HCBS Intake Tool

Name:
Date(s) of assessment:
Date of birth:
Service(s) being
assessed:

Diagnosis(From Care Manager or self-report)

Reason(s) for Intake Review
Goal(s) Identified in the Plan of Care:

MH/SUD Community Resources Identified by Participant:

WRAP Plan Involvement?:

- ☐ Yes
- ☐ No

Other plan for relapse management:

- ☐ Yes
- ☐ No

  If Yes, what is the plan?:

Mental Health
Mental Status (Can include affect, mood, thought, content, judgement, insight, attention, concentration, memory and impulse control):

Presenting symptoms/issues:

Past symptoms/past diagnosis:

History of Trauma (consider emotional, physica, sexual or other)?

Past/present abuse?

History of treatment:

Was this helpful? Why or why not?

What has helped you most?

History of psychiatric hospitalizations:

History or Psychiatric ER visits without admit:

Past suicidal ideation:

Current suicidal ideation:

Past suicide attempts?

- ☐ Yes
- ☐ No

History of self-injurious behavior:

Current self-injurious behavior:

Has anyone in your life expressed concern about your mental health? Who?

How have your mental health symptoms affected relationships in your life?

Job?

School?

Physical health?

Substance Use
When did you last use the following:

Alcohol
Caffeine
Marijuana/synthetic cannabinoids
Stimulants (Cocaine, amphetamines)
Hallucinogens (LSD, PCP, mushrooms)
Opiates (heroin, prescription painkillers)
Methamphetamines (Crack, meth, ice, crystal meth)
Inhalants (spray paint, glue, nitrates)
Prescription medications other than as prescribed
Over-the-counter medications at a higher than recommended dose

Age of first use:

Drug(s) of choice:

Frequency of use:

History of overdose?

Have you ever tried and failed to control, cut down or stop using?

History of treatment:

Was this helpful? Why or why not?

What has helped you most?

History of detox:

How often has your use led to health, social, legal or financial problems?

In the past three months, how often have you failed to do what was normally expected of you because of your substance use?

Has a friend, relative or anyone else ever expressed concern over you using substances?

How has your substance use affected relationships in your life?

Job?

School?

Physical health?

Legal History

Current involvement in the legal system:

Past involvement in the legal system:

History of incarceration:

Any active Orders of Protection?

- ☐ Yes
- ☐ No

Are you required to register as a sex offender?

- ☐ Yes
- ☐ No

Medical

Advance Directive?

- ☐ Yes
- ☐ No

If Yes:

- ☐ Living Will
- ☐ Health Care Proxy
- ☐ Do Not Resuscitate

Medical conditions (identified) that may affect participant's presenting issues:

Is participant open to identifying any infectious dieseases?

- ☐ Yes
- ☐ No

If Yes, please identify and any treatment individual is undergoing:

If Yes, please identify how the disease or treatment affects his or her ability to function:

Is participant currently utilizing any community-based services from the above? If so, which?:

Allergies (medications or other substances) (reported):

Strengths

What are some of your positive traits?

Who are positive supports in your life (natural, paid, otherwise) and level of supports?

Considerations for service (if none to consider, put "N/A" next to category)

Vocational:
Spiritual:
Cultural:
Educational:
Legal:

Assessor's Signature: Date:

Supervisor's Signature: Date: