

# Keller Army Community Hospital

## Department of Behavioral Health & Social Work Services

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

### IDENTIFICATION DATA

Today's Date: \_\_\_\_\_

Name (Last, First, MI): \_\_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_

Sponsor's Name: \_\_\_\_\_ Sponsor's SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Organization/Unit: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_ Rank/Grade: \_\_\_\_\_

Marital Status: Single \_\_\_\_ Married \_\_\_\_ Divorced \_\_\_\_ Separated \_\_\_\_ Widow(er) \_\_\_\_

Branch of Service: USA \_\_\_\_ USN \_\_\_\_ USAF \_\_\_\_ USMC \_\_\_\_ USCG \_\_\_\_ Other \_\_\_\_

Duty Status: Active Duty \_\_\_\_ Retired \_\_\_\_ Reserve \_\_\_\_ Family Member \_\_\_\_ National Guard \_\_\_\_

DOD Civilian \_\_\_\_

Referred by: Self \_\_\_\_ Command \_\_\_\_ Medical \_\_\_\_ Other (explain) \_\_\_\_ Command referral paperwork present \_\_\_\_

### PRESENTING PROBLEM

1. What is (are) your reason(s) for coming in today? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Do you believe symptoms are related to deployment? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Have you had difficulties or troubles like this before ( Yes or No )? If so, please describe \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## STRESS INVENTORY

1. Please check those areas that are current sources of increased stress for you:

Stressor	Yes	No	Stressor	Yes	No
Marital			Peers		
Family			Legal		
Children			Finances		
Divorce			Physical/Sexual Abuse		
Social			Alcohol Problems		
Death			Drug Problems		
Loss			Alcohol/Drug Problems of Others		
Medical			Relationships		
Job			School		
Military			N/A		

2. Is there another source of current stress not listed? (circle) Yes No If yes, please explain: \_\_\_\_\_

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## PSYCHOLOGICAL ASSESSMENT

1. Have you recently experienced or do you presently have any of the following:

Symptoms	Yes	No	Symptoms	Yes	No
Feeling Helpless/Hopeless			Racing Thoughts		
Thoughts of Hurting Others			Memory Problems		
Thoughts of Hurting Self			Panic/Anxiety		
Stress			Depression		
Loss of Interest in Activities			Troubling Thoughts		
Difficulty Concentrating			Flashbacks		
Guilt			Seeing things others do not see		
Rage			Hearing things others do not hear		
Mood Swings			Paranoia		
Irritability			Nightmares/Disturbing Dreams		
Loss of Energy			Poor Impulse Control		

2. List any psychiatric (past or current) or substance abuse evaluation, counseling, and/or hospitalizations: (This also includes primary care physicians and chaplains)

Reason	Location	Dates of Treatment	Diagnosis(If Known)

3. Does your family have any history of involvement with Child Protective Services or with the Family Advocacy Program? (circle) Yes or No

If so, where and when \_\_\_\_\_

4. Please list any biological family history of the following problems:

Problem	YES	NO	Problem	YES	NO
Drug/Alcohol Abuse			Physical Abuse/Sexual Abuse		
Legal Trouble			Hyperactivity		
Domestic Violence			Mental Retardation		
Suicide			Manic Episodes		
Attempted			Paranoia		
Depression			Schizophrenia		
Anxiety			Manic Depressive/Bipolar		
Psychiatric Hospitalization			Other		

5. Have there been any deaths in your family related to the problems listed above? Yes \_\_\_ No \_\_\_ If yes, please explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### PHYSICAL ASSESSMENT

1. Have you experienced in the past or do you presently have any of the following problems:

Problems	YES	NO	If undergoing treatment for any of these problems please explain
Loss of consciousness			
Headaches			
Speech problems			
Heart disease			
Respiratory problems			
Stomach and bowel problems			
Back or joint pain			
Neurological problems			
Kidney problems			
Hearing problems			

2. List all current and past medical or physical problems not asked already (including hospitalizations and traumas).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient's Name: \_\_\_\_\_

FMP/SSN: \_\_\_\_\_

3. Please list any allergies (including medications) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

4. List all past psychiatric medications and any current medications including over the counter medications, herbs, and supplements (i.e., St. John's Wart, Ginseng, vitamins, etc.)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SUBSTANCE USE ASSESSMENT**

	YES	NO	Where applicable please explain answer
Do you smoke or use tobacco products?			
How long have you been smoking or using tobacco products?			
How much tobacco do you use in a day?			
Have you attempted to quit smoking?			
Are you interested in quitting smoking?			
Do you drink alcohol? If yes, what do you drink and how often and how much?			
C-Have you ever felt the need to <b>cut down</b> on your drinking (or drug use)?			
A-Have you ever been <b>annoyed</b> by criticism of your drinking (or drug use)?			
G-Have you ever felt <b>guilty</b> about your drinking (or drug use)?			
E-Have you ever had a morning <b>eye-opener</b> (used drugs/alcohol first thing in the morning to get started)?			
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?			
Have you ever had times when you drank or used drugs to the point that you couldn't remember what you said or did the next day (i.e. blackouts)?			

**MILITARY HISTORY** (Family members disregard this section)

When did you enter the service? \_\_\_\_\_ Time in service \_\_\_\_\_ Time in current unit \_\_\_\_\_

MOS/Job Title \_\_\_\_\_ Highest rank held \_\_\_\_\_ Present job/MOS \_\_\_\_\_

ETS \_\_\_\_\_ GT Score \_\_\_\_\_ Military Training \_\_\_\_\_

Combat experience (circle) Yes No If yes, when and where \_\_\_\_\_

\_\_\_\_\_

**FAMILY RELATIONSHIP ASSESSMENT**

**EARLY FAMILY**

- 1. Where were you born and who raised you? \_\_\_\_\_
- 2. Where you adopted? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, at what age? \_\_\_\_\_
- 3. How many biological siblings do you have? \_\_\_\_\_
- 4. How many step-siblings do you have? \_\_\_\_\_
- 5. What was it like in your childhood home? Loving \_\_\_\_\_ Comfortable \_\_\_\_\_ Supportive \_\_\_\_\_ Chaotic \_\_\_\_\_  
Abusive \_\_\_\_\_ Other \_\_\_\_\_ (please explain) \_\_\_\_\_

**CURRENT FAMILY**

- 1. Rate your satisfaction with your marriage on a scale of 1-7, Poor Excellent  
1 2 3 4 5 6 7
- 2. Are you having any current problems in your marriage? If yes, please explain \_\_\_\_\_
- 3. How many times have you been married? \_\_\_\_\_

Date of Marriage	Date of Divorce/Death	Reason the Relationship Ended

- 4. Have you and/or any of your spouses ever been to counseling or to an agency such as Child Protective Services or Family Advocacy because of physical, sexual, or emotional abuse? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, who participated in the counseling, please explain: \_\_\_\_\_
- 5. Do you feel safe in your home? Yes \_\_\_\_\_ No \_\_\_\_\_

6. Please list the names, ages, and sex of your children:

Name	Age	Sex	Step/Biological	Currently resides with

**Patient's Name:** \_\_\_\_\_

**FMP/SSN:** \_\_\_\_\_

**SOCIAL SUPPORT ASSESSEMENT**

- 1. Do you have someone you can talk to or ask for help when you have a problem? Yes \_\_\_\_\_ No \_\_\_\_\_
- 2. Who would you say really cares about you? \_\_\_\_\_
- 3. Are you having trouble in your relationships with family and friends? Yes \_\_\_\_\_ No \_\_\_\_\_
- 4. Do you belong to any groups or organizations that are supportive and helpful to you? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain:  
\_\_\_\_\_  
\_\_\_\_\_

**PERCEPTION OF OWN STRENGHTS AND WEAKNESSES**

- 1. What do you like about yourself? \_\_\_\_\_  
\_\_\_\_\_
- 2. What do you dislike about yourself? \_\_\_\_\_  
\_\_\_\_\_
- 3. Please list anything else you are concerned about: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SPIRITUAL/CULTURAL ASSESSMENT**

- 1. What is your religious/spiritual affiliation? \_\_\_\_\_
- 2. How much is your religion/spirituality a source of strength and comfort to you? Not at all \_\_\_\_\_ not very much \_\_\_\_\_ somewhat \_\_\_\_\_ quite a bit \_\_\_\_\_ a great deal \_\_\_\_\_
- 3. How important a part of your daily life is your religion/spirituality? None \_\_\_\_\_ not much \_\_\_\_\_ some \_\_\_\_\_ quite a bit \_\_\_\_\_ a great deal \_\_\_\_\_

**EDUCATIONAL ASSESSMENT**

- 1. Highest level of education completed, elementary \_\_\_\_\_ junior high \_\_\_\_\_ high school \_\_\_\_\_ some college \_\_\_\_\_ Two year degree \_\_\_\_\_ four year degree \_\_\_\_\_ graduate school \_\_\_\_\_ tech school \_\_\_\_\_ other (please explain) \_\_\_\_\_  
\_\_\_\_\_

	Yes	No	Please explain applicable yes answers
Are you in school?			
Did you repeat any grades?			
Did you skip any grades?			
Did you ever have problems reading?			
Were you ever in any special education/gifted classes?			
Were you ever assigned a learning disability?			
Did you ever have any disciplinary problems in school?			

**LEGAL ASSESSMENT**

1. Have you ever been arrested? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please give year and reason: \_\_\_\_\_  
\_\_\_\_\_
2. Do you presently have any legal problems? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
3. (Military Only) Have you ever had any administrative action taken against you? Yes \_\_\_\_\_ No \_\_\_\_\_  
Article 15 \_\_\_\_\_ court martial \_\_\_\_\_ letter of reprimand \_\_\_\_\_ counseling statement \_\_\_\_\_ chapter \_\_\_\_\_
4. Do you have weapons in your home? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what type? Firearms \_\_\_\_\_ hunting or combat  
knives \_\_\_\_\_ other (please explain) \_\_\_\_\_  
\_\_\_\_\_
5. If you have weapons are they secured under lock and key? Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

**SEXUAL ASSESSMENT**

	Yes	No	If yes, please explain
Have you ever been sexually abusive to others?			
Do you feel guilty about any past sexual experiences?			
Do you engage in any risky behaviors?			

**LEISURE/RECREATIONAL/VOCATIONAL ASSESSMENT**

1. What are your favorite things/hobbies you like to do? \_\_\_\_\_  
\_\_\_\_\_
2. What limits your leisure/recreational activities? \_\_\_\_\_  
\_\_\_\_\_

**Patient's Name:** \_\_\_\_\_

**FMP/SSN:** \_\_\_\_\_

3. Are there any problems with your present job? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

4. If military, what are your plans? Stay in and re-enlist \_\_\_\_\_ Get out ASAP but with a good discharge \_\_\_\_\_

I don't know right now \_\_\_\_\_ Stay in the military until my ETS \_\_\_\_\_ Get out ASAP with any discharge \_\_\_\_\_

**NUTRITIONAL ASSESSMENT**

	Yes	No	Where it applies please explain:
Are you satisfied with your present weight?			
Are there any groups of food that you avoid?			
Have you recently gained or lost 10 pounds without trying?			
Have you ever had any problems with your weight in the past?			
Are you experiencing any other nutritional problems not asked in this section?			

1. What is your height? \_\_\_\_\_ feet \_\_\_\_\_ inches

2. What is your weight? \_\_\_\_\_ lbs.

**FINANCIAL ASSESSMENT**

1. Do you currently have any financial problems? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

2. Have you ever had any financial problems in the past? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

3. Do you need financial counseling? Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

Reviewed by: \_\_\_\_\_ (staff initials)