Residential Services INC
Nurturing Abilities

RSI ARMHS Intake Information/ Outpatient Mental Health Services

Name:_____ **Today's Date:**_____

Phone:_____ **Address:**_____

DOB:_____ **Age:**_____ **SSN:**_____ **Gender:** _____

Ethnicity or Cultural background:_____

Marital/ Family Status: Single Partnered Married Divorced Separated Parent of Child/ren

I am seeking the following services from RSI: ARMHS Psychotherapy Diagnostic Assmt.

Insurance/Payment information: MA #_____ **Other Payment?**_____

How did you find out about RSI ARMHS/therapy?_____ _____

What is your primary reason for seeking Outpatient Therapy Services and/or ARMHS? Please describe your personal goals, and the problems you are seeking help with. _____
_____
_____
_____
_____

Have you received mental health services or a diagnostic assessment in the past 12 months? Y N
If yes, list provider's name and location/agency_____

* * * * * * * * * * * * * * * *

Areas of concern – please note frequency/intensity if applicable. Feel free to ask your intake worker about any area you are unsure of.

Physical:
Sleep Problems_____ Fatigue/Loss of energy_____
Appetite change/ Wt. loss or gain_____ Headaches_____
Nausea, diarrhea, other stomach distress_____ Dizziness or faintness_____
Shortness of breath_____ Trembling or shaking_____
Trouble swallowing or "lump" in throat_____ Heart palpitations/ increased heart rate_____
Nightmares/frightening dreams_____ Body/muscle pain_____

Mood:
Depressed mood_____ Lonliness_____ Grief/loss_____
Frequent crying_____ Irritability_____
Feeling hopelessness / helplessness_____ Lack of interest in most activities_____
Low self-esteem_____ Thoughts about suicide_____
Suicide plans_____ Suicide attempts_____
Angry outbursts_____ Feeling high/excessive energy_____
Feeling powerful/more special than others_____ Feeling guilty/worthless_____
Anxiety:
Excessive worry_____ Stress, nervousness_____

Residential Services INC
Nurturing Abilities

Panic attacks_____Excessive fears/phobias_____
Social fears, shyness_____Shameful feelings_____
Don't feel safe_____ Fear other's intentions_____

Behavior:
Withdrawal, isolation_____Lack of assertiveness_____
Perfectionism_____Hyperactivity_____
Aggressive behavior_____Risk taking or dangerous behavior_____
Self- harm_____Compulsive behavior_____
Collecting/saving/excessive belongings_____Other_____

Thoughts, perceptions:
Problems with memory_____Difficulty concentrating_____
Trouble thinking, confusion_____Racing thoughts_____
Excessive fantasy, daydreaming_____Recurring/intrusive thoughts_____
Seeing or hearing things that others do not see/hear _____
Topics or activities of intense focus_____

Please list current medications:_____
_____
_____

Substances:
Do you use alcohol or drugs? No Yes- please list what, and how often_____
Reasons for use_____
List any negative consequences of your use_____
If you are in recovery, how long have you been sober?_____
Do you smoke cigarettes? Yes No Amount per day?_____
Do you drink caffinated /energy beverages? No Yes- what, and amount per day_____

What do you view as your personal strengths, skills, and resources? _____
_____
_____

Social and Family History:
Highest level of schooling competed_____ Degrees earned_____
Are you employed? Yes No Type of employment_____
Social network: Please describe number and quality of friendships_____
_____
Financial or legal issues?_____

Your parents: married separated divorced never married step-parent(s)? Yes No
Number of brothers_____ Number of sisters_____

Your children, if applicable_____
Have you experienced any kind of abuse, neglect, or other trauma in your history? _____
_____

Has anyone in your family experienced mental health problems? Yes No Don't know
<u>For ARMHS referrals only:</u> Please indicate areas in need of skill building to achieve desired goals:

Current Diagnosis:_____
Is person aware of Diagnosis? Yes No Is person aware of referral for ARMHS? Yes No

Residential Services INC
Nurturing Abilities

Areas of Assistance (Check all that apply)		Please Describe:
	Community Intervention/ Crisis Assist.	
	Communication Skills	
	Community Resource Utilization	
	Healthy Lifestyle Practices	
	Mental Illness Symptom Management & Recovery	
	Cooking and Nutrition Skills	
	Utilizing Transportation	
	Improving Household Management	
	Employment Related Skills	
	Transition to less restrictive setting	
	Medication Monitoring/education	
	Integration into the Community	

Signature of person completing form, and relationship to client (if not client) **Date**

To be completed by RSI staff:

Dates client contacted/contact attempted: _____Date of intake appointment:_____

(if applicable) Date s Case Manager Contacted :_____ Date Guardian contacted:_____

(if applicable) Date DA Requested: _____DA request submitted to:_____

RSI staff assigned to client: _____ RSI Duluth/ Virginia # 218-727-2696/ Fax # 218-249-0166