



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 _____

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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 _____



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

For ARMHS referrals only: 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

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