HDC
Human Development Center
Comprehensive Behavioral Healthcare
Professional. Compassionate. Dedicated.

HDC COMPREHENSIVE EVALUATION INTAKE — ADULT

IDENTIFYING INFORMATION:

Name: _____ **Today's Date**: _____

Preferred Pronouns: _____ **Date of Birth:** _____ **Age**: _____

Self-identified Gender: _____ **Sexual Orientation:** _____

Race: _____ **Ethnicity:** _____ **Primary Language:** _____

Secondary Language: _____

Ability to Read/Write? ☐Yes ☐No **Special Accommodations:** _____

Referred by/reason for referral: _____
_____
_____

In your own words what brings you in for services: _____
_____
_____

Are there any factors contributing to your presenting problem (i.e. work, family, finances, stressors, etc.) :
_____
_____

What is your perception of your current condition: _____
_____

Current Providers *(Provider, provider location, date last seen, reason and frequency of care)*

Primary Care Provider _____
Psychotherapist/CNP _____
Psychotherapist _____
Case Manager _____
ARMHS _____
Probation Officer _____
Other _____

DIMENSION I: Acute Risk or Acute Intoxication/Withdrawal Potential

Risk of Harm

Have you recently had thoughts or wishes to harm yourself? ☐No ☐Yes, _____
Have you recently had thoughts of harming others? ☐No ☐Yes, _____
Do you have a history of self-harm or suicide attempts? ☐No ☐Yes, _____

Substance Use

☐No ☐Yes Do you currently use any alcohol or illegal substances?
If yes, with what substances, when did they start and how often used? _____
_____

☐No ☐Yes Have you ever attended substance abuse disorder treatment?
If yes, where, and when? _____
_____

☐No ☐Yes Do you have any current or history of substance use withdrawal?
If yes, what symptoms were experienced and when? _____
_____

☐No ☐Yes Have relationships, social functioning, or work/school ever been affected by your substance use?
If yes, how had substance use had an impact on these areas? _____
_____

DIMENSION II: Biomedical and Physical Health History

How would you rate your current physical health? ☐Good ☐Fair ☐Poor

Are you experiencing any physical health concerns or have a current physical health diagnosis? _____
_____

Have you experienced any of the following? *(Please provide comments):*
Traumatic Brain Injury: _____
Significant Illness That Affects Your Brain or Oxygen Level: _____
Exposure to A Sexually Transmitted or Blood Borne Diseases: _____
Are you or could you be pregnant: _____
Physical Health Disability: _____

Are you suffering any physical pain? ☐No concerns with physical pain
☐Acute Pain (Identify Treatment Type Below) ☐Chronic Pain (Identify Treatment Type Below)
Treatment Type:
☐Prescribed Pain Medication ☐Home Remedies ☐Other, Non-Pharmacological Approach
☐Over the Counter Medication ☐Enrolled in Pain Management Program
☐Not Being Treated ☐Physical Therapy ☐Meditation ☐Medical Referral Needed

Does your family engage in, or want to engage in any cultural healing practices? ☐No ☐Yes, _____

Current Medications: (Include OTC Medication and/or Herbal Supplements):
Medication: _____ Dosage: _____ Frequency: _____
Medication: _____ Dosage: _____ Frequency: _____
Medication: _____ Dosage: _____ Frequency: _____
Medication: _____ Dosage: _____ Frequency: _____

Have you been prescribed mental health medications in the past? ☐No ☐Yes
Psychiatric Medication: _____ Dosage: _____ Frequency: _____
Psychiatric Medication: _____ Dosage: _____ Frequency: _____
Psychiatric Medication: _____ Dosage: _____ Frequency: _____

Do you have any known drug allergies? *(If yes, please provide comments)* ☐No ☐Yes
_____

Do you have any nutritional concerns? (i.e. significant changes in weight, changes in appetite, dietary restrictions) ___
_____
_____

Do you need to establish services with a primary care provider or other medical professional? *(If yes, please provide comments)* ☐No ☐Yes
_____

Additional Comments Regarding Your Current/Past Physical Health:
_____
_____

SUBSTANCE USE HISTORY:

Primary Substance Used	Age of First Use	Most Recent Pattern of Use/Duration	Date/Time of Last Use	Withdrawal Potential? Needs Special Care?	Method of Use
Alcohol					
Amphetamines					
Barbiturates					
Benzodiazepines					
Cannabis					
Cocaine					
Crack					
Hallucinogens					
Heroin					
Inhalants					
Methamphetamine					
Nicotine					
Other					
Other Opiates/Synthetics					
Over the Counter Drugs					

Have you ever been to detox or hospitalized for a substance use disorder? ☐No ☐Yes
If yes, where, and when? _____

Withdrawal Symptoms

Symptom	Past 12 Months	Recent (Past 30 Days)
Agitation		
Anxiety/Worry		
Confused/Disrupted Speech		
Diarrhea		
Diminished Appetite		
Dizziness		
Fatigue/Extremely Tired		
Fever		
Hallucinations		
Headaches		
High Blood Pressure		
Irritability		
Muscle Aches		
Nausea/Vomiting		
Paranoia		
Psychosis		
Sad/Depressed Feeling		
Seizures		
Sensitivity to Noise		
Shakiness/Jitteriness/Tremors		
Sweating and Rapid Pulse		
Unable to Eat		
Unable to Sleep		
Vivid/Unpleasant Dreams		
Other		

Is there anything else you would like us to know regarding your substance history or withdrawal symptoms?

_____
_____
_____

DIMENSION III: Emotional/Behavioral/Cognitive

Family Status/Psychosocial History

Please explain what life was like growing up in your family (*Family history, including parental marital status, who you were raised by, number of siblings, presence of abuse/neglect, and any other significant information).*

_____
_____
_____
_____

_____
_____

EDUCATIONAL HISTORY:
Where did you go to school? What was your experience with school growing up?
_____
_____
_____

Any developmental incidents? ☐Unremarkable ☐Delayed Milestones ☐Atypical ☐Other _____

Current/Highest Level of Education: _____

Did you receive any special educational services (IEP, 504, Title 1) or have special educational needs?
☐No ☐Yes, _____

Do you have any concerns with learning disabilities? _____
_____
_____

FAMILY HISTORY: Do you have any relatives (including parents, grandparents, aunts, uncles, or cousins) who have any of the following conditions?

	Relationship		**Relationship**
ADHD/ADD		Eating Disorders	
Alcohol or Drug Problems		Learning Disorders	
Anxiety/OCD		Mental Health Hospitalizations	
Autism/Autism Spectrum Disorder		Nerve Problems	
Bipolar Disorder		Personality Disorders	
Brain Damage		Physical Abuse	
Chronic Pain		PTSD	
Completion of or Suicide Attempts		Schizophrenia	
Convulsions/Seizures		School Problems	
Dementia		Sexual Abuse	
Depression		Thyroid Problems	
Developmental Delays		Tic/Tourette's Disorder	
Domestic Violence		Other	

PAST MENTAL HEALTH SERVICES:

AHRMS/Case Management Services: _____
Mental Health/Substance Use Hospitalizations: _____
Partial Hospitalization Program: _____
Previous Mental Health Diagnosis: _____

Psychiatric Care: _____
Psychological Testing: _____
Psychotherapy: _____
Other: _____

Do you currently have a diagnosis, or have you ever had a diagnosis of a mental health or substance use disorder? ☐No ☐Yes, _____

Have you ever been hospitalized due to mental health or substance use? If yes, please explain when and where: ☐No ☐Yes, _____

Are you currently or have you ever received any other mental health or substance use treatment? If yes, please explain when and where: ☐No ☐Yes, _____

If you are currently taking medication to manage your mental health, are they adequately managing/stabilizing mental health symptoms? ☐No ☐Yes

CURRENT SYMPTOMS: Please check the follow symptoms you are currently experiencing and elaborate on how often and long this has been a problem.

Addictive Behavior

Check if Applies	Symptom	Describe (Include how long and how often)
	Computer/Gaming	
	Exercise/Fitness	
	Gambling	
	Sexual Activity	
	Shopping/Spending	
	Other	

Anxiety

Check if Applies	Symptom	Describe (Include how long and how often)
	Anxiety Around Others	
	Anxiety/Worry	
	Compulsions (Unwanted Behaviors)	
	Difficulty Breathing	
	Fears/Phobias	
	Muscle Tension/Headaches/Stomachaches	
	Obsessions (Unwanted Thoughts)	
	Panic Attacks	
	Racing Thoughts	
	Restlessness	
	Other	

Behavior and Attention

Check if Applies	Symptom	Describe (Include how long and how often)

	Aggressive Behaviors	
	Anger Concerns	
	Concentration Problems	
	Easily Bored/Impatient	
	Easily Distracted	
	Excessive Energy	
	Impulse Control Problems	
	Lying	
	Memory Problems	
	Stealing	
	Thoughts of Harming Others	
	Other	

Mood

Check if Applies	Symptom	Describe (Include how long and how often)
	Crying Spells	
	Fatigue/Loss of Energy	
	Feelings of Worthlessness	
	Guilt	
	Irritability	
	Low Motivation	
	Mood Swings	
	Negative Beliefs/Thoughts About Self	
	Reduced Interest/Enjoyment	
	Sad/Depressed Mood	
	Thoughts of Harming Self	
	Other	

Nutrition

Check if Applies	Symptom	Describe (Include how long and how often)
	Appetite/Weight Changes	
	Self-Starving	
	Severe Overeating	
	Significant Weight Loss/Gain	
	Vomiting After Eating	
	Other	

Trauma

Check if Applies	Symptom	Describe (Include how long and how often)
	Avoidance of Certain People/Places/Things	
	Difficulty Initiating Sleep	
	Disrupted Sleep	
	Flashbacks	
	Hypervigilant	
	Inability to Experience	

	Positive Emotions	
	Intrusive Thoughts	
	Jumpy/Startles Easily	
	Nightmares	
	Sleep Problems	
	Other	

Psychosis

Check if Applies	Symptom	Describe (Include how long and how often)
	Believe or Believed Others Were Controlling Your Thoughts/Plotting Against You	
	Believe or Believed You Have Special Powers	
	Feeling/Hearing/Seeing/Smelling Things That Aren't Really There	
	Sexual Concerns/Problems	
	Sexual Identity Concerns/Problems	
	Other	

Adverse Events

Have you experienced any events of maltreatment, physical, emotional, sexual abuse, or neglect in childhood or as an adult?

_____
_____
_____

Have you experienced or been part of a group that experienced community violence or historical trauma?

_____
_____
_____

Are there any other symptoms or issues that you think it would be helpful for us to know about?

_____
_____
_____

DIMENSION IV: Readiness for Change

How would you describe your current concerns related to your mental health to family, friends, or others in the community?

_____
_____
_____

What causes you the most difficulties regarding your current concerns? Has anything helped with those concerns in the past?

_____
_____

_____

What kinds of help would be the most useful to you at this time, and are you open to making these changes?

_____
_____
_____

DIMENSION V: Relapse, Continue Use/Problem Potential

What would you identify as your personal strengths?

_____
_____
_____

What would you identify as your personal challenges?

_____
_____
_____

DIMENSION VI: Recovery Environment

Current Living Situation Do you feel safe in your current living environment? ☐No ☐Yes If no, please feel free to communicate further at time of evaluation with a mental health professional.

Please describe your current living situation *(Include length of residency, household members or status of current housing).* _____
_____
_____

Are you currently, or have you ever served in the military? If yes, please share what branch and years of service:
☐No ☐Yes, _____

Employment/Financial
Current and Previous Employment: _____
_____
_____
Any concerns with meeting your basic needs or accessing services: _____
Current Financial Difficulties or Strain: _____

LEGAL:
Have you in the past, or are you currently working with Child Protective Services? ☐No ☐Yes
Please provide details on social workers involved, dates of involvement, etc. _____

Are you currently on probation, parole, and/or involved with a specialty court program? ☐No ☐Yes
Please provide details on probation officers involved, dates of involvement, etc.

_____
_____

Have you been arrested or had any legal interactions? _____
_____

SUPPORTS:
What significant relationships do you have in your life right now? _____
_____
_____

How would you currently describe the quality of your current relationships (with significant other, children, others)
_____
_____

Do you have supports that you want to participate in your treatment at this time? _____
_____

Do you have any children that live with you? ☐No ☐Yes That do not live with you? ☐No ☐Yes
_____

CULTURAL/SPIRITUAL:
Do you have any spiritual, or other types of belief systems, that are important to your recovery?
_____

Do you have any cultural practices that are important for your recovery?
_____

Thank you for taking the time to fill out this questionnaire.