Today's Date: _______________

INTAKE/ADMISSION ASSESSMENT

Client Name: ____

Record Number: ____________________________________

Date of SERVICES: __________________________________

Unique ID #: ____

1). All information is due within 24hours of admission. Histories are due within 30 days
2). Screening /other information gathered Within 30 days prior to admission may be used in documenting admission assessment.

SERVICE REQUESTED: ____

Array of Brighter Beginnings meet the service needs of this consumer: ___ yes ___no

RECOMMENDATIONS/REFERRALS: ____

I. Identifying Data:

Name: ____
(Last) (First) (Middle) (Also Known As)

Address: ____

Race: __________ Sex: ___________ Marital Status: ___________ DOB: _________________________

County of Residence: _____________________

Guardian or Next of Kin: __________________ Guardian Email: _______________________________

Relationship of Guardian or Next of Kin to Client: ________________________

Client's Living Arrangement: ____

School: _____________________________ Grade: _________ Special Services: _________________

School Contact: ______________________ Phone: _________________

Reason for Referral: ____

____

____

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II. Presenting Problem and/or reason for Admission: *If applicable, cover the following areas: age of onset, any significant events that coincide with presenting problem, and any previous intervention/results that have been attempted with the problem.*

____

____

____

____

II. Present Condition: *Based on consumers presenting problem, describe the following. If area is not applicable, this must be noted in space given.*

Developmental Condition or Impairment:____

Current Medical Condition: ____

Allergies:____

Current Medications: ____

Current Substance Use/Abuse:____

Current Legal Status or Circumstances:____

Family/Other Support Systems:____

Family/Significant Other's Description of the Client's Condition:_________________________

____

IV. Assessment of Consumers Needs/Strengths: *Describe the consumer's needs and strengths. If applicable, cover needs/strengths in the home, school, and community.*

Client Needs: ____

____

____

Client Strengths: ____

____

____

Intake Study/Matching Assessment:

____

____

V. Mental Health/Behavioral Status: ***Circle*** *where appropriate and add any additional comments in space provided.*

General Appearance: Well-Groomed Dirty Disheveled Obese Slim Unshaven
Other: Attractive

Physical Stature: Small Average Large

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Other: ____

Posture: Straight Slumped
Other: ____

Attitude: ____

____

History of Actions:		SUICIDAL	HOMICIDAL
	PAST	Yes No	Yes No
	PRESENT	Yes No	Yes No

Orientation: Person: Yes No Place: Yes No Time: Yes No

VII. Admitting Diagnosis:

Axis I: ______________________________________ Code: _________

Axis II: ______________________________________ Code: _________

Axis III: ______________________________________ Code: _________

Axis IV: ______________________________________ Code: _________

Axis V: ______________________________________ Code: _________

VIII. Preliminary Treatment Plan (may be used up to 30 days on client's presenting problem/needs):

____

____

____

____

____

____

____

____

____

Person Responsible for Treatment Plan Development: ______________________________________

IX. Other Recommendations: ____

____

____

____ ____________________
Qualified Professional Date

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Client Name:_________________________ DOB:____________ MID#_______ Record#:_____

STABLE RESOURCE TOOLKIT

Date:

The Patient Health Questionnaire (PHQ-9) - Overview

The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression:

- The PHQ-9 incorporates DSM-IV depression diagnostic criteria with other leading major depressive symptoms into a brief self-report tool.
- The tool rates the frequency of the symptoms which factors into the scoring severity index.
- Question 9 on the PHQ-9 screens for the presence and duration of suicide ideation.
- A follow up, non-scored question on the PHQ-9 screens and assigns weight to the degree to which depressive problems have affected the patient's level of function.

Clinical Utility

The PHQ-9 is brief and useful in clinical practice. The PHQ-9 is completed by the patient in minutes and is rapidly scored by the clinician. The PHQ-9 can also be administered repeatedly, which can reflect improvement or worsening of depression in response to treatment.

Scoring

See PHQ-9 Scoring on next page.

Psychometric Properties

- The diagnostic validity of the PHQ-9 was established in studies involving 8 primary care and 7 obstetrical clinics.
- PHQ scores;, 10 had a sensitivity of 88% and a specificity of 88% for major depression.
- PHQ-9 scores of 5, 10, 15, and 20 represents mild, moderate, moderately severe and severe depression.[1]

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1 *Kroenke K, Spitzer R, Williams W The PHQ-9: Validity of a brief depression severity measure. JGIM, 2001,* 76:606-676

Client Name:______________________________________ DOB:__________ MID#__________ Record#:________

The Patient Health Questionnaire (PHQ-9) Scoring

Use of the PHQ-9 to Make a Tentative Depression Diagnosis:

The clinician should rule out physical causes of depression, normal bereavement and a history of a manic!hypomanic episode

Step 1: Questions 1 and 2

Need one or both of the first two questions endorsed as a "2" or a "3"
(2 = "More than half the days" or 3 = "Nearly every day")

Step 2: Questions 1 through 9

Need a total of five or more boxes endorsed within the shaded area of the form to arrive at the total symptom count. (Questions 1-8 must be endorsed as a "2" or a "3"; Question 9 must be endorsed as "1" a "2' ora "3")

Step 3: Question 10

This question must be endorsed as "Somewhat difficult" or "Very difficult" or "Extremely difficult"

Use of the PHQ-9 for Treatment Selection and Monitoring

Step 1

A depression diagnosis that warrants treatment or a treatment change, needs at least one of the first two questions endorsed as positive ("more than half the days" or "nearly every day") in the past two weeks. In addition, the tenth question, about difficulty at work or home or getting along with others should be answered at least "somewhat difficult"

Step 2

Add the total points for each of the columns 2-4 separately
(Column 1 = Several days; Column 2 = More than half the days; Column 3 = Nearly every day. Add the totals for each of the three columns together. This is the Total Score
The Total Score = the Severity Score

Step 3

Review the Severity Score using the following TABLE.

PHQ-9 Score	Provisional Diagnosis	Treatment Recommendation *Patient Preferences should be considered*
5-9	Minimal Symptoms*	Support, educate to call if worse, return in one month
10-14	Minor depression ++ Dysthymia* Major Depression, mild	Support, watchful waiting Antidepressant or psychotherapy Antidepressant.or.psychotherapy
15-19	Major depression, moderately severe	Antidepressant or psychotherapy
>20	Major Depression, severe	Antidepressant and psychotherapy (especially if not improved on monotherapy)

* *If symptoms present ; two years, then probable chronic depression which warrants antidepressants or psychotherapy (ask "In the past 2 years have you felt depressed or sad most days, even if you felt okay sometimes?")*

++ *If symptoms present ; one month or severe functional impairment consider active treatment*

Client Name:___________________________________ DOB:__________________ MID#___________ Record#:_________

Date:

The Patient Health Questionnaire (PHQ-9)

Patient Name: __________________ Date of Visit: _____________

Over the past 2 weeks, how often have you been bothered by any of the following problems? (use "✓"to indicate your answer, if written.) (Type number, when typing numbers. Numbers will calculate automatically.)	**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 asleep, 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're 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

Column Totals _____ + _____ + _____

Add Totals Together ______________

10. If you checked off any problems, how difficult have those problems made it for you to Do your work, take care of things at home, or get along with other people 7

D Not difficult at all D Somewhat difficult D Very difficult D Extremely difficult

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