MENTAL HEALTH CHECKUP

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HEALTHCARE TECHNOLOGIES, LLC

Section I - Demographics

Screening Date:	Last Name, First Name, MI	Date of Birth	Best Phone Numbers(s) to call:	Gender
				☐ Male ☐ Female

Please complete the following Sections; ask your counselor for help if needed.

Section II – General Health

1. In general, your health is:..... ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. Have you received medication, counseling or other treatment for Depression, Anxiety, PTSD or other mental health issue? ..... ☐ Now ☐ In the past ☐ Never

3. Have you received treatment for Alcohol or Drug Use problems? ..... ☐ Now ☐ In the past ☐ Never

Section III - Post Traumatic Stress Disorder Screening (PTSD)

1. Have you witnessed or had a terrible experience that most people never go through, such as a natural disaster, a serious accident, a violent crime, being sexually assaulted or raped, or being in a military war zone or combat?

☐ Yes
☐ No ***(If "No", SKIP to the next section, SECTION IV; otherwise continue)***

(Question 2 – 7) Each "Yes" = 3 points, if you answer yes, place a 3 in the line provided.

Pts.

2. In the past month have you repeatedly remembered these experiences when you did not want to?..... ☐ Yes ☐ No [___]

3. In the past month have you had repeated dreams or nightmares about these experiences? ..... ☐ Yes ☐ No [___]

4. In the past month have you thought about these experiences when you did not want to, or been bothered by repeated, disturbing memories, feelings, or dreams? ..... ☐ Yes ☐ No [___]

5. In the past month have you tried hard not to think about these experiences, or avoided situations, conversations, people, or feelings that reminded you? ..... ☐ Yes ☐ No [___]

6. In the past month have you often felt extremely unsafe, on-guard, watchful when you didn't need to be, or jumpy and easily startled?..... ☐ Yes ☐ No [___]

7. In the past month have you felt emotionally numb (unable to feel most feelings) or detached from your relationships, activities, or surroundings? ..... ☐ Yes ☐ No [___]

(Further assessment recommended for a score of 6 and higher) Total Points [___]

(Over - Continue)

Section IV - Mental Health Inventory – 5 (MHI-5)

Please check only one box, place the number next to the box you checked in the line provided. **Pts.**

1. During the past month, how much of the time were you a happy person?

All of the time	*Most of the time*	*A good bit of the time*	*Some of the time*	*A little of the time*	*None of the time*	Pts.
☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	[ ]

2. How much of the time during the past month have you felt calm and peaceful?

All of the time	*Most of the time*	*A good bit of the time*	*Some of the time*	*A little of the time*	*None of the time*	Pts.
☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	[ ]

Continue on next page

3. How much of the time during the past month have you been a very nervous person?

All of the time	*Most of the time*	*A good bit of the time*	*Some of the time*	*A little of the time*	*None of the time*	Pts.
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	[ ]

4. How much of the time during the past month have you felt downhearted and blue?

All of the time	*Most of the time*	*A good bit of the time*	*Some of the time*	*A little of the time*	*None of the time*	Pts.
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	[ ]

5. How much of the time during the past month did you feel so down in the dumps that nothing could cheer you up?

Always	*Very often*	*Fairly often*	*Sometimes*	*Almost never*	*Never*	Pts.
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	[ ]

(Further assessment recommended for a score of 18 and lower) Total Points

Section V - Simple Screening Instrument for AOD Abuse (SSI)

Each "Yes" = 3 points, if you answer yes, place a 3 in the line provided.) **Pts.**

1. During the past six months, have you used alcohol or other drugs? ..... ☐ Yes ☐ No [ ]
   (*If "No", GO TO SECTION VI; otherwise continue)*
2. During the past six months, have you felt that you use too much alcohol or other drugs? ..... ☐ Yes ☐ No [ ]
3. During the past six months, have you tried to cut down or quit drinking or using drugs?..... ☐ Yes ☐ No [ ]
4. Do you feel that you have a drinking or drug problem now? ..... ☐ Yes ☐ No [ ]

(Further Assessment recommended for a score of 6 and higher) Total Points

Section VII - Services Request ☐ N/A (not applicable if initial appointment has already been set)

Please keep your Counseling handouts and call us for assistance as necessary.

I would like assistance from the Counseling Team members with the following:

- I would like help from the Counseling Team in identifying other community mental health resources for me. ..... ☐ Yes ☐ No
- I would like more information about Post Traumatic Stress Disorder (PTSD). ..... ☐ Yes ☐ No
- I would like individual counseling from the Team or to see if counseling is right for me ..... ☐ Yes ☐ No
- I would like to know about additional Counseling Team services such as case management..... ☐ Yes ☐ No

Stop here.

STAFF USE ONLY (If screening performed to support a referral for counseling, Fax to Case Manager: 1 866 318-0828)

Sec. III	*Sec. IV*	*Sec. V*	*Sec. VI*
PTSD SCORE: [ ]	**MHI-5:** [ ]	**SSI:** [ ]	**Multiple Barriers:** [ ]
☐ Further Assessment; recommended if score = ***6 or higher***	☐ Further Assessment; recommended if score = ***18 or lower***	☐ Further Assessment; recommended if score = ***6 or higher***	☐ Further Assessment; recommended if score = ***3 or higher***

Date of Contact	Staff Name	Client Case # (staff initials, date of service, time, and program initials)