Intake Profile
-- Part 1 --

Name: __________________________________________

You have been referred for services to help with your general health and well-being, including behavioral health. You may or may not have a clear idea of what behavioral health means, that’s OK. We’ll talk more about that as we go along. For now, our first job is to complete a brief Intake Profile together. Let’s get started.

In some ways, the Intake Profile is a story told about your life. You will be presented with a series of short, open-ended questions. Much of what you say will be recorded to make the responses as close to your own words as possible. We will also ask more focused questions intended to capture specific information required for your health record, for administrative purposes and to make sure we have everything needed to begin a healthier life for you. Always, our intention is to be helpful.

Sometime after we finish, we will review your Intake Profile to see what you think. Working together, it is very likely we can agree on an Intake Profile that reflects you and your life circumstances. Thank you for working with us to complete this part of your health record.

☐ We Agree

* = Required Fields

Presenting Concerns & Circumstances

* If you were referred by someone for help, who are they and what is their main concern? __________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________
* What are your own concerns or main problems? What brought you here? 


Education

* Are you currently in school? If yes, indicate level; if not, check "no."
  ☐ No ☐ Preschool ☐ Grade School ☐ Middle School ☐ High School
  ☐ Post Secondary ☐ Other

* Check highest level completed:
  ☐ Grade School ☐ Middle School ☐ High School ☐ GED ☐ Associate Degree
  ☐ Bachelor’s Degree ☐ Graduate Degree ☐ Other (certification, apprenticeship, diploma, etc.)

* Are you interested in furthering your education?  ☐ Yes  ☐ No
If yes, how can we help? 


Income

* What is your main source of income?  ☐ Employment ☐ Disability Income
  ☐ Job & Family Services ☐ Family
  ☐ Social Security ☐ Retirement/Pension
  ☐ Other

* Is your family income sufficient to meet basic needs?  ☐ Yes ☐ No
If no, how can we help? 


Residence

* How many people are in your household?  □ 1 □ 2 □ 3 □ 4 □ 5 or more

* Are you up to date on your rent or mortgage?  □ Yes □ No

* Do you consider your housing situation stable?  □ Yes □ No

If no, how can we help? ____________________________________________

Nutrition

* Are you able to adequately feed yourself and your family?  □ Yes □ No

* Do you consider yourself underweight or overweight?  □ Yes □ No

* Do you have problems related to nutrition?  □ Yes □ No

If yes, how can we help? ____________________________________________

Military Service

* Are you or anyone in your immediate family currently serving in the armed forces?  □ Yes □ No

* Are you or anyone in your immediate family a veteran of military service?  □ Yes □ No

* Do you need assistance with military service related benefits?  □ Yes □ No

If yes, how can we help? ____________________________________________

________________________________________________________________
Legal

* What is your current legal status?
  - None reported  
  - AoD Related  
  - Conditional Release  
  - On Probation  
  - On Parole  
  - Outpatient Commitment  
  - Awaiting Charge  
  - Court-ordered to Treatment  
  - Children’s Services  
  - Other

* Indicate your history of legal involvement:
  - None reported  
  - Juvenile Status Offense  
  - Juvenile Delinquency  
  - Adult Misdemeanor  
  - Adult Felony  
  - Children’s Services  
  - Other

* Do you have a living will and/or advanced directives?  
  - Yes  
  - No

* Do you currently have legal problems?  
  - Yes  
  - No

If yes, how can we help? ____________________________________________________________

Physical Health Problem Checklist

* Please check if you have now or have ever had:

  - Heart Disease / Problems
  - Arthritis
  - Kidney Disease / Trouble
  - Asthma
  - Hepatitis C

  - Stomach Problems
  - Venereal Disease
  - Epilepsy
  - Diabetes
  - N/A

  - High Blood Pressure
  - HIV / AIDS
  - Head Injury
  - Stroke

Behavioral Health Problem Checklist

* Please check if you have now or have ever had:

  - Nutritional / Eating Disorder
  - Pain Management
  - Depressed Mood / Sad
  - Bereavement Issues
  - N/A

  - Anxiety
  - Traumatic Stress
  - Anger / Aggression
  - Mood Swings

  - Substance Use
  - Addictive Behavior
  - Sleep Disturbance
  - Psychosocial Stress
  - N/A
Family History

* Please check if blood relative has ever had:

- Hypertension
- Heart Trouble
- Kidney Trouble
- Diabetes
- N/A
- Cancer
- Asthma / Hayfever
- Epilepsy
- Mental Illness
- Blood Disorder
- Suicide
- Ulcers
- Allergies

Developmental Issues

* Please check if you have experienced developmental challenges at any time:

- During Mother's Pregnancy
- Infancy (Age 0-1)
- Pre-School (Age 2-4)
- N/A
- Childhood (Age 5-12)
- Adolescent (Age 13-17)
- History of Special Education

Habits

* Do you use tobacco?  Yes  No
If so, which?  cigarettes  snuff  other

* Do you drink alcohol?  Yes  No
If so, how often?  daily  weekly  occasionally

* Has anyone ever told you to cut down on your drinking?  Yes  No

* Have you ever used drugs for anything other than medical?  Yes  No

* Do you exercise?  Yes  No
If so, how often?  daily  weekly  occasionally

* Do you sleep well at night?  Yes  No

* Do you wake up feeling rested?  Yes  No

* Do you have hobbies?  Yes  No
Primary Healthcare

* Do you have a primary care physician or nurse practitioner? □ Yes □ No
   If yes, please remember to complete the Primary Care Provider Form in the ECR.

* Have you had a routine physical exam within the last year? □ Yes □ No

* Are you or anyone in your family pregnant or need assistance with issues related to women's health? □ Yes □ No

* Have you been treated in the ER, Urgent Care or admitted into the hospital in the last 90 days? □ Yes □ No

* Do you have access to healthcare services to meet your basic needs? □ Yes □ No
   If no, how can we help? _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________

Medications

* Are you currently prescribed medications? □ Yes □ No
   If yes, please list:

* Prescribing professional(s): __________________________________________________________
   _____________________________________________________________
   _____________________________________________________________

* Medication(s): _________________________________________________________________
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________
* Are you currently taking over the counter medications? ☐ Yes ☐ No

If yes, please list:

* Medication(s): __________________________

* GAF score: ______________

<table>
<thead>
<tr>
<th>GAF Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>91 - 100</td>
<td>No symptoms. Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities.</td>
</tr>
<tr>
<td>81 - 90</td>
<td>Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).</td>
</tr>
<tr>
<td>71 - 80</td>
<td>If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily failing behind in schoolwork).</td>
</tr>
<tr>
<td>61 - 70</td>
<td>Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.</td>
</tr>
<tr>
<td>51 - 60</td>
<td>Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).</td>
</tr>
<tr>
<td>41 - 50</td>
<td>Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).</td>
</tr>
<tr>
<td>31 - 40</td>
<td>Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed adult avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).</td>
</tr>
<tr>
<td>21 - 30</td>
<td>Behavior is considerably influenced by delusions or hallucinations OR serious impairment, in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day, no job, home, or friends).</td>
</tr>
<tr>
<td>11 - 20</td>
<td>Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).</td>
</tr>
<tr>
<td>1 - 10</td>
<td>Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.</td>
</tr>
<tr>
<td>0</td>
<td>Inadequate information</td>
</tr>
</tbody>
</table>
### Brief Mental Status Exam

**Member Name:** ____________________________

**UCare ID#:** ____________________________

**Date:** ____________________________

**Care Manager Name:** ____________________________

- **UCare**
- **Other Partner:** ____________________________

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Appearance</td>
<td>[ ] Casual Dress, normal grooming &amp; hygiene</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Other (describe):</td>
</tr>
<tr>
<td>2.</td>
<td>Attitude</td>
<td>[ ] Calm &amp; Cooperative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Other (describe):</td>
</tr>
<tr>
<td>3.</td>
<td>Behavior</td>
<td>[ ] No usual movements or psychomotor changes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Other (describe):</td>
</tr>
<tr>
<td>4.</td>
<td>Speech</td>
<td>[ ] Normal rate/tone/volume/without pressure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Other (describe):</td>
</tr>
<tr>
<td>5.</td>
<td>Affect</td>
<td>[ ] Reactive &amp; Mood</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Normal range congruent</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Depressed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Labile</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Constricted</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Tearful</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Flat</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Blunted</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Other (describe):</td>
</tr>
<tr>
<td>6.</td>
<td>Mood</td>
<td>[ ] Euthymic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Anxious</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Depressed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Irritable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Elevated</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Other (describe):</td>
</tr>
<tr>
<td>7.</td>
<td>Thought Process</td>
<td>[ ] Goal-directed &amp; Logical</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Disorganized</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Other (describe):</td>
</tr>
<tr>
<td>8.</td>
<td>Thought Content</td>
<td>[ ] Suicidal Ideation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Homicidal Ideation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] If Active: Plan Y N</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Intent Y N</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Means Y N</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] If Active: Plan Y N</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Intent Y N</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Means Y N</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Delusions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Obsessions/compulsions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Phobias</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Other (describe):</td>
</tr>
<tr>
<td>9.</td>
<td>Perception</td>
<td>[ ] No hallucinations or delusions during interview</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Other (describe):</td>
</tr>
<tr>
<td>10.</td>
<td>Orientation</td>
<td>[ ] Oriented x 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Other (describe):</td>
</tr>
<tr>
<td>11.</td>
<td>Memory/Concentration</td>
<td>[ ] Short Term Intact</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Long Term Intact</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Distraictible/Inattentive</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Other (describe):</td>
</tr>
<tr>
<td>12.</td>
<td>Insight/Judgment</td>
<td>[ ] Good</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Fair</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Poor</td>
</tr>
</tbody>
</table>
## Diagnostic Formulation

<table>
<thead>
<tr>
<th>Check Primary</th>
<th>Axis</th>
<th>Code</th>
<th>Narrative Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>*</td>
<td>Axis I</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>*</td>
<td>Axis II</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Axis III</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Axis IV</td>
</tr>
<tr>
<td></td>
<td>Axis V</td>
<td>Current GAF:</td>
<td>Highest GAF in the Past Year (if known):</td>
</tr>
</tbody>
</table>

Authentication Required