

**Community Mental Health Center of Crawford County  
Psychiatric Diagnostic Interview (Intake Summary) 90801**

Last name:		First name:		Middle initial:	
Intake Date:		Intake Clinician:			
Gender:		Race:			
Date of Birth		Age:		Marital Status	
Referral Source:					

<b>Sources of Information:</b>	
--------------------------------	--

<b>Presenting Problem:</b>	Include Signs, Symptoms, Onset, Duration and Functional Impairment

<b>Psychiatric History:</b>			
<input type="checkbox"/> No Psychiatric Treatment History Reported			
Provider:	Date of Service:	Type of Service	Reason

<b>Substance Abuse History:</b>			
<input type="checkbox"/> No Substance Abuse History Reported			
If yes, specify type of substance, age of first use, amount at highest use, date of last use:			
<b>Substance Abuse Treatment History:</b>			
<input type="checkbox"/> No Substance Abuse Treatment History			
Provider:	Date of Service:	Type of Service:	

<b>Medical History:</b>				
<input type="checkbox"/> No Medical History Reported				
Allergies:				
Include developmental history if not within normal limits or explain other history:				
<i>Current Medications (Include Psychotropic, Medical, Prescription, OTC, and Herbal)</i>				
<input type="checkbox"/> None reported				
Current Medications & Dose	Prescribed by:	Medication for:	Compliance	
			Yes	No
			<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"/>
Primary Care Physician:				
Additional Information:				
<b>Family Medical and Psychiatric History:</b>				
<input type="checkbox"/> No Family Medical History Reported		<input type="checkbox"/> No Family Psychiatric History Reported		
If history is positive, report relationship and type of ailment:				

<b>Family History:</b>	

<b>Educational History:</b>			
Current or Highest Grade Completed:		Degree:	
Other education information:			

<b>Military History:</b>			
<input type="checkbox"/> No Military History Reported			
If Yes, Branch:		<input type="checkbox"/> Combat	<input type="checkbox"/> Non-Combat
Other military information:			

<b>Legal History:</b>				
<input type="checkbox"/> No Legal History Reported				
Current Legal Status:	None reported			
Corrections Officer, If Applicable:				
Conditions:				
History of Legal Charges:				
Date	Juvenile	Adult	Type of Charge	Description of Sentence
	<input type="checkbox"/>	<input type="checkbox"/>		None
	<input type="checkbox"/>	<input type="checkbox"/>		None
	<input type="checkbox"/>	<input type="checkbox"/>		None
Other legal information:				

<b>Employment History:</b>	<input type="checkbox"/> Child, Not Applicable		
<input type="checkbox"/> Full time Employed <input type="checkbox"/> Part-time employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled			
<input type="checkbox"/> Pending disability, Attorney:			
Other Employment Information:			

<b>Abuse History:</b>			
<input type="checkbox"/> No Abuse History Reported			
<input type="checkbox"/> Victim		<input type="checkbox"/> Perpetrator <input type="checkbox"/> Alleged Perpetrator	
Type of Abuse:	Yes	No	If yes, Describe:
Sexual	<input type="checkbox"/>	<input type="checkbox"/>	
Physical	<input type="checkbox"/>	<input type="checkbox"/>	
Emotional/Neglect	<input type="checkbox"/>	<input type="checkbox"/>	

<b>Mental Status:</b>	
Orientation:	<input type="checkbox"/> Oriented x 4 <input type="checkbox"/> Impaired person <input type="checkbox"/> Impaired place <input type="checkbox"/> Impaired time <input type="checkbox"/> Impaired situation
General Appearance:	<input type="checkbox"/> Appropriate Hygiene/Dress <input type="checkbox"/> Poor hygiene <input type="checkbox"/> Overweight <input type="checkbox"/> Underweight <input type="checkbox"/> Eccentric
Sensory/Physical Limitations:	<input type="checkbox"/> No limitations noted <input type="checkbox"/> Hearing <input type="checkbox"/> Physical <input type="checkbox"/> Visual <input type="checkbox"/> Speech
Attitude:	<input type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Guarded <input type="checkbox"/> Suspicious <input type="checkbox"/> Hostile <input type="checkbox"/> Apathetic
Mood:	<input type="checkbox"/> Calm <input type="checkbox"/> Cheerful <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed <input type="checkbox"/> Fearful <input type="checkbox"/> Labile <input type="checkbox"/> Euphoric <input type="checkbox"/> Irritable <input type="checkbox"/> Guilty <input type="checkbox"/> Hostile <input type="checkbox"/> Histrionic <input type="checkbox"/> Angry <input type="checkbox"/> Marked mood shifts <input type="checkbox"/> Other:
Affect:	<input type="checkbox"/> Congruent with mood <input type="checkbox"/> Incongruent with reported mood <input type="checkbox"/> Flat <input type="checkbox"/> Restricted <input type="checkbox"/> Blunted <input type="checkbox"/> Detached <input type="checkbox"/> Tearful <input type="checkbox"/> Broad Range <input type="checkbox"/> Other:
Speech:	<input type="checkbox"/> Within normal limits <input type="checkbox"/> Loud <input type="checkbox"/> Slurred <input type="checkbox"/> Rapid/pressured <input type="checkbox"/> Soft/mumbled <input type="checkbox"/> Latency <input type="checkbox"/> Monotone <input type="checkbox"/> Animated <input type="checkbox"/> Impediment <input type="checkbox"/> Other:
Thought content:	<input type="checkbox"/> Within normal limits <input type="checkbox"/> Grandiose <input type="checkbox"/> Paranoid <input type="checkbox"/> Tangential <input type="checkbox"/> Flight of Ideas <input type="checkbox"/> Circumstantial <input type="checkbox"/> Disorganized <input type="checkbox"/> Obsessive <input type="checkbox"/> Ideas of Reference <input type="checkbox"/> Blocking <input type="checkbox"/> Racing <input type="checkbox"/> Spontaneous <input type="checkbox"/> Loose associations <input type="checkbox"/> Other:
Memory:	<input type="checkbox"/> No impairment noted <input type="checkbox"/> Remote impairment <input type="checkbox"/> Recent impaired
Insight:	<input type="checkbox"/> Age appropriate <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Lacking
Cognition:	<input type="checkbox"/> No impairment noted <input type="checkbox"/> Distractibility <input type="checkbox"/> Indecisiveness <input type="checkbox"/> Impaired abstraction
Perceptual:	<input type="checkbox"/> No impairment noted <input type="checkbox"/> Visual Hallucinations <input type="checkbox"/> Auditory Hallucinations <input type="checkbox"/> Delusional <input type="checkbox"/> Olfactory Hallucinations <input type="checkbox"/> Kinesthetic Hallucinations <input type="checkbox"/> Depersonalization <input type="checkbox"/> Derealization <input type="checkbox"/> Other
Behavioral/Motor Activity:	<input type="checkbox"/> Within Normal Limits <input type="checkbox"/> Poor eye contact <input type="checkbox"/> Lethargic <input type="checkbox"/> Self destructive <input type="checkbox"/> Catatonic <input type="checkbox"/> Feigning of symptoms <input type="checkbox"/> Tense <input type="checkbox"/> Compulsive <input type="checkbox"/> Loss of interest <input type="checkbox"/> Withdrawn <input type="checkbox"/> Tremors/tics <input type="checkbox"/> Aggression <input type="checkbox"/> Agitated <input type="checkbox"/> Impulsive <input type="checkbox"/> Avoidance <input type="checkbox"/> Bizarre <input type="checkbox"/> Restless <input type="checkbox"/> Overactive <input type="checkbox"/> Repetitions <input type="checkbox"/> Disorganized <input type="checkbox"/> Uncoordinated <input type="checkbox"/> Decreased energy/fatigue <input type="checkbox"/> Increase social, occupational, sexual behavior <input type="checkbox"/> Other
Eating/sleep disturbance:	<input type="checkbox"/> No disturbance noted <input type="checkbox"/> Increased appetite <input type="checkbox"/> Decreased appetite <input type="checkbox"/> Weight gain/loss ___#/___time <input type="checkbox"/> Binge eating <input type="checkbox"/> Pica <input type="checkbox"/> Purging <input type="checkbox"/> Laxative abuse <input type="checkbox"/> Hypersomnia <input type="checkbox"/> Insomnia <input type="checkbox"/> Encopresis <input type="checkbox"/> Enuresis <input type="checkbox"/> Nightmares/Night terrors <input type="checkbox"/> Other
Anxiety Symptoms:	<input type="checkbox"/> Within normal limits <input type="checkbox"/> Generalized anxiety <input type="checkbox"/> Panic attacks

	<input type="checkbox"/> Fear of social situations <input type="checkbox"/> Obsessions/compulsions <input type="checkbox"/> Hypervigilance <input type="checkbox"/> Relieving traumatic events <input type="checkbox"/> Avoidance of environment
Conduct Disturbance:	<input type="checkbox"/> Conduct appropriate <input type="checkbox"/> Stealing <input type="checkbox"/> Lying <input type="checkbox"/> Truancy <input type="checkbox"/> Running away <input type="checkbox"/> Projects blame <input type="checkbox"/> Vindictive <input type="checkbox"/> Fire setting <input type="checkbox"/> Short tempered <input type="checkbox"/> Defiant <input type="checkbox"/> Cruelty to animals or people <input type="checkbox"/> Violent behavior <input type="checkbox"/> Destructive to others or property <input type="checkbox"/> Argumentative <input type="checkbox"/> Other:
Impairment of functioning:	<input type="checkbox"/> No impairment noted <input type="checkbox"/> Not attending school or work <input type="checkbox"/> Impairment in occupational functioning <input type="checkbox"/> Impairment of academic functioning <input type="checkbox"/> Impairment of interpersonal relationships
Interpersonal Characteristics:	<input type="checkbox"/> No significant traits noted <input type="checkbox"/> Exploitive <input type="checkbox"/> Entitled <input type="checkbox"/> Inability to sustain consistent work behavior <input type="checkbox"/> Perfectionist <input type="checkbox"/> Self-centered <input type="checkbox"/> Avoidant of relationships <input type="checkbox"/> Procrastinates <input type="checkbox"/> Excessive devotion to work <input type="checkbox"/> No close friends <input type="checkbox"/> Poor choices in relationships <input type="checkbox"/> Indifferent to others <input type="checkbox"/> Expects to be harmed or exploited by others <input type="checkbox"/> Unstable, intense relationships <input type="checkbox"/> Persistent emptiness <input type="checkbox"/> Manipulative <input type="checkbox"/> Seeks praise
Judgment:	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Marginal <input type="checkbox"/> Impaired

<b>Risk Assessment:</b>	
Current Danger to Self:	<input type="checkbox"/> None <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Threat <input type="checkbox"/> Gesture/Attempt <input type="checkbox"/> Intent with means <input type="checkbox"/> History <input type="checkbox"/> Intent with means <input type="checkbox"/> Risk aggravated by substance abuse <input type="checkbox"/> Able to contract no self harm If yes, explain:
Current Danger to Others:	<input type="checkbox"/> None <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Threat <input type="checkbox"/> Gesture/Attempt <input type="checkbox"/> Intent with means <input type="checkbox"/> History <input type="checkbox"/> Intent with means <input type="checkbox"/> Risk aggravated by substance abuse <input type="checkbox"/> Able to contract no harm If yes, explain:

<b>Provisional Diagnosis:</b>		
Axis	Diagnosis Code	Diagnosis
<b>I</b>		
<b>II</b>		
<b>III</b>		
<b>Axis IV: Problems With (Check all that apply)</b>		
<input type="checkbox"/> Primary Sup. Group:	<input type="checkbox"/> Housing:	
<input type="checkbox"/> Social Environment:	<input type="checkbox"/> Economic:	
<input type="checkbox"/> Education:	<input type="checkbox"/> Access/Health Care:	
<input type="checkbox"/> Job/Occupation:	<input type="checkbox"/> Legal/Crime:	

<input type="checkbox"/> Other:			
<b>Axis V:</b>	<b>Current GAF:</b>	<b>Highest GAF Last yr.</b>	<b>Prognosis:</b>
<b>Diagnostic Impression:</b>			

<b>Strengths:</b>	
<b>Barriers:</b>	

<b>Treatment Plan:</b>			
Treatment Plan Goal:			
Treatment Plan Objective:			
<b>Staff Signatures:</b>			
Intake Clinician Signature/Credentials		Medical Director Signature	
Treatment Team Signatures:		Review Date:	