INJURY :: 1
of Dallas

BEHAVIORAL HEALTH INTAKE EVALUATION – Personal Injury

PATIENT INFORMATION

Last Name	First	M.I.	Today's Date
Treating Doctor	Hand Dominance ☐ Left ☐ Right	Date of Injury	

HISTORY OF PRESENT INJURY

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: _____

TREATMENT HISTORY OF PRESENT INJURY

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

Where did you go? ☐ Emergency Room ☐Urgent Care ☐ 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 for your injury:

Diagnostic Procedure	For which body part(s)	Date(s)	Results
X-rays			
MRI(s) #___			
CT Scan			
CT Myleogram or Discogram			
EMG/NCV(Nerve Study) ☐ Lower Extremity ☐ Upper Extremity			
Other:			
Psychological Testing			

Treatment/Service	For which body part(s)	Date(s)	Outcome
Physical Therapy (PT) # sessions ____			
Referral to Specialist(s) Name of Dr(s)_____			
Referral to Neurologist			
Steroidal Injections (ESIs) #_____			
Surgery How many?___			
Post-Surgical PT # sessions ____			
Work Conditioning # days____			
Work Hardening # days____			
Chronic Pain Management # days___			
Designated Doctor Exam			
Individual Psychotherapy # ____			
Spinal Cord Stimulator Trial or Implant			
Other:			

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

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? Pets_

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) _____

Employer: Job title:

Current Work Status ☐ Off Work ☐ Terminated/Laid off ☐ Quit ☐ Unemployed ☐ Student 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? _____

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:

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

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

☐ Changes in tobacco usage? ☐ 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: Date:

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	**Not at all**	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I'm bad, there's something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4