INJURY :: 1™

ASPIRE to Excellence® carf ACCREDITED

# BEHAVIORAL HEALTH INTAKE EVALUATION

| **PATIENT INFORMATION** | | | | | |
|---|---|---|---|---|---|
| Last Name | | First | | M.I. | Today's Date |
| Treating Doctor | Hand Dominance | ☐ Left ☐ Right | Date of Injury | | |

| **EMPLOYMENT INFORMATION & HISTORY OF PRESENT INJURY** | |
|---|---|
| Employer Name | Your Job Title |
| Date Hired | Length of time employed at time of injury: ___ Year(s) ___ Month(s) |

**Current Work Status** ☐ Off Work ☐ Terminated/Laid off ☐ Quit ☐ Unknown Last date worked?_________________
☐ Working full-time ☐ Working part-time ☐ Working without Restrictions ☐ Working with Restrictions including:______________________________________

If you are working, are you with the same employer? ☐ Yes ☐ No, my new employer is: ____________________________
Please note any difficulties you are having with fulfilling your current work duties:

If not currently working, did you attempt to return to work following your injury? ☐ No ☐ Yes
If yes, did your employer: ☐ state that no work was available for you? ☐ accommodate you with restrictions? ☐ accept you without restrictions or ☐ other __________________________________ For how long did you work? ____________

**Area(s) of Bodily Injury:** ☐ Head/face ☐ Neck (Cervical Spine) ☐ Mid-back (Thoracic spine) ☐ Low Back (Lumbar spine) ☐ Chest ☐Groin ☐ Abdomen/Stomach ☐ Tail bone ☐ Other:

***Left*** ☐ Shoulder ☐ Upper arm ☐ Elbow ☐ Lower arm ☐ Wrist ☐ Hand/fingers ☐ Side/Ribs ☐ Hip ☐ Buttock ☐ Upper Leg ☐ Knee ☐ Lower Leg ☐ Ankle ☐ Foot/toes

***Right*** ☐ Shoulder ☐ Upper arm ☐ Elbow ☐ Lower arm ☐ Wrist ☐ Hand/fingers ☐ Side/Ribs ☐ Hip ☐ Buttock ☐ Upper Leg ☐ Knee ☐ Lower Leg ☐ Ankle ☐ Foot/toes

**Please describe how you were injured:**

**When and to whom was the injury reported?**

* If a head injury was sustained, please indicate if you've experienced any of the following: ☐ Loss of consciousness for___min ☐ Nausea/vomiting ☐ Frequent and/or severe headache ☐ Dizziness/balance problems ☐ Seizures/blackouts ☐ Memory problems or confusion ☐ Hearing loss ☐ Visual problems or changes ☐ Unexpected outbursts of anger ☐ Weakness or loss of sensation ☐ Other symptoms: __________________________

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## TREATMENT HISTORY OF PRESENT INJURY

When did you first seek medical treatment for your injury? ____________________

Where did you go? ☐ Emergency Room ☐Company Doctor ☐ Family Doctor ☐Current Doctor ☐ Transported by ambulance ☐ Other_____________________________

What services were performed at that time?

***Please indicate which of the following diagnostic procedures and treatments you have received since then:***

| **Diagnostic Procedure** | **For which body part(s)** | **Date(s)** | **Results** |
|---|---|---|---|
| X-rays | | | |
| MRI(s) #___ | | | |
| CT Scan | | | |
| CT Myleogram or Discogram | | | |
| EMG/NCV(Nerve Study)<br>☐ Lower Extremity<br>☐ Upper Extremity | | | |
| Other: | | | |
| Psychological Testing | | | |
| **Treatment/Service** | **For which body part(s)** | **Date(s)** | **Outcome** |
| Physical Therapy (PT)<br># sessions ____ | | | |
| Referral to Specialist(s)<br>Name of Dr(s)_________ | | | |
| Referral to Neurologist | | | |
| Steroidal Injections (ESIs) #_____ | | | |
| Surgery<br>How many?___ | | | |
| Post-Surgical PT<br># sessions ____ | | | |
| Work Conditioning<br># days____ | | | |
| Work Hardening<br># days____ | | | |
| Chronic Pain Management # days___ | | | |
| Designated Doctor Exam | | | |
| Individual Psychotherapy<br># ____ | | | |
| Spinal Cord Stimulator Trial or Implant | | | |
| Other: | | | |

## PAIN STATUS & IMPACT

| | |
|---|---|
| ***On a scale of 0-10 where 10 is the worst you could imagine, please rate the following:*** | Extent to which pain interferes with your normal daily activities<br>0 1 2 3 4 5 6 7 8 9 10 |
| **Average** Pain Rating: __ since injury __ past 6 months<br>0 1 2 3 4 5 6 7 8 9 10 | Extent to which pain interferes with your recreational, social, & family activities<br>0 1 2 3 4 5 6 7 8 9 10 |
| Pain Rating: **Without** Activity and **With** Activity (circle levels of both)<br>0 1 2 3 4 5 6 7 8 9 10 | Extent to which pain interferes with your ability to work<br>0 1 2 3 4 5 6 7 8 9 10 |

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## PAST MEDICAL & MENTAL HEALTH HISTORY

Please list any previous surgical procedures and hospitalizations and dates:

Please list any other medical condition(s) or problem(s), both past and present, that you have sought treatment for:

Have you ever been treated for a head injury? ☐ Yes ☐ No If yes, when and how?

Have you previously participated in counseling or psychotherapy treatment? ☐ Yes ☐ No
If yes, when and what prompted you to seek treatment?

Have you previously seen a psychiatrist or been prescribed medications for depression, anxiety, mood or sleep? ☐ Yes ☐ No
If yes, please elaborate:

Have you ever attempted to end your life/commit suicide? ☐ Yes ☐ No Engaged in self-injurious behaviors? ☐ Yes ☐ No
If yes, please elaborate:

Have you ever been hospitalized for psychological or psychiatric issues? ☐ Yes ☐ No
If yes, please elaborate:

## SOCIAL, EDUCATIONAL & VOCATIONAL HISTORIES

Current age: Race/Ethnicity: Place of birth: Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married (#of years____) ☐ Divorced ☐ Separated ☐ Widowed ☐ Other___________

Children: # of Daughters___ Ages of daughters _______________ # of Sons___ Ages of sons _______________

With whom are you currently living? (please check all that apply) ☐ Alone ☐ Spouse ☐ Parent(s) ☐ Child(ren) ☐ Sibling(s) ☐ Other(s) ☐ Pet(s)
How many people live with you?

Highest Educational Level Completed: Where?

Please note any specialized training or certifications or licenses that you hold:

Language(s) Spoken: ☐ English ☐ Spanish ☐ Other(s) ______________

Language(s) Read: ☐ English ☐ Spanish ☐ Other(s) _______________

Types of jobs held (Check all that apply): ☐ Heavy Labor ☐ Trade/Skilled Labor (plumber, electrician, etc.) ☐ Construction ☐ Clerical ☐ Entrepreneur ☐ Landscaping/Farming/Agricultural ☐ Driver/Delivery service ☐Food service ☐ Customer service ☐ Sales/Retail ☐ Teaching/Child Care ☐ Healthcare ☐ Management/Supervisory ☐ Professional ☐ Other

________________________________

**Job History (including those jobs you held recently and those you were at the longest)**

*Employer* *Position* *Length of Employment* *Reason Left Employment*

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*(continued from page 3)*

| *Employer* | *Position* | *Length of Employment* | *Reason Left Employment* |
|---|---|---|---|
| | | | |

**Current Vocational Plans:** ☐ Return to work at most recent job with the same employer ☐ Return to the same employer in a different position ☐ Return to work in the same position with a different employer ☐ Return to work in a new position with a new employer ☐ Seek additional training/education ☐ Unknown ☐ Other:

## LIFESTYLE CHANGES RELATED TO INJURY

*Please check to indicate activities with which you have had difficulties and/or altered or discontinued since the work injury*:

☐ Self-grooming/care ☐ Household chores ☐ Yard work ☐ Cooking ☐ Caring for family members ☐ Exercise/playing sports

☐ Driving for more than____ min/hrs ☐ Sitting for more than ____min/hrs ☐ Standing for more than ____min/hrs

☐ Walking for more than ____min/distance ☐ Overhead reaching ☐ Bending ☐ Squatting ☐ Crawling ☐ Climbing stairs

☐ Lifting/carrying____max lbs. ☐ Engaging in Sexual Activity ☐Other:______________________

***Please give some specific examples of any other changes or difficulties you have experienced since the injury:***

At what percentage were you functioning in your life ***prior to the injury*** (where 0% is dead and 100% is perfect)? _____%

What is your ***current*** percentage of overall life functioning? _____%

Mobility Status: ☐ Independent ☐ Unable to walk without assistive devices (e.g. crutches or cane) ☐ Difficulty with balance ☐ Fall within last 3 months ☐ Fear of falling ☐ Other:

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***Please indicate if you have experienced any of the following since your injury:***

☐ Changes in relationship: ☐ More conflict with family ☐ Less involved in family activities ☐ Isolate from others
☐ Less participation in social outings ☐ Not having anyone to talk to about pain
Feeling ☐ abandoned by co-workers ☐ lonely ☐ ignored ☐ misunderstood

☐ Changes in self-perception: ☐ Losing confidence in yourself ☐ More sensitive to criticism ☐ Feelings easily hurt
Feeling ☐ useless ☐ helpless ☐ like a burden ☐ unattractive ☐ a lack of control in your life
Feeling ☐ disappointed in yourself ☐ angry with yourself

☐ Sleep disturbance: ☐ Difficulty falling asleep ☐ Multiple awakenings at night, # of times______ ☐ Early AM awakening

Approximately how many **hours a night** did you sleep **prior to the injury**? _____ How many **now**? _____

☐ Changes in appetite? ☐ increase ☐ decrease ☐ no change

☐ Changes in weight? ☐ increase by _____pounds ☐ decrease by _____pounds ☐ no change

Do you currently use tobacco products? ☐ Yes ☐ No If yes, with what frequency?

☐ Changes in tobacco usage? ☐ no change ☐ increase ☐ decrease *Please explain any changes*:

Do you currently consume alcohol? If so, with what frequency?

☐ Changes in alcohol consumption? ☐ no change ☐ increase ☐ decrease *Please explain any changes*:

Please describe any other changes you have experienced as a result of your injury:

Who has helped support you since your injury (emotionally, financially, with information, etc.)?

What personal strengths or resources do you have to help you manage injury-related problems?

**VERIFICATION AND SIGNATURE**

*I certify that my answers are true and correct to the best of my knowledge.*

Signature:

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