Bent Creek Behavioral Health Services, PLLC

PO Box 177, Seiling, Ok 73663 | (580) 922-5656 | info@bentcreekbhs.com

Brief Self-Report Assessment

Patient Name:_____ Date:_____

Provider:_____

Location:_____

Confidentiality Issues?

Yes No If yes, describe:_____

What would you like help with (reason for seeking services)? _____

_____

What are your immediate/urgent needs (including medical)?_____

_____

Current thoughts of harming self and/or others?:

Yes No Not Provided (NP)

Currently receiving or past services?

Yes No If yes, where?_____

Annual Household Income: $_____ **# in Household:**_____

Source of Income:_____

Are you currently taking any medication including over the counter?

Yes No NP

Name of Primary Care Physician, address, phone: _____

_____

Are you currently homeless?

Yes No If yes, for how long?_____

Been homeless at any time during the past 3 years?

Yes No If yes, # of times:_____

Anyone you would choose to come and participate in your services?

Yes No NP

Bent Creek Behavioral Health Services, PLLC

PO Box 177, Seiling, Ok 73663 | (580) 922-5656 | info@bentcreekbhs.com

Need any special help/equipment?

Yes No If yes, describe:_____

Psychiatric & Medical Medications

Name / Dosage / Quantity / Frequency	Effectiveness / Side Effects / Efficacy	Prescribing Physician	Reason	Date Prescribed	Refills

Mental Health - Within the last 90 days (3 months) have you had a significant period in which you have experienced:

- ☐ 1. Serious Depression (felt sadness, hopelessness, loss of interest, change of appetite or sleep pattern, difficulty going about your daily activities)?
- ☐ 2. Serious anxiety or tension (felt uptight, worried, unable to relax)?
- ☐ 3. Being prescribed medication for psychological/emotional problems?
- ☐ 4. Thoughts of harming yourself?
- ☐ 5. Hallucinations (heard/seen things others don't hear or see)?
- ☐ 6. An attempted suicide?

Substance Abuse - During the past 12 months have you:

- ☐ 1. Been preoccupied with drinking alcohol and/or using other drugs?
- ☐ 4. Need to drink and/or use more to get the same effect you used to?
- ☐ 3. Had problems caused by drinking/using drugs, and you kept using?
- ☐ 2. Tried to stop drinking alcohol and/or using other drugs, but couldn't?
- ☐ 5. Drunk alcohol and/or used other drugs more than you intended?
- ☐ 6. Experienced periods of time where your thinking speeds up and you have trouble keeping up with your thoughts?
- ☐ 7. Drunk alcohol and/or used other drugs to alter the way you feel?:

Bent Creek Behavioral Health Services, PLLC

PO Box 177, Seiling, Ok 73663 | (580) 922-5656 | info@bentcreekbhs.com

Trauma - During the past year (12 months) have you:

- ☐ 1. Experienced a traumatic event, natural disaster, war, accident, injury, loss of a loved one?
- ☐ 2. Had periods of time where you felt that you could not trust family or friends?
- ☐ 3. Ever been afraid of your partner and/or family member?
- ☐ 4. Ever been hit, slapped, kicked, emotionally or sexually hurt, or threatened?:

Gambling - During the past year (12 months) have you

- ☐ 2. Had to lie to people important to you about how much you gamble?
- ☐ 1. Felt the need to bet more and more money?:

Child/Adolescent Section

- ☐ 1. Are you feeling mad, sad, hopeless, nervous, or have you had a change in your sleeping, eating, or school performance?
- ☐ 2. Are you spending less time with friends, care less about your appearance, or feel alone?
- ☐ 3. Get into trouble for acting up, fighting, setting fires, hurting animals or tearing up stuff?
- ☐ 4. Have you ever experienced a very bad thing or person (traumatic event) where you continued to feel scared, worried, or nervous or even had nightmares that bothered you after it was all over?
- ☐ 5. Are you using alcohol and/or illegal drugs including inhalants?
- ☐ 6. Are you misusing any prescription medication or over the counter products?:

Source of Information/Relationship:_____

Significant other to notify in case of emergency:_____

Does the patient have a representative payee/guardian/conservator/personal representative? Yes No

If yes, which one and who, Phone # and Address:_____

_____

Patient Chart #:_____

Feeling/Mood/Affect

Problem Areas:

- ☐ mood lability
- ☐ coping skills
- ☐ suicidal/homicidal ideation/plan
- ☐ depression
- ☐ anger anxiety
- ☐ euphoria
- ☐ change in appetite/sleep patterns

Evidenced by (Give at least one specific example per problem selected, how often it happens, how long it lasts when it happens, and intensity 0-10 how problematic it is [0 being not at all; 10 being maximum issue]):_____
_____
_____

Self-Care/Basic Needs

Problem areas:

- ☐ hygiene
- ☐ food
- ☐ clothing
- ☐ shelter
- ☐ medical/dental
- ☐ transportation
- ☐ personal mobility
- ☐ communication / hearing / vision

Evidenced by (Give at least one specific example per problem selected, how often it happens, how long it lasts when it happens, and intensity 0-10 how problematic it is [0 being not at all; 10 being maximum issue]):_____
_____
_____

Patient Chart #:_____

Bent Creek Behavioral Health Services, PLLC

PO Box 177, Seiling, Ok 73663 | (580) 922-5656 | info@bentcreekbhs.com

Urgent Needs

Risk for:

- ☐ Harm to Others
- ☐ Person & Property
- ☐ Person
- ☐ Property
- ☐ Self Harm
- ☐ Other:_____

Are risk taking behaviors present? Yes No If yes, describe:_____

Family

Currently resides with: biological family adoptive family foster family

Problem areas:

- ☐ parenting
- ☐ conflict
- ☐ abuse/violence
- ☐ communication
- ☐ marital
- ☐ sibling
- ☐ parent/child
- ☐ other:_____

Evidenced by (Give at least one specific example per problem selected, how often it happens, how long it lasts when it happens, and intensity 0-10 how problematic it is [0 being not at all; 10 being maximum issue]):_____

_____

_____

Current Social Support (need for & availability):_____

_____

Family (history of relationships w/ family):_____

_____

Marital/Significant Other (relationship history, separations, divorce, functional level of current relations):_____

_____

Patient Chart #:_____

Affect of patient problems on family:_____
_____

Family issues affecting the patient(such as history of mental health, addictive disorders, or others. Including issues related to past or current trauma and domestic violence): _____
_____

Childhood history of adults:_____
_____

Childhood history of birth parents:_____
_____

Social/Interpersonal

Problem areas:

- ☐ peers/friends
- ☐ social interaction
- ☐ withdrawal
- ☐ make/keep friends
- ☐ conflict
- ☐ Independent Living Skills

Evidenced by (Give at least one specific example per problem selected, how often it happens, how long it lasts when it happens, and intensity 0-10 how problematic it is [0 being not at all; 10 being maximum issue]):_____
_____
_____

Historical relationships w/friends, groups in life and include natural supports:_____
_____

Recreational/Leisure (previous and current abilities and/or interest, activities for relaxation and pleasure and community involvement):_____
_____

Sexual (history, problems in intimate relationships, other significant experiences):_____
_____

Sexual Orientation:_____

Gender Expression:_____

HIV/AIDS/STD at risk behaviors? Yes No If YES, describe:_____

Cultural Details

Community Integration (How are you a part of your community?):_____
_____

Cultural Orientation/Background/Ethnicity (how this relates to treatment):_____
_____

Spiritual Beliefs/Religious Orientation/and Grief Practices:_____
_____

Caregiver Resources (ex: a person(s) who give physical and emotional support):_____
_____

Highest grade/education completed:_____
Level of Intellectual Functioning: below average average above average

Military History (combat?):_____

Occupational/Vocational (past and present job roles, stability):_____
_____

Economic Resources (past and present annual income/means of support/type insurance):_____
_____

Functional Role Performance

Problem areas:

- ☐ employment/volunteer
- ☐ school/day care
- ☐ home management
- ☐ other:_____

Evidenced by (Give at least one specific example per problem selected, how often it happens, how long it lasts when it happens, and intensity 0-10 how problematic it is [0 being not at all; 10 being maximum issue]):_____
_____
_____

Bent Creek Behavioral Health Services, PLLC

PO Box 177, Seiling, Ok 73663 | (580) 922-5656 | info@bentcreekbhs.com

Current Socio/Legal Issues

Problem areas:

- ☐ ability to follow rules/laws
- ☐ authority issues
- ☐ legal issues
- ☐ aggression
- ☐ probation/parole
- ☐ abides by personal ethical/moral value system
- ☐ antisocial behaviors

Evidenced by (Give at least one specific example per problem selected, how often it happens, how long it lasts when it happens, and intensity 0-10 how problematic it is [0 being not at all; 10 being maximum issue]):_____

_____

_____

Has the patient been arrested? 6 months 30 days please describe:_____

Past legal involvement:_____

Current legal involvement:_____

Attorney Name and Phone:_____

Probation/Parole Officer:_____

Has the patient received perpetrator treatment services? Yes No
If YES, describe:_____

Does the patient have a history and/or current issues with…

	Verbal	Physical	Sexual	Neglect	Emotional
…abusive behavior?	Yes	No	If YES, describe:_____		

Bent Creek Behavioral Health Services, PLLC

PO Box 177, Seiling, Ok 73663 | (580) 922-5656 | info@bentcreekbhs.com

Thinking/Mental Status

Problem Areas:

- ☐ memory
- ☐ cognitive process
- ☐ concentration
- ☐ judgement
- ☐ obsessions
- ☐ delusions/hallucinations
- ☐ belief system
- ☐ learning disabilities
- ☐ impulse control

Evidenced by (Give at least one specific example per problem selected, how often it happens, how long it lasts when it happens, and intensity 0-10 how problematic it is [0 being not at all; 10 being maximum issue]):_____

_____

_____

Trauma Issues

Has the patient ever witnessed Trauma/Abuse/Neglect/Violence/Domestic Violence/Sexual Assault/Exploitation? Yes No

If YES, please describe:_____

_____

If YES, what services were received? Please describe:_____

_____

Does patient have a history and/or current issues with Trauma/Abuse/Neglect/Violence/Domestic Violence/Sexual Assault/Exploitation?

Yes No

If YES, please describe:_____

_____

If YES, what services were received? Please describe:_____

_____

Bent Creek Behavioral Health Services, PLLC

PO Box 177, Seiling, Ok 73663 | (580) 922-5656 | info@bentcreekbhs.com

Medical/Physical Health

Historical Medical/physical conditions:_____
_____

Current condition of health (including diagnoses):_____
_____

Impact/limitations on day-to-day function:_____

Adjustments to disorders/disabilities:_____

Adherence to Medication or Treatment Recommendations:_____

List any medications previously prescribed for mental health issues:_____
_____

Does the patient have any medication/food allergies or adverse reactions? Yes No
If YES, list:_____

Does the patient have a medical advance directive? Yes No

Does the patient have a psychiatric advanced directive? Yes No

Last Physical Exam Date:_____

Female only - Is the patient pregnant? Yes No Please indicate month:_____
If pregnant, has the patient sought prenatal care? Yes No

Does the child have any of the following problems:

- ☐ Difficulty Chewing
- ☐ Difficulty Swallowing
- ☐ Nausea / Vomiting
- ☐ Constipation / Diarrhea
- ☐ Mouth Sores

Does the patient need a nutritional referral? Yes No

Bent Creek Behavioral Health Services, PLLC

PO Box 177, Seiling, Ok 73663 | (580) 922-5656 | info@bentcreekbhs.com

Addiction Issues (alcohol/drug/tobacco/porn/eating/sex/etc)

Do you do any of the following? If so, each item should be documented in the grid below.

- ☐ Use alcohol?
- ☐ Use Tobacco?
- ☐ If tobacco, need help with quitting or treatment?
- ☐ Use Drugs?
- ☐ Have issue with Porn?
- ☐ Have issue with eating?
- ☐ Have issue with Sex?
- ☐ Have issue with Gambling?
- ☐ Have issue with Other? _____

Functional impact of current use:_____

Discuss family history of addictions:_____

Consequences of dependency and addiction:_____

Patient Treatment

Patient/Guardian expectations/goals for treatment:_____
_____

Patient strengths:_____

Patient abilities:_____

Patient preferences\expectations:_____

Patient liabilities\needs:_____

Current and Historical Treatment (Psychiatric, Medical, Addictions, etc.)
Agency Name:_____
Treatment Start Date:_____
Treatment End Date:_____
Diagnosis:_____
Type of Treatment:_____

Bent Creek Behavioral Health Services, PLLC

PO Box 177, Seiling, Ok 73663 | (580) 922-5656 | info@bentcreekbhs.com

Complete this section for children intake only

Are immunizations current: Yes No

If NO, what is deficient?_____

Has the child experienced prenatal exposure to alcohol, tobacco, lead, prescription or illicit drugs? Yes No If YES, please describe:_____

Has the child been exposed to or been abusive to others? Yes No

If YES, which types of abuse? Verbal Physical Sexual Emotional

Comments:_____

Does anyone, other than the biological parent, have custody or guardianship of this child? Yes No

Who/relationship:_____

Comments:_____

Are parents and/or guardians able and willing to participate in services? Yes No

Comments:_____

Name of school child currently attends:_____

Grade:_____

Has anyone ever told you your child's milestones were not in normal range?

Yes No

If YES, describe (walking, talking, toilet training, self dressing, etc.):_____

Have any concerns or problems related to the child's learning ability been identified?

Yes No If YES, Please describe:_____

Does your child have an IEP/504 plan? Yes No

If YES, Please describe:_____

Is your child receiving school based behavioral health services? Yes No

If YES, Please describe:_____

By signing below I attest to the information provided in this assessment screener to be true and accurate, and that I am the appropriate informant for this assessment screener.

Patient Signature (*If 14+*): _____ **Date**: _____

Parent / Guardian's Signature: _____ **Date**: _____