

BEHAVIORAL HEALTH ASSESSMENT

(Please provide the following information to assist your provider in making a complete evaluation)

Part 1 – IDENTIFYING DATA				
Name (<i>Last, First, MI</i>)		Your SSN		Sponsor's SSN
Age:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Race: <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Other (Please specify):		
Home Phone:		Work Phone:		
Cell phone/Pager:		E-mail address:		
Address:				
Who referred you to the clinic? <input type="checkbox"/> Self <input type="checkbox"/> Health Care Provider <input type="checkbox"/> Command-Directed <input type="checkbox"/> Other:				
Part 1A – MILITARY INFORMATION (Active Duty Only)				
Rank/Grade:	Branch of service: <input type="checkbox"/> USA <input type="checkbox"/> USN <input type="checkbox"/> USMC <input type="checkbox"/> USAF <input type="checkbox"/> USCG <input type="checkbox"/> Other		<input type="checkbox"/> Active <input type="checkbox"/> Guard <input type="checkbox"/> Reserve	Military occupational specialty:
Unit name, address and phone number:				
Commander / First Sergeant name and phone number:				
Time in service:	Time in current unit:	Work phone:		
List any deployments and combat experience: <input type="checkbox"/> OIF <input type="checkbox"/> OEF <input type="checkbox"/> Bosnia <input type="checkbox"/> Somalia <input type="checkbox"/> Desert Shield/Desert Storm <input type="checkbox"/> Panama <input type="checkbox"/> Grenada <input type="checkbox"/> Viet Nam <input type="checkbox"/> Other:				
Part 2 – PRESENTING PROBLEM				
What is (are) your reason(s) for coming in today?				
How long have you been experiencing these problems?				
Have you had difficulties like this before? <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If yes, please explain</i>)				
Are you having any self-destructive or suicidal thoughts? <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If yes, please explain</i>)				

Date:	Patient's name:	Rank	Sponsor SSN:	Patient's date of birth:
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Part 3 – PAST PSYCHIATRIC HISTORY

List any previous psychiatric or substance abuse evaluations, counseling or hospitalizations:

Reason	Location	Dates	Diagnosis (if known)

Military Only – Were any of the above evaluations, counseling or hospitalizations command directed? Yes No

List any previous psychiatric medication therapy:

Medication	Dates	Effectiveness	Side Effects	Reason for Discontinuation

Have you ever attempted suicide in the past? Yes No *(If yes, please explain)*

Part 4 – MEDICAL HISTORY

Name and Location of Primary Care Provider:	Office Phone of Primary Care Provider:

List all allergies and reactions to medications:

List all medications that you are currently taking (please continue in Part 18 if more space required):

Name of Drug	Amount taken (dose)	Name of Drug	Amount taken (dose)

List all current and past medical or physical problems, including hospitalizations and traumatic injuries:

List any over the counter medications	Herbal products	Supplements/Vitamins

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Part 4A - PAIN ASSESSMENT

Are you currently experiencing any physical pain? Yes No (If yes, please explain below)

(If experiencing pain, please score your pain on a 10 point scale where 0 = no pain and 10 = worst pain imaginable)

Please score your pain: 0 1 2 3 4 5 6 7 8 9 10

For provider only

Is Further evaluation or referral required?

YES NO

Use Initials

Part 5 – SUBSTANCE USE ASSESSMENT

In the past year, have you ever drunk alcohol or used drugs more than you intended? Yes No

In the past year, have you felt you wanted or needed to cut down on your alcohol or drug use? Yes No

What, if any, recreational or illicit drugs or medications have you used recently or in the past?

Did you ever find that you needed to drink a lot more or use more drugs in order to get an effect, or that you could no longer get high on the amount that you were using? N/A Yes No

For provider only

Is Further evaluation or referral required?

YES NO

Use Initials

AUDIT Screening Tool	0	1	2	3	4
Instructions: Please check the box that most applies to you.	Never	Monthly or less	2-4 times monthly	2-3 times weekly	4 + times weekly
1. How often do you have a drink containing alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Never	Monthly or less	Monthly	Weekly	Daily or almost daily
3. How often do you have six or more drinks on one occasion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. How often during the last year have you found that you were not able to stop drinking once you had started?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. How often during the last year have you been unable to remember what happened the night before because of drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Never		Yes, but not in last year		Yes, during the last year
9. Have you or someone else been injured as a result of your drinking?	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
10. Has anyone been concerned about your drinking or suggested that you should cut down	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Total AUDIT Score	←				

TOBACCO USE

CAFFEINE USE

Do you smoke or use tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no please go to next section)	How many caffeinated beverages do you consume per day on average?
What do you smoke or use? <input type="checkbox"/> Cigarettes <input type="checkbox"/> Snuff <input type="checkbox"/> Cigars <input type="checkbox"/> Pipe	
How much do you use in a day?	Do you ever feel irritable, jumpy or nervous because of your caffeine use? <input type="checkbox"/> Yes <input type="checkbox"/> No
How long have you been using tobacco products?	
Do you wish to quit? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does caffeine use impair your sleep? <input type="checkbox"/> Yes <input type="checkbox"/> No

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Part 6 – FAMILY PSYCHIATRIC HISTORY

List any family members who have been diagnosed or treated for any of the mental health problems?

Relationship	Problem/Diagnosis	Hospitalized	Medications prescribed?
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Have there been any deaths or suicidal behavior in your family? Yes No (If yes, please explain)

PART 7 – PSYCHOSOCIAL / DEVELOPMENTAL HISTORY

Where were you born? Who raised you? Both Parents Mother Father
 Other Family
 Foster Parent(s) Adoptive Parent(s) Other:

Were there any complications at birth? Yes No (If yes, please explain below)

How many siblings do you have and what number child were you?

What was it like in your childhood home? Loving Comfortable Supportive Chaotic Abusive Other:

What type of discipline was used in your childhood home?

Did you have any developmental delays or problems? Yes No (If yes, please explain below)

Have you ever been physically, sexually or emotionally abused? : Yes No (If yes, please explain)

Part 8 - CURRENT FAMILY RELATIONSHIP ASSESSMENT

Marital Status? Single Married Divorced Separated Widowed If married, how long have you been married?

If married, are you currently having any stressors or problems in your marriage? Yes No N/A (If yes, please explain)

Have you been married previously? Yes No N/A (If yes, please explain)

Do you have any concerns about domestic violence or abuse? Yes No (If yes, please explain)

For provider only
Is Further evaluation or referral required?
 YES NO
Use Initials

Have you or any of your spouses ever been referred to any agency such as Child Protective Services or Family Advocacy?
 Yes No (If yes, please explain)

Please list all your children: N/A (continue below, if needed)

Child's name	Child's age	Child's Gender	Biological or stepchild	Does this child currently reside with you?
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

Date: Patient's name: Rank: Sponsor SSN: Patient's date of birth:

Does anyone else reside in your household?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>(If yes, please explain below)</i>
Are you having any problems with your children?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Part 9 – RISK ASSESSMENT

Are there any firearms in your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	For provider only Is Further evaluation or referral required? <input type="checkbox"/> YES <input type="checkbox"/> NO Use Initials
Is there any history of domestic violence in your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a history of suicidal or self-destructive thoughts or behaviors?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a history of homicidal (harm to others) thoughts or behaviors?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have any other safety concerns at this time?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Part 10 - SOCIAL SUPPORT ASSESSMENT

Do you have someone to talk to when you have a problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there someone you would ask for help if you needed it?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you geographically separated from family and friends?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you having trouble with your relationships with family, friends or coworkers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you recently withdrawn from family or friends?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you belong to any groups or organizations that are supportive and helpful to you? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, please explain)</i>	

Active Duty Only: Do you feel supported and/or accepted by your unit? Yes No *(If NO, please explain)*

Part 11 – SPIRITUAL/ CULTURAL ASSESSMENT

What is your religious or spiritual affiliation?	For provider only Is Further evaluation or referral required? <input type="checkbox"/> YES <input type="checkbox"/> NO Use Initials
How much is your religion or spirituality a source of strength or comfort to you? <input type="checkbox"/> Not at all <input type="checkbox"/> Not very much <input type="checkbox"/> Somewhat <input type="checkbox"/> Quite a bit <input type="checkbox"/> A great deal	
How much is your spiritual community a source of support to you? <input type="checkbox"/> Not at all <input type="checkbox"/> Not very much <input type="checkbox"/> Somewhat <input type="checkbox"/> Quite a bit <input type="checkbox"/> A great deal	
Do you have any religious, spiritual or cultural practices that your provider needs to be aware of during treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, please explain)</i>	

Part 12 - EDUCATIONAL ASSESSMENT

Highest level of education completed? <input type="checkbox"/> GED <input type="checkbox"/> HS <input type="checkbox"/> Some College <input type="checkbox"/> 4yr College <input type="checkbox"/> Masters <input type="checkbox"/> Doctoral	
Are you currently in school or training?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did you repeat or skip any grades?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did you attend any special education or gifted classes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did you have any learning disabilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did you have any disciplinary problems in school?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, were you ever suspended or expelled?	<input type="checkbox"/> Yes <input type="checkbox"/> No

(If yes, please explain below)

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PART 13 - LEGAL ASSESSMENT

Have you ever been arrested?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>(If yes, please explain below)</i>
Are you currently on probation or parole?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you presently have any other legal problems ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

(Military only) Have you ever had any administrative actions taken against you? Yes No *(If yes, please explain)*

- Negative counseling statement
- Letter of reprimand
- Article 15
- Court-martial
- Chapter

Part 14 – SEXUAL ASSESSMENT

Are you experiencing any sexual concerns?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>(If yes, please explain below)</i>
Have you ever been sexually abused, assaulted or harassed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Part 15 – LEISURE, RECREATIONAL AND VOCATIONAL ACTIVITIES

What is your present job?

Are there any problems with your present job?

What do you like to do in your free time?

What limits your ability or desire to participate in leisure and recreational activities?

Part 16 – NUTRITIONAL ASSESSMENT

Height	Weight	In the last month have you gained or lost weight without trying? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, please explain below)</i>
How many meals do you eat per day?		
Have you ever had problems with: <i>(If checked, please explain)</i> <input type="checkbox"/> Being overweight <input type="checkbox"/> Being underweight <input type="checkbox"/> Binge eating <input type="checkbox"/> Compulsive overeating <input type="checkbox"/> Vomiting <input type="checkbox"/> Laxative Abuse <input type="checkbox"/> Excessive dieting <input type="checkbox"/> Diuretic (Water pill) Abuse <input type="checkbox"/> Other eating disorders/problems		For provider only Is Further evaluation or referral required? <input type="checkbox"/> YES <input type="checkbox"/> NO Use Initials

Part 17 - FINANCIAL ASSESSMENT

Do you currently have any financial problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>(If yes, please explain below)</i>
Do you think you need financial counseling?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		For provider only Is Further evaluation or referral required? <input type="checkbox"/> YES <input type="checkbox"/> NO Use Initials

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Part 18 – PATIENT DISCLOSURE

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

Patient Signature and Date: _____

Please list any individuals that you consent to have contacted regarding your care:

<input type="checkbox"/> Spouse	<input type="checkbox"/> Gather further information	<input type="checkbox"/> Release information	<input type="checkbox"/> Make recommendations
<input type="checkbox"/> Supervisor	<input type="checkbox"/> Gather further information	<input type="checkbox"/> Release information	<input type="checkbox"/> Make recommendations
<input type="checkbox"/> First Sergeant	<input type="checkbox"/> Gather further information	<input type="checkbox"/> Release information	<input type="checkbox"/> Make recommendations
<input type="checkbox"/> Commander	<input type="checkbox"/> Gather further information	<input type="checkbox"/> Release information	<input type="checkbox"/> Make recommendations
<input type="checkbox"/> Doctor	<input type="checkbox"/> Gather further information	<input type="checkbox"/> Release information	<input type="checkbox"/> Make recommendations
<input type="checkbox"/> Other Person or Agency	<input type="checkbox"/> Gather further information	<input type="checkbox"/> Release information	<input type="checkbox"/> Make recommendations

**(PATIENTS, DO NOT COMPLETE THE SECTION BELOW)
PROVIDER REVIEW**

I have reviewed this form for clinically relevant information.

Additional Assessments:	Score:
OQ- 45	<input type="checkbox"/> Yes <input type="checkbox"/> No
Symptom Check List	<input type="checkbox"/> Yes <input type="checkbox"/> No
Beck Depression Inventory – II	<input type="checkbox"/> Yes <input type="checkbox"/> No
PTSD Check List	<input type="checkbox"/> Yes <input type="checkbox"/> No
Post Deployment Health Assessment Tool	<input type="checkbox"/> Yes <input type="checkbox"/> No
Yale Brown Obsessive Compulsive Scale	<input type="checkbox"/> Yes <input type="checkbox"/> No
Folstein Mini Mental State	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Referrals made for further assessment: <input type="checkbox"/> PCM (for medical issue or Pain > 4 / 10) <input type="checkbox"/> ASAP (for additional substance screening) <input type="checkbox"/> Family Advocacy (for suspected domestic abuse) <input type="checkbox"/> Psychiatrist/Psychologist (for Safety Assessment) <input type="checkbox"/> Chaplain <input type="checkbox"/> Nutrition <input type="checkbox"/> Army Community Service (for financial services)	Comments:
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Signature:	Date:
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Date:	Patient's name:	Rank	Sponsor SSN:	Patient's date of birth:
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This Section is for Optional Use by Provider

Part 19 – HISTORY OF PRESENT ILLNESS

(This area is intentionally left blank for provider use.)

Symptom Check List:

Psychosis (Need 2 Sxs)	<input type="checkbox"/> Delusions <input type="checkbox"/> Hallucinations	<input type="checkbox"/> Disorganized speech <input type="checkbox"/> Disorganized/Catatonic behavior	<input type="checkbox"/> Negative Symptoms (affective flattening, alogia, or avolition)
Mania (Need ↑Mood, and 3 Sxs)	<input type="checkbox"/> Elev, expansive or irritable mood <input type="checkbox"/> Grandiosity <input type="checkbox"/> Decreased need for sleep	<input type="checkbox"/> Pressured speech <input type="checkbox"/> Racing thoughts <input type="checkbox"/> Distractibility	<input type="checkbox"/> Increased activity or agitation <input type="checkbox"/> High risk behavior
Depression (Need 5 Sxs)	<input type="checkbox"/> Depressed mood <input type="checkbox"/> Anhedonia <input type="checkbox"/> Change in Weight/Appetite	<input type="checkbox"/> Sleep disturbance <input type="checkbox"/> Agitation/Retardation <input type="checkbox"/> Fatigue	<input type="checkbox"/> Worthlessness/Guilt <input type="checkbox"/> Cognitive deficit <input type="checkbox"/> Thoughts of Death or Suicide
Panic (Need 4 Sxs)	<input type="checkbox"/> Palpitations <input type="checkbox"/> Sweating <input type="checkbox"/> Trembling or shaking <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Choking	<input type="checkbox"/> Chest pain or discomfort <input type="checkbox"/> Nausea or abdominal distress <input type="checkbox"/> Lightheadedness <input type="checkbox"/> Derealization / Depersonalization <input type="checkbox"/> Fear of losing control	<input type="checkbox"/> Fear of dying <input type="checkbox"/> Paresthesias <input type="checkbox"/> Chills or hot flushes <input type="checkbox"/> Agoraphobia
PTSD	Re-experiencing Symptoms (Need 1) <input type="checkbox"/> Intrusive recollections <input type="checkbox"/> Distressing dreams <input type="checkbox"/> Flashbacks <input type="checkbox"/> Psych distress at cues <input type="checkbox"/> Phys. distress at cues <input type="checkbox"/> Restricted range of affect	Avoidance Symptoms (Need 3) <input type="checkbox"/> Foreshortened future <input type="checkbox"/> Avoids thoughts/feelings <input type="checkbox"/> Avoids activities <input type="checkbox"/> Loss of recall <input type="checkbox"/> Withdrawal from activities <input type="checkbox"/> Feelings of detachment	Arousal Symptoms (Need 2) <input type="checkbox"/> Insomnia <input type="checkbox"/> Irritability/anger <input type="checkbox"/> Poor concentration <input type="checkbox"/> Hypervigilance <input type="checkbox"/> Startle

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Part 20 – MENTAL STATUS EXAMINATION

Behavior:	<input type="checkbox"/> cooperative	<input type="checkbox"/> agitated	<input type="checkbox"/> hostile	<input type="checkbox"/> disruptive	<input type="checkbox"/> violent
Grooming:	<input type="checkbox"/> good hygiene and grooming	other: <input type="checkbox"/> unkempt	<input type="checkbox"/> odiferous	other:	
Alertness:	<input type="checkbox"/> fully alert	<input type="checkbox"/> tired	<input type="checkbox"/> somnolent	<input type="checkbox"/> lethargic	<input type="checkbox"/> obtunded
Orientation:	<input type="checkbox"/> x 4	other: <input type="checkbox"/> to person	<input type="checkbox"/> to place	<input type="checkbox"/> to time/date	<input type="checkbox"/> to situation
Speech:	<input type="checkbox"/> normal rate, tone, and prosody	Rate <input type="checkbox"/> agitated	<input type="checkbox"/> slow	<input type="checkbox"/> rapid	<input type="checkbox"/> pressured
Motor:	<input type="checkbox"/> no agitation or retardation	Tone <input type="checkbox"/> retarded	<input type="checkbox"/> inaudible	<input type="checkbox"/> soft	<input type="checkbox"/> loud
Eye Contact:	<input type="checkbox"/> good	Prosody <input type="checkbox"/> agitated	<input type="checkbox"/> monotone	<input type="checkbox"/> rambling	<input type="checkbox"/> deficits
Cognition:	<input type="checkbox"/> intact attention, recall & memory	other: <input type="checkbox"/> poor	<input type="checkbox"/> fair	<input type="checkbox"/> staring	
Mood:	<input type="checkbox"/> euthymic	other: <input type="checkbox"/> inattentive	<input type="checkbox"/> poor recall	<input type="checkbox"/> poor recent	<input type="checkbox"/> poor remote
Affect:	<input type="checkbox"/> full ranging and appropriate	other: <input type="checkbox"/> depressed	<input type="checkbox"/> irritable	<input type="checkbox"/> anxious	<input type="checkbox"/> angry
Thought Process:	<input type="checkbox"/> linear, logical, and goal-directed	<input type="checkbox"/> elated	<input type="checkbox"/> euphoric	other:	
Thought Content:	<input type="checkbox"/> no SI/HI or abnormal perceptions	<input type="checkbox"/> dyphoric	<input type="checkbox"/> restricted	<input type="checkbox"/> blunted	<input type="checkbox"/> flat
Judgment:	<input type="checkbox"/> good	<input type="checkbox"/> fearful	<input type="checkbox"/> anxious	<input type="checkbox"/> bright	<input type="checkbox"/> expansive
Insight:	<input type="checkbox"/> good	<input type="checkbox"/> concrete	<input type="checkbox"/> perseverates	<input type="checkbox"/> circumstantial	<input type="checkbox"/> tangential
Impulse Control:	<input type="checkbox"/> intact	<input type="checkbox"/> LOA	<input type="checkbox"/> FOI	<input type="checkbox"/> disorganized	other:
		<input type="checkbox"/> self-injury	<input type="checkbox"/> death	<input type="checkbox"/> SI	<input type="checkbox"/> HI
		<input type="checkbox"/> IOR	<input type="checkbox"/> delusions	<input type="checkbox"/> hallucinations	other:
		<input type="checkbox"/> fair	<input type="checkbox"/> poor		
		<input type="checkbox"/> fair	<input type="checkbox"/> limited	<input type="checkbox"/> poor	
		<input type="checkbox"/> impaired			

Part 21 – LAB / RADIOLOGY

Part 21 – BIO-PSYCHO-SOCIAL FORMULATION

Bio -

Psycho -

Social -

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Part 22 – ASSESSMENT / IMPRESSION

Suicide Risk Assessment (if indicated) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sex (male) <input type="checkbox"/> Age >45 <input type="checkbox"/> Depression <input type="checkbox"/> Previous Attempt <input type="checkbox"/> Ethanol Abuse <input type="checkbox"/> Rational Thinking Loss <input type="checkbox"/> Social Support Deficit <input type="checkbox"/> Organized Plan <input type="checkbox"/> No Spouse <input type="checkbox"/> Sickness	Suicide Risk is estimated to be: <input type="checkbox"/> 0-2 Little Risk <input type="checkbox"/> 3-4 Moderate Risk Follow Closely <input type="checkbox"/> 5-6 High Risk Strongly Consider Hospitalization <input type="checkbox"/> 7-10 Very High Risk Hospitalize or Commit
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Strengths / Assets:

Limitations / Impediments to Therapy:

Learning needs:

Diagnosis: (DSM-IV)

Axis I

Axis II

Axis III

Axis IV

Axis V

Military / Occupational Readiness: <input type="checkbox"/> Fit for Duty <input type="checkbox"/> Fit for Duty with Profile (see attached DD3349) <input type="checkbox"/> Not Fit for Duty, Chapter Separation Required (see DA4038) <input type="checkbox"/> Not Fit for Duty, Medical Evaluation Board Required <input type="checkbox"/> Not Fit for Duty, Hospitalization Required	Comments: <input type="checkbox"/> DA 3349 Completed <input type="checkbox"/> DA 4038 Completed <input type="checkbox"/> Narrative Summary Completed <input type="checkbox"/> Assign to Medical Hold (WRAMC FL 14)
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Part 23 - PLAN

Labs: CBC Chem TSH HCG Drug Screening Drug Level Other

Rads: Head CT Brain MR Other

Medications:

Date:	Patient's name:	Rank	Sponsor SSN:	Patient's date of birth:
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Psychotherapies: <input type="checkbox"/> Supportive <input type="checkbox"/> Psychodynamic <input type="checkbox"/> CBT <input type="checkbox"/> ET <input type="checkbox"/> Group <input type="checkbox"/> Other			
Referrals: <input type="checkbox"/> Psychological Testing <input type="checkbox"/> PCM <input type="checkbox"/> ASAP <input type="checkbox"/> SWS/FAP <input type="checkbox"/> Chaplain <input type="checkbox"/> Nutrition <input type="checkbox"/> ACS <input type="checkbox"/> Other			
Other Plans:			
Expected Outcome: <input type="checkbox"/> Return to Normal functioning <input type="checkbox"/> Expect Improvement <input type="checkbox"/> Relieve Acute Symptoms <input type="checkbox"/> Maintain current status <input type="checkbox"/> Prevent Deterioration <input type="checkbox"/> Evaluation Only			
<input type="checkbox"/> Case discussed with Chain of Command: Comments:		Name:	Phone:
<input type="checkbox"/> The risks, benefits and alternatives to the proposed treatments have been discussed with the patient. Informed consent is obtained.			
Signature:			Date:
Supervision Note: Chart reviewed, case discussed in supervision. <input type="checkbox"/> I saw and evaluated the patient. I agree with the findings and plan of care as documented above. <input type="checkbox"/> I saw and evaluated the patient. I agree with the findings and plan of care except for : <input type="checkbox"/> I recommend the following: Supervisor Signature and Stamp: _____			Date:

Date:	Patient's name:	Rank	Sponsor SSN:	Patient's date of birth:
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