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

☐ Bucks County ☐ Cambria 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?)

Clinical Symptoms:

Depression:

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

Anxiety:

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

Mania:

- ☐ Periods of Elevated, Expansive Mood
- ☐ Inflated Self-esteem or Grandiosity
- ☐ Decreased Need for Sleep
- ☐ More Talkative than Usual/Pressure to keep Talking
- ☐ Racing Thoughts
- ☐ Distractibility
- ☐ Increase in Goal-directed Activity
- ☐ 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)
- ☐ Delusions (without influence of drugs/alcohol)
- ☐ Hallucinations (WITH 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

_____

_____

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						

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

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? _____

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

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: _____

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 ☐ SSD

☐ Pension ☐ Employment

☐ Child Support ☐ Trust Fund

☐ Alimony ☐ 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: _____

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: _____

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: _____