

CLINICAL INTAKE FORM

3. MEDICAL HISTORY

A. How many times have you been hospitalized for medical reasons?

When?				
Where?				
Reason (s)				
Primary doctor				

B. Do you have a chronic medical condition? Yes No If yes, which?.....

C. Are you currently taking any prescribed medication? Yes No
If yes, which ones? How often?

D. *For women are pregnant at this time? Yes No

4. PSYCHIATRIC HISTORY

A. How many times have you been hospitalized for psychiatric reasons?

When?				
Where?				
Reason (s)				
Duration				
Primary doctor				

B. What is the diagnosis of your condition?

C. Are you currently taking any prescribed medication for a psychiatric condition? Yes No
If yes, which ones? How often?

5. COUNSELING HISTORY

A. How many times have you sought professional counseling?

When? Where?
Reason (s) Primary counselor

B. Are you currently under the care of a counselor? Yes No

6. HISTORY OF LETHALITY

A. Do you have any suicidal or homicidal ideation? Yes No

If yes to suicide, what is the plan?

If yes to homicide, toward whom?

What is the plan?

B. Have you attempted to commit suicide? Yes No

If yes, how many times? When? How?

7. SEXUAL HISTORY

A. At what age did you experience your first sexual contact (intercourse)?.....

B. How many sexual partners have you had?

C. How often do you have sex?.....

D. What is your sexual orientation? Heterosexual Homosexual Bisexual

E. Have you ever had sex with the same gender as your own (circle)? Yes No

F. Have you ever been treated for sexual transmitted infection (s) *kuchomeka ama homa? Yes No

If yes, when?

Which: Kisonono -Gonorrhea Kaswende -Syphilis Miguu sita -Pubic lice Others.....

CLINICAL INTAKE FORM

8. HIV STATUS

- A. Have you been tested for HIV? Yes No If yes, when?.....
- B. What was the result of the HIV test ? HIV positive HIV negative Refuses to Disclose
If HIV positive, are you on ARV treatment? Yes No

9. LEGAL HISTORY

- A. Has this visit been prompted by any legal implication? Yes No
If yes, which one: Committed an offense On probation
Suggested by a chow worker Suggested by family/friend Other:
- B. How many times have you been in police cells *netty*?
What were the reasons?.....
When were you last in the police cells?.....
- C. How many times have you been arrested and fined?.....
What were the reasons?.....
When were you last arrested and fined?.....
- D. How many times have you been arrested and incarcerated *kutingwa*?
Which prison (s)?.....
For how long in total?.....
- E. Are you currently awaiting trial, sentence or charges *una cas*? Yes... No...
What is the allegation?.....

10. EDUCATION AND EMPLOYMENT HISTORY

- A. Can you read and/ or write? Yes No
- B. What is your level of education (circle)?
No formal school Completed primary school Completed high school
Completed university Advance in postgraduate Level of drop-out.....
- Total number of years in school
- C. Do you have training in technical education? Yes No
If yes, what are you trained in?
- D. Are you currently employed? Yes No What type of
employment?.....
- E. How many people depend on you for food shelter and education?
- F. How long have you experienced employment problems?

11. FAMILY HISTORY AND SOCIAL RELATIONSHIPS

Information of Spouse

- A. Name.....
- B. Age..... If deceased: Year and age of demise:..... Cause of death:.....
- C. Occupation..... D. Use of substances? Yes No
- D. Is your spouse aware of your past substance abuse? Yes No
- E. What has been your usual living arrangement (past 3 years)?
With sexual partner and (child) With sexual partner alone (If more than one indicate)
With children alone With parents With family With friends
Alone On the streets Controlled environment (prison, rehab)No stable environment
- F. Is there anyone who abuses alcohol and/or drugs in your immediate or extended family? Yes No
If yes,

Relation			
Age			
Choice of drug			
Emotional closeness with client			

- G. With whom you spend most of your free time?
Family Friends Alone Users

CLINICAL INTAKE FORM

H. Have you had significant periods in which you have experienced serious problems getting along with others in your life (family, workplace, socially)? Yes No If yes, who?..... When?.....

I. Have you been abused physically, sexually or emotionally? Yes No If yes, when?.....

Comments:.....

12. CURRENT FUNCTIONING

A. What time do you go to sleep?

B. Are you sleeping through the night?

C. What time do you get up in the morning?

D. Do you sleep during the day?

E. Do you have an appetite to eat?

F. How many times a day do you eat?

G. Have there been any changes in your weight? Yes No

If yes, what kind of change?.....

How much (kg) over what amount of time?.....

13. MENTAL STATUS EXAM

Physical appearance	<input type="checkbox"/> Appropriate <input type="checkbox"/> Describe other
Behavior	<input type="checkbox"/> Co-operative <input type="checkbox"/> Guarded <input type="checkbox"/> Passive <input type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile <input type="checkbox"/> Other
Psychomotor Activities	<input type="checkbox"/> Abnormal gait <input type="checkbox"/> Hyperactive <input type="checkbox"/> Restless <input type="checkbox"/> Retardation <input type="checkbox"/> Agitation <input type="checkbox"/> Posturing <input type="checkbox"/> Ritualistic behavior <input type="checkbox"/> Other
Speech	<input type="checkbox"/> Slurred <input type="checkbox"/> Stuttering <input type="checkbox"/> Mumbling <input type="checkbox"/> Mute <input type="checkbox"/> Pressured <input type="checkbox"/> Slowed <input type="checkbox"/> Essence of blocking <input type="checkbox"/> Excessive impairment <input type="checkbox"/> Other
Mood/ Affect	<input type="checkbox"/> Appropriate <input type="checkbox"/> Depressed <input type="checkbox"/> Sad <input type="checkbox"/> Crying <input type="checkbox"/> Fearful <input type="checkbox"/> Apathetic <input type="checkbox"/> Helpless <input type="checkbox"/> Hopeless <input type="checkbox"/> Feels worthless/ guilty <input type="checkbox"/> Flat <input type="checkbox"/> Blunted <input type="checkbox"/> Multiple somatic complains <input type="checkbox"/> Confused <input type="checkbox"/> Anxious <input type="checkbox"/> Angry <input type="checkbox"/> Euphoric <input type="checkbox"/> Irritable <input type="checkbox"/> Other
Thought	FORM: <input type="checkbox"/> Organized <input type="checkbox"/> Tangential <input type="checkbox"/> Circumstantial <input type="checkbox"/> Loose <input type="checkbox"/> Word salad <input type="checkbox"/> Vague <input type="checkbox"/> Flight of ideas <input type="checkbox"/> Clang Associations <input type="checkbox"/> Neologisms <input type="checkbox"/> Echolalia <input type="checkbox"/> Perseveration <input type="checkbox"/> Blocking <input type="checkbox"/> Indecisive <input type="checkbox"/> Incoherent <input type="checkbox"/> Doubting
	CONTENT: <input type="checkbox"/> Appropriate <input type="checkbox"/> Delusions <input type="checkbox"/> Suicidal/Homicidal ideation <input type="checkbox"/> Compulsions <input type="checkbox"/> Suspicious <input type="checkbox"/> Paranoid <input type="checkbox"/> Phobias <input type="checkbox"/> Feelings of unreality <input type="checkbox"/> Obsessions <input type="checkbox"/> Magical thinking <input type="checkbox"/> Suspicions <input type="checkbox"/> Hallucinations (tactile, auditory, visual) <input type="checkbox"/> Preoccupations <input type="checkbox"/> Grandiosity <input type="checkbox"/> Depersonalization <input type="checkbox"/> Confabulations <input type="checkbox"/> Ideas of reference/ influence <input type="checkbox"/> Other
INTELLECTUAL PERFORMANCE	ATTENTION: <input type="checkbox"/> Sufficient <input type="checkbox"/> Easily distracted <input type="checkbox"/> No eye contact <input type="checkbox"/> Short attention span <input type="checkbox"/> Poor concentration <input type="checkbox"/> Not responsive to verbal speech
	ABSTRACT ABILITY: <input type="checkbox"/> Intact <input type="checkbox"/> Impaired
	ORIENTATION: Person <input type="checkbox"/> Yes <input type="checkbox"/> No Place <input type="checkbox"/> Yes <input type="checkbox"/> No Time <input type="checkbox"/> Yes <input type="checkbox"/> No
	MEMORY: Immediate: <input type="checkbox"/> Intact <input type="checkbox"/> Impaired Short-term: <input type="checkbox"/> Intact <input type="checkbox"/> Impaired Long-term: <input type="checkbox"/> Intact <input type="checkbox"/> Impaired
	INSIGHT: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor

Overview of treatment intervention options discussed with the client:

IE: Outpatient Individual, group/types of groups, and explanation of Naltrexone and any other intervention methods discussed.

Treatment Recommendations ie: individual, group detox, Naltrexone, rehab, halfway house, etc.
Client's choice or selection of treatment modality.