

Dear Veteran,

Welcome! You are here for a comprehensive assessment with the Mental Health Service at the Pacific Islands Health Care System (PIHCS). Services begin with a Comprehensive Mental Health Evaluation to help us determine how to best meet your needs. Please fill out the attached forms as best you can for this evaluation and bring your completed forms with you to your Intake appointment. Completing this form is a very important part of the assessment process. The mental health professional with whom you have an appointment will be able to refer you to the program within Mental Health Services that best fits your needs. The Comprehensive Mental Health Evaluation is a thorough evaluation that may take 90 minutes or more.

Thank you for your service to our Nation,

Mental Health Service, PIHCS

You have been scheduled for a Comprehensive Mental Health Evaluation appointment on:

Date:

Provider:

Time:

If you need to cancel or reschedule your appointment, please call your Clinic staff.

PLEASE DO NOT BE A "NO-SHOW," AS THIS DEPRIVES A FELLOW VETERAN OF AN APPOINTMENT

This document will be shredded once the information has been used for your comprehensive mental health evaluation.

Mental Health Personal Information Form

NAME:

LAST 4 of SSN:

What brings you in to the clinic today? What are your concerns?

If any of these symptoms are currently bothering you, please briefly describe:

obsessions:

compulsions:

phobias:

socially avoidant:

easily startled:

always on alert:

intrusive thoughts of:

panic attacks:

excessive anxiety and worry:

social isolation:

loss of ability to enjoy anything:

grief:

guilt/self-blame:

tearfulness:

unable to let things go:

fatigue/loss of energy:

feelings of worthlessness:

depressed mood/feeling blue:

recent suicidal thoughts:

elevated mood/feeling high:

distractibility:

decreased need for sleep:

reckless behavior:

easily angered/frequent irritability:

excessive worries about health?

trouble concentrating/memory problems:

feeling everything is unreal or distant

hearing or seeing things:

SLEEP ASSESSMENT:

Estimated number of hours you sleep nightly:

Please enter an ✓ for each that applies to you.

No difficulty

Difficulty falling asleep

Frequent awakenings

Difficulty returning to sleep

Tired on awakening

Early morning awakenings

Sleepwalking

Snoring

Sleep apnea

Sleep too much

Sleep during the day rather than at night

How many caffeine drinks do you take each day?

SUBSTANCE USE: Please enter a ✓ to mark your choice.

Alcohol Use:

- | | | |
|-----|----|--|
| Yes | No | Do you drink alcohol: |
| | | If yes, do you drink alcohol daily weekly monthly |
| Yes | No | Have you had any problems associated with your alcohol use? |
| Yes | No | Has anyone else complained about or commented on your alcohol use? |
| Yes | No | Have you lost a job because of your alcohol or drug use? |
| Yes | No | Has your alcohol or drug use affected your relationships with family or friends? |
| Yes | No | Have you had a DUI? If yes, how many and when? |
| Yes | No | Are you currently in recovery from drugs and/or alcohol? |
| | | If so, Current time in sobriety: |
| | | What is your longest period of sobriety? |

Has anyone in your family had a drinking problem?

- | | | |
|-----|----|------|
| Yes | No | Who: |
|-----|----|------|

Drug Use: Have you used any of the following within the past twelve months?

- | | | |
|-----|----|--|
| Yes | No | Cannabis (pot, marijuana, weed, pakalolo) |
| Yes | No | Amphetamines, ecstasy (meth, crystal, "X") |
| Yes | No | Cocaine |
| Yes | No | Hallucinogens/psychedelics (LSD, acid, mushrooms...) |
| Yes | No | Inhalants: gas, glue, paint thinner, etc. |
| Yes | No | Opioids, other sedative-hypnotics (other than exactly as prescribed) |
| Yes | No | Other (OTC, prescribed drugs, etc.) other than as directed |
| Yes | No | Spice, "bath salts" and/or other designer drugs |
| Yes | No | Steroids |
| Yes | No | Caffeine, energy drinks & supplements |

Other Addictive Behaviors (gambling, overeating, sexual excess, internet):

If yes, please describe

Please describe any past use of alcohol, drugs and/or other addictive behaviors prior to the past 12 months.

Has anyone in your family had a drug problem? Yes No

Who:

Have you had any past Substance Use Treatment, including 12 Step Programs?

Yes No If yes, when and where:

Do you use tobacco? Please enter an X for each question that applies to you.

1. Lifetime NONUSER of tobacco

2. Former tobacco user but quit:

 MORE THAN 7 years ago

 MORE THAN 12 months ago but LESS THAN 7 years ago

 Within the past 12 months

3. Current tobacco user

 Would you like information about, or to participate in a smoking cessation program?

 Yes No

MENTAL HEALTH HISTORY:

Have you had any previous mental health counseling or treatment?

Please specify when and where:

Have you ever been hospitalized for a mental health problem? Please specify when and where:

Have you ever been on mental health medications? If so, please describe, including names, dosages & effects:

PERSONAL RISK:

Yes No Have you ever thought seriously of suicide?

Yes No Have you ever attempted suicide?

If yes, please give details (when, why, how, what happened):

Yes No Have you have firearm or access to weapons? Please explain:

Yes No Are you feeling hopeless about the present or future?

Yes No Have you had recent thoughts of hurting yourself?

If yes, when? How? Please describe:

Yes No Do you have a plan for suicide or self-harm? If yes, what is your plan?

OTHER RISK:

Yes No Have you ever thought of killing or seriously injuring someone?

Yes No Have you ever thought attempted to kill or seriously injure someone?

If yes, please give details (when, why, how, and what happened):

Yes No Have you had recent thoughts of killing or seriously injuring someone?

If yes, who?

FAMILY HEALTH HISTORY: Please comment on family members with major illness:

Has anybody in your family ever been diagnosed with or treated for a mental health problem?
Please describe:

MEDICAL HISTORY/HEALTH PROBLEMS:

Please enter a ✓ for each question that applies to you.

High blood pressure, history of heart problems

History of head injury, strokes, Parkinson's

Orthopedic (broken bones, back, shoulder, hip, knees)

Respiratory (emphysema, asthma)

Digestive system, including liver

Reproductive, including prostate for men and breast for women

Skin disease

Kidney disease

Diabetes, thyroid

Hepatitis, HIV

Hearing impairment

Visual impairment

Chronic pain

Yes No Do you have any tattoos, body piercing or history of needle use?

If yes, please explain:

Yes No Do you have any problems with sexual functioning? If yes, please explain:

Please list any major illnesses in your immediate, biological family members;

Are you currently suffering from a condition causing pain Yes No

Describe if answer was yes:

ALLERGIES? Yes No

Please list allergies, if answer was yes:

CURRENT ACTIVE MEDICATIONS (including herbs, vitamins, supplements):

Primary care provider:

NUTRITION ASSESSMENT:

Please enter a ✓ for each question that applies to you regarding problems with eating:

weight change in last 6 months

teeth or mouth problems

known dietary problems or food intolerance

inadequate money for food

no problem

SOCIAL/DEVELOPMENTAL HISTORY:

Where were you born and raised?

With whom did you grow up with (parents, grandparents, foster home, etc.):

Describe your relationship with your caregivers (parents, etc.):

How many brothers and sisters do you have?

Describe your relationship with your siblings:

Was there any violence in your home? What kind?

Where you abused as a child or adolescent? Please enter a ✓ for each question that applies.

physical abuse

emotional abuse

sexual abuse

Did you have any difficulties in school? If so, please explain:

MARITAL/RELATIONSHIP HISTORY:

Marital Status: Single Married/Civil Union/Domestic Partner/Common Law
 Divorced Separated

Length of Current Relationship:

Sexual Orientation:

Number of Children and their Ages

Are there any problems in your current relationship? If so, please specify:

Verbal abuse, threats or violence may occur in some relationships. Is this a concern for you?

Yes No

Have you ever experienced traumatic events outside the military such as sexual assault, physical assault with injury, natural disasters, etc.):

Yes No

Describe if answer was yes:

CURRENT SOCIAL SITUATION:

Housing Situation (please describe: home/condo/renting a room/shelter, etc., and with whom you live with):

Are there any problems in your current living situation? If so, please describe:

EDUCATION/VOCATIONAL EXPERIENCE:

Highest level of education (list degrees):

Specialized training or skills:

Current employment:

Past employment (where and time frame):

If unemployed, date of most recent job and why you left:

Vocational goals:

Preferred learning modality: handouts/reading doing hearing
Place a ✓ by your choice. video/computers one to one instruction
other:

Barriers to learning: Place a ✓ by your choice.

cognitive impairment/TBI problems with communication
difficulty with reading and writing English as second language physical limitations
other:

If there's other, including special operations, that are not listed above. Please specify:

Yes No Were you ever a POW? If yes, please describe:

Yes No Did you receive friendly or hostile incoming fire from small arms, artillery, mortars, bombs, etc.? If yes, please explain:

Yes No Did you experience sever injury in combat or think you were going to die? If yes, please explain:

Yes No Have you ever witnessed severe injury or death in combat of another person? If yes, please explain:

Yes No When you were in the military did you ever receive unwanted or unwarranted sexual attention (i.e., touching, cornering, pressure for sexual favors or inappropriate verbal remarks, etc.)?

Yes No When you were in the military did anyone ever use force or the threat of force to have sex against your will?

Please briefly describe your military experience:

Tell us briefly about the most distressing event of your military career:

PERSONAL STRENGTHS, NEEDS, ABILITIES & PREFERENCES:

STRENGTHS

What do you consider to be your personal strengths, assets and resources (for example: friendly, intelligent, healthy, have a place to live, supportive family/friends, etc):

What do people like about you?

NEEDS

What do you want to get from treatment?

What are your needs or concerns at this time in your life?

What would you like to change in your life and what obstacles and limitations are getting in the way of what you want to achieve?

ABILITIES

What are your personal talents, skills, and abilities? (What are you good at?)

What are your interests, hopes, and/or dreams?

PREFERENCES

What preferences do you have that might improve your experience in treatment?

What are your short-term goals (weeks to months)?

What are your long-term goals (months to years)?

Is there anything else that you feel we should know about you at this time, please write it Here:

If you have served in **Operation Enduring Freedom (OEF)** or **Operation Iraqi Freedom (OIF)** (on the ground, in coastal waters, or in the air above), please answer items A through E below:

A. The location of your most recent OEF/OIF service was (choose only one):

- | | |
|--------------|-----------------|
| Iraq | Turkey |
| Kuwait | Afghanistan |
| Saudi Arabia | Other location: |

B. Do you have any problems with chronic diarrhea or other gastrointestinal complaints since serving in the area of conflict? If yes, please provide information about your specific symptoms:

C. Do you have any unexplained fevers? Yes No

D. Do you have a persistent rash that began after deployment to Southwest Asia?

Yes No

E. Do you have or suspect that you have retained fragments or shrapnel as a result of injuries you received while serving in the area of conflict (for example, were you injured as a result of small arms fire or a blast or explosion caused by an IED, RPG, land mine, enemy or friendly fire)? If yes, please provide further information:

Yes No

Over the past TWO WEEKS, how often have you been bothered by the following problems?

Please place a ✓ for all that apply:

a. Little interest or pleasure in doing things?

Not at all Several days

More than half the days

Nearly every day

b. Feeling down, depressed, or hopeless?

Not at all Several days

More than half the days

Nearly every day

c. Trouble falling or staying asleep, or sleeping too much

Not at all Several days

More than half the days

Nearly every day

d. Feeling tired or having little energy

Not at all Several days

More than half the days

Nearly every day

e. Poor appetite or overeating

Not at all Several days

More than half the days

Nearly every day

f. Feeling bad about yourself or that you are a failure or have let yourself or your family down

Not at all Several days

More than half the days

Nearly every day

g. Trouble concentrating on things, such as reading the newspaper or watching TV

Not at all Several days

More than half the days

Nearly every day

h. Moving or speaking so slowly that other people have noticed. Or the opposite – being so fidgety or restless that you have been moving a lot more than usual.

Not at all Several days

More than half the days

Nearly every day

i. Thoughts that you would be better off dead or of hurting yourself in some way

Not at all Several days

More than half the days

Nearly every day

j. 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 to get along with other people?

Not at all Several days

More than half the days

Nearly every day

MENTAL HEALTH TREATMENT EXPECTATIONS

APPOINTMENTS

Treatment will consist primarily of weekly to monthly 30-90 minute appointments held at the Spark Matsunaga Medical Center or one of the Community Based Outpatient Clinics (CBOC). More frequent or less frequent appointments may be arranged if necessary or clinically indicated. Arriving late will reduce the amount of time available for contact with your therapist during that visit.

ATTENDANCE

Consistent attendance at scheduled appointments is necessary to make best use of treatment. Please provide 24-hour notice for cancelled appointments when possible. Occasionally circumstances may make 24-hour notice impossible. In those instances, please contact the clinic (433-0660) as soon as possible **before** the scheduled appointment. Because we have a limited number of appointments available, any no-show is an appointment that could have been given to a fellow Veteran. If you can't make an appointment or decide you don't want to come. Please call to cancel so that we can give your appointment to a fellow Veteran.

TREATMENT PLAN

Early in treatment, your therapist will work with you to develop a treatment plan to help address your individual needs. This plan will be informed by the best available scientific evidence for your particular problem, or problems, and will utilize all assessment information and your treatment goals, needs and preferences. Your therapist will offer his/her best judgment to collaborate with you in developing this treatment plan. You are encouraged to ask any questions you like about the plan. This will be your individualized treatment plan, and treatment will not proceed without your agreement and commitment to the plan. You and your therapist will also discuss any changes or additions to the treatment plan during the course of treatment that may be needed. Feel free to discuss any questions or concerns you have about your treatment plan or progress at any point during your treatment.

EMERGENCIES

It is not possible to reach your therapist (or clinic representative) 24-hours a day, in the event of a mental health emergency. If you ever feel that your safety or that of others may be in jeopardy or if you feel that you need immediate support to prevent harm from occurring, **call 9-1-1- or go directly to the nearest emergency room.** After the emergency has been addressed and health and safety are assured, call your therapist to inform them of the situation. If you are having thoughts of hurting yourself you can also **call 1-800-273-8255**, the national 24-hour Veterans Crisis hotline.

COMMUNICATION

Open communication with your therapist is a critically important part of your treatment experience. Please feel free to open any topic for conversation with your therapist, including any questions or concerns about your treatment or your relationship with your therapist. Although it is rarely necessary, assignment to a different therapist may be possible in situations where you find it difficult to work with your current therapist.

UNACCEPTABLE BEHAVIOR

Certain behaviors are unacceptable and may be grounds for immediate termination of mental health services. Such behaviors include violence, threat of violence, verbal aggression, verbal threats and/or intimidation, inappropriate sexual advances, and/or inappropriate gifts. Please be respectful of other veterans in the waiting area. Behaviors that disrupt the clinic will not be tolerated.

ENDING TREATMENT

Ideally, the end of treatment is mutually agreeable to the veteran and therapist after satisfactory progress on treatment goals. However, you may choose to end treatment at any time for any reason. You do not have to provide a reason or ask permission to end therapy. If you do choose to end therapy, please inform your therapist. Your therapist will discuss it with you if he/she feels that ending treatment may be appropriate, and the two of you may negotiate an appropriate timeline for ending treatment. As stated above, your therapist may also end therapy due to inconsistent attendance, although this is the least ideal scenario.