Magellan Behavioral Health of Pennsylvania, Inc.
Initial Interview and Assessment for Behavioral Health Services

☐ Bucks County ☐ Cambria County ☐ Delaware County ☐ Lehigh County ☐ Northampton County ☐ Montgomery County

Date: ______________________

Full Name: ______________ Birth Name: ______________ Preferred Pronouns: ______________

Date of Birth: __________ Age: __________ Sex: ☐ Male ☐ Female ☐ Intersex

Gender Identity: ______________ Race: ______________ Social Security #: __________

Address: ______________ City: __________ State: ______ Zip Code: ______

Home Phone #: ______________ Cell Phone #: ______________

Email Address: ______________________________

Educational Status: ______________ Referral Source: ______________

Physical or Mental Disabilities: ______________________________

Emergency Contact Information:

Full Name: ______________ Relationship to Member: ______________

Phone #: ______________ Additional Phone #: ______________

Medications and Supplements:

Current:	Past Medications:	Medication Allergies:

Current Status (Presenting concerns, what brings you in?)

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Clinical Symptoms:

Depression:

- ☐ Depressed Mood
- ☐ Social Isolation
- ☐ Weight Gain
- ☐ Restlessness
- ☐ Loss of Energy/Fatigue
- ☐ Sleep Disturbance
- ☐ Loss of Interest in Activities of Daily Living
- ☐ Indecisiveness
- ☐ Increased Sleep
- ☐ Thoughts of Death
- ☐ Difficulty Concentrating
- ☐ Decreased Sleep
- ☐ Thought of Suicide
- ☐ Irritability
- ☐ Decreased Sex Drive
- ☐ Crying Spells
- ☐ Weight Loss
- ☐ Lack of Motivation

Anxiety:

- ☐ Nervousness
- ☐ Feeling of Choking
- ☐ Difficulty Concentrating
- ☐ Easily Fatigued
- ☐ Abdominal Distress
- ☐ Pounding/Racing Heart
- ☐ Muscle Tension
- ☐ Fear of Losing Control or Going Crazy
- ☐ Shortness of Breath
- ☐ Irritability
- ☐ Excessive Worry
- ☐ Chest Pain or Tightness
- ☐ Sweating
- ☐ Unable to Control Worry
- ☐ Lightheaded/Dizzy/Faint
- ☐ Trembling/Shaking
- ☐ Restlessness/Feeling Edgy
- ☐ Chills or Hot Flushes
- ☐ Sleep Disturbance (Difficulty falling or staying asleep, restless, or unsatisfying sleep)

Mania:

- ☐ Periods of Elevated, Expansive Mood
- ☐ Racing Thoughts
- ☐ Inflated Self-esteem or Grandiosity
- ☐ Distractibility
- ☐ Decreased Need for Sleep
- ☐ Increase in Goal-directed Activity
- ☐ More Talkative than Usual/Pressure to keep Talking
- ☐ Psychomotor Agitation
- ☐ Excessive involvement in pleasurable activities that have a high potential for painful consequences

Psychosis (Note whether the person was/was not under the influence of drugs/alcohol):

- ☐ Hallucinations (without influence of drugs/alcohol)
- ☐ Hallucinations (WITH influence of drugs/alcohol)
- ☐ Delusions (without influence of drugs/alcohol)
- ☐ Delusions (WITH influence of drugs/alcohol)

Assaultive to Others or the Environment: ☐ Yes, describe below ☐ No

____

____

Self-Injurious: ☐ Yes, describe below ☐ No

____

____

Previous Counseling or Treatment (Mental Health and Drug & Alcohol): ☐ Yes (When? Reason? Type? Outcome?) ☐ No

____

____

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Have you ever been diagnosed with a Learning Difference? ☐ Yes ☐ No

If Yes, what Type? ____________ When was the Member Diagnosed: ____________

Treatment Received: ____________

Have you ever been diagnosed with a Mental Health Condition? ☐ Yes ☐ No

If yes, List the most recent Diagnosis: ____________

Family History of Mental Illness and/or Addiction:

Family Member: Nature of Problem:

Is there any Family History of Suicide? ☐ Yes, describe below ☐ No

Member's Suicide History:

Current Ideation: ☐ Yes, describe below ☐ No Plan: ☐ Yes, describe below ☐ No

Previous Ideation: ☐ Yes ☐ No Previous Attempts: ☐ Yes ☐ No

Age: How Attempted: Circumstances:

Drug and Alcohol History:

Substance	Age of 1st Use	Age of Regular Use	Frequency	Amount	Method	Last Use
Alcohol						
Heroin/Opioids						
Cocaine						

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Substance	Age of 1st Use	Age of Regular Use	Frequency	Amount	Method	Last Use
Fentanyl						
Marijuana						
Hallucinogens						
Inhalants						
Amphetamines						
Prescription Drugs						
Tobacco						
Other:						

Periods of Abstinence (Include how long and what happened):

____

____

Circumstances of Usage:

☐ Always Alone ☐ Mostly Alone ☐ Alone & with Others ☐ Mostly with Others ☐ Always with Others

Symptoms of Withdrawal:

Current Symptoms (Check only those that apply in the past 30 days):

☐ None ☐ Chills ☐ Hallucinations ☐ Restlessness ☐ Tactile Disturbances
☐ Abdominal Cramping ☐ Cravings ☐ Headaches ☐ Runny Nose ☐ Visual Disturbances
☐ Agitation ☐ Depression ☐ Hot/Cold Flashes ☐ Seizures ☐ Vomiting
☐ Anxiety ☐ Delirium Tremens (DTs) ☐ Insomnia ☐ Shakes
☐ Appetite Change ☐ Blackouts ☐ Muscle Aches ☐ Sweats
☐ Auditory Disturbances ☐ Elevated Pulse ☐ Nausea ☐ Tremors

Past Symptoms (Check those that have ever applied):

☐ None ☐ Chills ☐ Hallucinations ☐ Restlessness ☐ Tactile Disturbances
☐ Abdominal Cramping ☐ Cravings ☐ Headaches ☐ Runny Nose ☐ Visual Disturbances
☐ Agitation ☐ Depression ☐ Hot/Cold Flashes ☐ Seizures ☐ Vomiting
☐ Anxiety ☐ Delirium Tremens (DTs) ☐ Insomnia ☐ Shakes
☐ Appetite Change ☐ Blackouts ☐ Muscle Aches ☐ Sweats
☐ Auditory Disturbances ☐ Elevated Pulse ☐ Nausea ☐ Tremors

History of Overdoses:

____

____

Narcan Administered: ☐ Yes, describe below ☐ No

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Current Medication Assisted Treatment (MAT) Use: ☐ Yes, describe below ☐ No Past MAT Use: ☐ Yes, describe below ☐ No

Member's Perceptions:

What has been the effect of your drug/alcohol use on your life in the following areas?

Social:

Physical:

Emotional:

Do you think you have a drug/alcohol problem? ☐ Yes ☐ No

How do you support your use of substances?:

Symptoms of Drug/Alcohol Dependency:

- ☐ Tolerance (increased amounts needed, or diminished effect with continued use of same amount)
- ☐ Withdrawal
  - Withdrawal Symptoms:
  - Substance(s) taken to relieve or avoid withdrawal:
- ☐ Substance is often taken in larger amounts or over a longer period of time than intended.
- ☐ Persistent desire of unsuccessful efforts to cut down or control use.
- ☐ A great deal of time is spent in obtaining the substance, using the substance, or recovering from its effects.
- ☐ Important social, occupational, or recreational activities are given up or reduced.
- ☐ Use of substance despite knowledge that it exacerbates a physical or psychological problem.

Other Compulsive Behaviors:

Gaming: ☐ Yes ☐ No

If yes, how many hours per day online? ________ How many days a week? ________

Role Playing: ☐ Yes ☐ No

If yes, how many hours per day online? ________ How many days a week? ________

Gambling: ☐ Yes ☐ No

If yes, how many hours per day online? ________ How many days a week? ________

What type of activities? ________ Debts? ________

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Shopping: ☐ Yes ☐ No

If yes, how many hours per day? ______________ How many days a week? ______________

What type of shopping? Online: ☐ Yes ☐ No Debts: ______________

TV: ☐ Yes ☐ No Debts: ______________

In Person: ☐ Yes ☐ No Debts: ______________

Sex Addiction: ☐ Yes ☐ No Circumstance: ______________

Has the member ever been involved in Human Trafficking, in any manner? ☐ Yes ☐ No

Disordered Eating History:

Height: ______________ Weight: ______________

Pounds in Last Month: Lost: ______________ Gained: ______________

Pounds in Three (3) Months: Lost: ______________ Gained: ______________

Pounds in Last Year: Lost: ______________ Gained: ______________

Denial of Low Weight: ☐ Yes ☐ No

Disturbance About: Weight: ☐ Yes ☐ No Shape: ☐ Yes ☐ No

Laxative Use: ☐ Yes ☐ No Frequency: ______________ Last Use: ______________

Enemas: ☐ Yes ☐ No Frequency: ______________ Last Use: ______________

Diet Pill Use: ☐ Yes ☐ No Type: ______________ Dosage: ______________

Frequency: ______________ Last Use: ______________

Amenorrhea (Absence of at least three (3) consecutive periods): ☐ Yes ☐ No Last Period: ______________

Bingeing: ☐ Yes ☐ No

Frequency: ______________

Last Time: ______________

Amount: ______________

Purging: ☐ Yes ☐ No

Frequency: ______________

Last Time: ______________

Restricting: ☐ Yes ☐ No

Frequency: ______________

Last Time: ______________

Amount: ______________

Exercise: ☐ Yes ☐ No

Frequency: ______________

Type: ______________

Overeating: ☐ Yes ☐ No

Frequency: ______________

Last Time: ______________

Amount: ______________

What Eaten: ______________

Obsessive Thoughts: ☐ Yes ☐ No

If yes, describe: ______________

Sense of Lack of Control: ☐ Yes ☐ No

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If yes, describe: ____________________

Have the member's feelings about themselves or social interactions changes as a result of weight changes? ☐ Yes ☐ No

If yes, describe: ____________________

How preoccupied were the member's parents with their own weight?

☐ Very Preoccupied ☐ Slightly Preoccupied ☐ Neutral/Not Sure ☐ Occasionally Preoccupied ☐ Not at all Preoccupied

How preoccupied were the member's parents with the member's weight?

☐ Very Preoccupied ☐ Slightly Preoccupied ☐ Neutral/Not Sure ☐ Occasionally Preoccupied ☐ Not at all Preoccupied

Assessment of Physical Appearance:

____

____

____

Physical Health History (Include treatment of issues, most recent dates, etc.):

Past Surgeries (Include Dates): ____________________

Does the member have a history of any of the following?

Seizures	☐ Yes	☐ No	If yes, Date of Last Episode: ________
Heart/Cardio Issues	☐ Yes	☐ No	If yes, Describe: ________
Traumatic Brain Injury	☐ Yes	☐ No	If yes, Describe: ________
Diabetes	☐ Yes	☐ No	If yes, Describe: ________
Hepatitis	☐ Yes	☐ No	If yes, Describe: ________

Other Physical Health Related Issues: ____________________

Mobility Issues: ____________________

Name of Primary Care Physician: ____________________ Date of Last Visit: ________

Name of Medical Specialist (if applicable): ____________________ Date of Last Visit: ________

Name of Medical Specialist (if applicable): ____________________ Date of Last Visit: ________

Social Determinants of Health (Check all that Apply):

☐ Not Assessed ☐ Education/Low Literacy ☐ Lack of Childcare

☐ Medical Cost Barrier ☐ Financial Instability ☐ Unemployment/Underemployment

☐ None Known ☐ Interpersonal Violence ☐ Stress

☐ Transportation ☐ Housing/Homeless ☐ Addiction

☐ Food insecurity ☐ Social Isolation

☐ Other: ____________________

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Member's Work History:

Currently Employed: ☐ Yes ☐ No If Yes, Name of Employer: ______________________________

Longest Period of Employment: ______________ If unemployed, are you seeking employment? ☐ Yes ☐ No

What are your future work goals?

____

____

Source of Income (Check all that Apply):

☐ SSI
☐ Pension
☐ Child Support
☐ Alimony
☐ SSD
☐ Employment
☐ Trust Fund
☐ Other: ______________________

Abuse History:

Type	Victim	Perpetrator	Comments:
Emotional	☐	☐	______________________
Physical	☐	☐	______________________
Sexual	☐	☐	______________________
Verbal	☐	☐	______________________

Legal History: (includes arrests, DUI, probation)

____

____

Pending Legal Charges:

____

____

Probation/Parole:

Contact Name: ______________________ **Contact Phone Number:** ______________

Family of Origin:

Parent	Living	Deceased	Date of Death	Age	Does parent know you are seeking counseling?
Mother	☐	☐	__________	______	Yes ☐ No ☐
Father	☐	☐	__________	______	Yes ☐ No ☐

Mother's cause of death: ______________________________

Father's cause of death: ______________________________

Describe relationship with Mother: ______________________________

Describe relationship with Father: ______________________________

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Do you have a stepmother? Yes ☐ No ☐

Do you have a stepfather? Yes ☐ No ☐

Who raised you? ____________________

Relationship to the person who raised you: ____________________

Siblings:

Name	Age	Describe relationship:

Relationship History:

Current Relationship/Marital Status: ____________________

Past Relationships: ____________________

List all children from relationships:

Name	**Age**

Military History: (Be sure to include branch, rank, job, years of service, and discharge status if applicable)

Is client a veteran? Yes ☐ No ☐ ____________________

Does client have combat experience? Yes ☐ No ☐ ____________________

Does client have potential trauma issues? Yes ☐ No ☐ ____________________

Leisure/Recreational:

____

____

What are your goals? (Include educational, financial, housing goals, etc.)

____

____

Assessment and Determination of Care:

Height: __________ **Weight** __________ **UDS:** ____________________

Vitals: ____________________

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Mental Status Information:

Appearance

☐ Appropriate ☐ Casual ☐ Disheveled ☐ Meticulous ☐ Malodorous ☐ Neat

Behavior/Manner:

☐ Cooperative ☐ Vague ☐ Poor Eye Contact ☐ Delusional ☐ Hostile ☐ Irritable ☐ Calm
☐ Agitated ☐ Guarded ☐ Tearful ☐ Pressured ☐ Restless ☐ Hallucinations

Affect/Mood

☐ Appropriate ☐ Inappropriate ☐ Labile ☐ Flat ☐ Depressed ☐ Blunted ☐ Angry
☐ Panicky ☐ Euphoric ☐ Expansive ☐ Anxious

Speech

☐ Normal ☐ Fast ☐ Loud ☐ Pressured ☐ Soft ☐ Incoherent

Sleep

☐ Normal ☐ Interrupted ☐ Insomnia ☐ Hyper-insomnia

Oriented

☐ Self ☐ Place ☐ Time

Stage of Change Assessment:

☐ Pre-Contemplative ☐ Contemplative ☐ Preparation/Determination ☐ Action ☐ Maintenance ☐ Relapse

List of Strengths:

____

____

Level of Motivation:

____

____

Challenges:

____

____

COWS Results:

____

____

CIWA Results:

____

____

Dimension 1-6 Criteria:

____

____

Recommended LOC: ____

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