



# MERITUS HEALTH, INC

## Behavioral Health Services Health Screening And Patient Intake Sheet

Patient Name: \_\_\_\_\_ Date \_\_\_\_\_

To help us know you better and provide comprehensive treatment for you while at Behavioral Health Services, we need the following information:

**Nutrition Screening – Please complete the following questions: YES**  
**check Yes for all that apply.**

- I have a condition that made me change the type/amount of food I eat? \_\_\_\_\_ (2)
- I eat fewer than 2 meals per day? \_\_\_\_\_ (3)
- I don't eat many fruits, vegetables or milk products? \_\_\_\_\_ (2)
- I have 3 or more drinks of beer, liquor or wine almost every day? \_\_\_\_\_ (2)
- I have a tooth/mouth problem that makes it hard for me to eat? \_\_\_\_\_ (2)
- I eat alone most of the time? \_\_\_\_\_ (1)
- I take 3 or more different medicines per day? \_\_\_\_\_ (1)
- Without wanting to, I have lost or gained 10 pounds in the last six months? \_\_\_\_\_ (2)
- I am not always physically able to shop, cook or feed myself? \_\_\_\_\_ (2)

**Nicotine Use Screening – Do you use nicotine products? \_\_\_\_\_ No \_\_\_\_\_ Yes**  
**If yes, check all that apply:**

- How soon after you wake do you smoke your first cigarette?  
 \_\_\_\_\_ Within 5 minutes (3) \_\_\_\_\_ 6–30 min (2) \_\_\_\_\_ 31–60 min (1) \_\_\_\_\_ Over 60 min (0)
- Do you find it hard to not smoke in places it is forbidden? \_\_\_\_\_ Yes (1) \_\_\_\_\_ No (0)
- How many cigarettes a day do you smoke? \_\_\_\_\_ 1–10 (0) \_\_\_\_\_ 11–30 (1) \_\_\_\_\_ 21–30 (2) \_\_\_\_\_ Over 31 (3)
- Do you smoke if you are so ill that you are in bed all day? \_\_\_\_\_ Yes (1) \_\_\_\_\_ No (0)
- What is your willingness to change your smoking:  
 \_\_\_\_\_ Decline, Not ready or interested in information  
 \_\_\_\_\_ Thinking about it over the next 6 months – would like education  
 \_\_\_\_\_ Ready to stop and would like referral information to a program

**Chronic Pain Screening – Do you suffer from chronic pain? \_\_\_\_\_ No \_\_\_\_\_ Yes**  
**If yes, answer all the questions below:**

- On a scale of 1–10 with 10 being the worst, what is the number of your pain? \_\_\_\_\_
- What kind of pain \_\_\_\_\_ Sharp \_\_\_\_\_ Dull \_\_\_\_\_ Burning \_\_\_\_\_ Aching \_\_\_\_\_ Numbing
- Where is the pain? \_\_\_\_\_
- How often? \_\_\_\_\_
- How long does it last? \_\_\_\_\_
- What is the pattern? \_\_\_\_\_ Intermittent \_\_\_\_\_ Constant \_\_\_\_\_ With Activity
- What makes it better? \_\_\_\_\_
- What makes it worse? \_\_\_\_\_
- How does your pain disrupt your daily life and functioning? \_\_\_\_\_
- What treatments have you tried? \_\_\_\_\_
- What means of coping with the pain to you use? \_\_\_\_\_
- What doctor do you see for your pain? \_\_\_\_\_

PLACE LABEL HERE



# MERITUS HEALTH, INC

## Behavioral Health Services Health Screening And Patient Intake Sheet

### RELIGION AND SPIRITUALITY

How active are you in religious or spiritual activities? \_\_\_ Daily \_\_\_ Weekly \_\_\_ Monthly \_\_\_ Annually  
How important is religion or spirituality to you now? \_\_\_ Very \_\_\_ Somewhat \_\_\_ A little \_\_\_ Not at all  
Check all that apply:

- I have a belief in a higher power or power greater than myself
- Daily prayer and/or meditation give me comfort and strength
- I consider spiritual tools important in getting better or for recovery
- Helping others/service is a part of my spiritual belief system
- I am familiar with the 12 step program spiritual approach to living
- I identify with an organized religion or church
- This is an area I would like to develop to help with my treatment and recovery
- I want to share other cultural or religious/spiritual information with my doctor or therapist

### LEISURE AND RECREATIONAL ACTIVITIES

Identify 3 leisure or recreational activities – things you do in free time?

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

My Leisure and Recreational Activities; check all that apply below:

- Keep me in contact with supportive and positive people
- Put me in contact with negative people or bad influences
- Structure my time so I don't focus on my problems
- Help me learn new things and form new relationships
- Provide the physical release and/or fun or relaxation from stress
- This is an area I would like to enhance to help with my treatment and recovery
- I want to share other cultural or leisure /recreational information with my doctor or therapist

### Family Involvement in your Treatment

If you want to have a family member involved in your treatment, you must provide their name and sign a release \_\_\_\_\_. If no, check here \_\_\_\_\_.

### PRELIMINARY PLAN OF CARE

Assessment modality – Individual sessions not to exceed 3 visits

Goals During Initial Assessment Period

Completion of psychosocial assessment and ITP in a compassionate non-judgmental way using all appropriate sources of information.

Continual assessment for continuum of care interventions which might provide rapid symptom stabilization – Inpt, IOP, ADD, MD.

Identification and clarification of initial problems.

Education about cx, mental health and related treatment options.

Education on the role of family, as appropriate in treatment.

If additional, Provide Details: \_\_\_\_\_

I consent to automated reminder calls: \_\_\_ Y \_\_\_ N

To help with your request, follow-up, and referrals there will be an electronic summary of your appointment today.

I consent to the above information and have received the new patient informational packet

Signature \_\_\_\_\_

Date \_\_\_\_\_

PLACE LABEL HERE