**BEHAVIORAL HEALTH INTAKE EVALUATION – Personal Injury**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 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: | |  | | |  | |  | | | | | |

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| 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  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 and **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) | | |  | Other(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? | | |

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| 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 |