AONE BEHAVIORAL HEALTH SERVICES

Complete Clinical Intake & Assessment Packet

SECTION 1 – CONTACT & DEMOGRAPHICS

Last Name*

First Name*

Middle Initial or Name

SSN # (optional)

Birth Date* (mm/dd/yyyy)

Age*

Height/Feet

Height/Inches

Weight/Lbs

Gender*

- ☐ Male
- ☐ Female
- ☐ Non-binary

Address*

City*

State*

Zip*

Best Contact Phone Number*

Messages OK?*

- ☐ Text
- ☐ Voice

Email*

Highest level of Education*

Employment/Student Status

- ☐ Employed
- ☐ Unemployed
- ☐ Student

Occupation*

Employer/School*

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SECTION 1 – CONTACT & DEMOGRAPHICS (CONTINUED)

Relationship Status*

- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Separated
- ☐ Dating
- ☐ Prefer not to specify

Race*

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black/African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White or Caucasian

Number of Children _____

Emergency Contact

Name* _____

Relation to Client* _____

Best Contact Phone Number* _____

Insurance Information

Insurance Company _____

Insured Name/Responsible Party _____

Member Id _____

Effective Date (mm/dd/yyyy) _____

DOB (mm/dd/yyyy) _____

Relationship

- ☐ Self
- ☐ Spouse
- ☐ Father
- ☐ Mother

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SECTION 2 – CONSENT & AGREEMENTS

- HIPAA Notice of Privacy Practices Acknowledgement
- Treatment Agreement & Patient Responsibilities
- Prescription / Medication Agreement (if applicable)
- Telehealth & Electronic Communication Consent
- Transcription & Documentation Consent

Client Signature:

Date:

SECTION 3 – PHQ-9 Depression Screening

1. Little interest or pleasure in doing things
   - ☐ 0 – Not at all
   - ☐ 1 – Several days
   - ☐ 2 – More than half the days
   - ☐ 3 – Nearly every day

2. Feeling down, depressed, or hopeless
   - ☐ 0 – Not at all
   - ☐ 1 – Several days
   - ☐ 2 – More than half the days
   - ☐ 3 – Nearly every day

3. Trouble falling/staying asleep, or sleeping too much
   - ☐ 0 – Not at all
   - ☐ 1 – Several days
   - ☐ 2 – More than half the days
   - ☐ 3 – Nearly every day

4. Feeling tired or having little energy
   - ☐ 0 – Not at all
   - ☐ 1 – Several days
   - ☐ 2 – More than half the days
   - ☐ 3 – Nearly every day

5. Poor appetite or overeating
   - ☐ 0 – Not at all
   - ☐ 1 – Several days
   - ☐ 2 – More than half the days
   - ☐ 3 – Nearly every day

6. Feeling bad about yourself
   - ☐ 0 – Not at all
   - ☐ 1 – Several days
   - ☐ 2 – More than half the days
   - ☐ 3 – Nearly every day

PHQ-9 Depression Screening (continued)

7. Trouble concentrating

- ☐ 0 – Not at all
- ☐ 1 – Several days
- ☐ 2 – More than half the days
- ☐ 3 – Nearly every day

8. Moving/speaking slowly OR being restless

- ☐ 0 – Not at all
- ☐ 1 – Several days
- ☐ 2 – More than half the days
- ☐ 3 – Nearly every day

9. Thoughts of self-harm

- ☐ 0 – Not at all
- ☐ 1 – Several days
- ☐ 2 – More than half the days
- ☐ 3 – Nearly every day

SECTION 4 – GAD-7 Anxiety Screening

1. Feeling nervous, anxious, or on edge
   - ☐ 0 – Not at all
   - ☐ 1 – Several days
   - ☐ 2 – Over half the days
   - ☐ 3 – Nearly every day

2. Not able to stop or control worrying
   - ☐ 0 – Not at all
   - ☐ 1 – Several days
   - ☐ 2 – Over half the days
   - ☐ 3 – Nearly every day

3. Worrying too much about different things
   - ☐ 0 – Not at all
   - ☐ 1 – Several days
   - ☐ 2 – Over half the days
   - ☐ 3 – Nearly every day

4. Trouble relaxing
   - ☐ 0 – Not at all
   - ☐ 1 – Several days
   - ☐ 2 – Over half the days
   - ☐ 3 – Nearly every day

5. Restless; hard to sit still
   - ☐ 0 – Not at all
   - ☐ 1 – Several days
   - ☐ 2 – Over half the days
   - ☐ 3 – Nearly every day

6. Easily annoyed or irritable
   - ☐ 0 – Not at all
   - ☐ 1 – Several days
   - ☐ 2 – Over half the days
   - ☐ 3 – Nearly every day

GAD-7 Anxiety Screening (continued)

7. Feeling afraid something awful might happen

- ☐ 0 – Not at all
- ☐ 1 – Several days
- ☐ 2 – Over half the days
- ☐ 3 – Nearly every day

SECTION 5 – SBQ-R Suicide Risk Questionnaire

1. Ever thought about or attempted suicide?

- ☐ Never
- ☐ Brief passing thought
- ☐ Had a plan but did not try
- ☐ Had a plan and wanted to die
- ☐ Attempted but did not want to die
- ☐ Attempted and hoped to die

2. Frequency of thoughts in past year?

- ☐ Never
- ☐ Rarely (1 time)
- ☐ Sometimes (2 times)
- ☐ Often (3–4 times)
- ☐ Very often (5+)

3. Ever told someone you might attempt?

- ☐ No
- ☐ Yes once (not serious)
- ☐ Yes once (serious)
- ☐ More than once (not serious)
- ☐ More than once (serious)

4. Likelihood you will attempt in future?

- ☐ Never
- ☐ No chance at all
- ☐ Unlikely
- ☐ Likely
- ☐ Rather likely
- ☐ Very likely

SECTION 6 – MDQ Mood Disorder Questionnaire

1. Felt extremely good / hyper
   - ☐ Yes
   - ☐ No

2. Very irritable; arguments or fights
   - ☐ Yes
   - ☐ No

3. Higher self-confidence
   - ☐ Yes
   - ☐ No

4. Needed less sleep
   - ☐ Yes
   - ☐ No

5. More talkative
   - ☐ Yes
   - ☐ No

6. Racing thoughts
   - ☐ Yes
   - ☐ No

7. Easily distracted
   - ☐ Yes
   - ☐ No

8. More energy
   - ☐ Yes
   - ☐ No

9. More active
   - ☐ Yes
   - ☐ No

MDQ Mood Disorder Questionnaire (continued)

10. More social / outgoing

- ☐ Yes
- ☐ No

11. Increased sexual interest

- ☐ Yes
- ☐ No

12. Unusual / risky behavior

- ☐ Yes
- ☐ No

13. Spent money excessively

- ☐ Yes
- ☐ No

Did several YES answers occur during same period?

- ☐ Yes
- ☐ No

How much of a problem did these cause (impairment)?

- ☐ No problem
- ☐ Minor
- ☐ Moderate
- ☐ Serious

Family history of bipolar disorder?

- ☐ Yes
- ☐ No

Ever diagnosed with bipolar disorder?

- ☐ Yes
- ☐ No

SECTION 7 – FINAL SIGNATURES

Patient Name: _____

Patient Signature: _____

Representative Name (if applicable): _____

Relationship to Patient: _____

Representative Signature: _____

Provider Name: _____

Provider Signature: _____

Date: ____ / ____ / _____