need that might help you with your medications? ________________

____

____

E. On a scale of one to ten, how motivated are you to take your **HIV medications**?

(Circle one number)

Not Motivated **Very Motivated**

1	2	3	4	5	6	7	8	9	10

F. On a scale of one to ten, how motivated are you to take your **Mental Health Medications**?

(Circle one number)

Not Motivated **Very Motivated**

1	2	3	4	5	6	7	8	9	10

VII. Informed Consent for Group Treatment

By signing below, I give informed consent for Group Counseling at Care Resource. I understand I have the right to revoke this consent at any time. I understand that my diagnosis is listed above and for this reason; I'm participating in group treatment. I understand the main purpose of group treatment is to provide and receive support to and from other group participants. I also know that I could obtain support by going to social activities, attending individual therapy or many other sources, but I choose to come here. I understand that I may choose to attend up to thirty two sessions of group therapy, but do not anticipate that it will take that many sessions to feel better and more connected to a supportive group. I understand that there are limits to my confidentiality including the following: Your case file may be subject to review when ordered by a judge; If we believe you intend to harm yourself or someone else, it is our ethical and professional duty to inform others, as the circumstance requires; In situations of suspected child or vulnerable adult abuse, it is required that we report this to the appropriate authorities; Other professionals associated with your care may have access to information on record in your case file without your written consent; During a medical emergency, we will disclose information that will assist emergency personnel in treatment; You may request in writing to see your record; You may consent in writing to disclose parts of your record to someone else; Your information may be disclosed to law enforcement when a crime is committed on the premises or against a member of staff; Payers have access to your information for the purpose of oversight, quality review, utilization review and public health reporting; You may be seen in group therapy. If so, you and every other member of the group will be told that anything discussed is private. This includes the names of group members of any problems they discussed in group. This is not to be talked about with anyone outside the group. Confidentiality will exist only to the extent that each patient trusts and respects every other member of the group. I understand that while this group is free to me, costs are covered by either the Ryan White Part A Program or General Revenue Funding from South Florida AIDS Network and are reimbursed by them at the rate of $35. per half hour. If I do not qualify for assistance through either of these programs or any other, I am responsible for the fees in accordance with Care Resource's Psychosocial Services Therapy Program Sliding Fee Scale. I have the following questions: ____

Name: DOB: SS#:

Signatures:

Client Signature: ____ Date: _____________

Therapist Signature: ____ Date: _____________

Print Name Here: _____

Student: ☐ Barry;☐ Carlos Albizu; ☐ Florida Memorial University; ☐ Florida Atlantic; Florida State; ☐ FIU**;** ☐ Nova Southeastern **in** ☐ Social Work; ☐ Mental Health Counseling; ☐ Marriage and Family Therapy.

or

State Registration: ☐ Registered Clinical Social Worker Intern, ☐ Mental Health Counselor Intern or ☐ Marriage and Family Therapist Intern. Registration Number: _____

or

License: ☐ Licensed Clinical Social Worker, ☐ Licensed Mental Health Counselor, ☐ Licensed Marriage and Family Therapist. License. Registration Number: _____

***If Registered Intern*,**

Supervisor's signature Here: ______________________________________ Date: _____________

Print name Here: Thomas S. Pietrogallo Contact 305-576-1234 x 283

License: ☒ Licensed Clinical Social Worker; ☐ Licensed Mental Health Counselor; ☐ Licensed Marriage and Family Therapist.. License Number: 6330