



**C. CHILDREN:**

Name (Last, First, Middle Initial)	SSN	Sex	Age / Date of Birth	Race	Grade / School	Living with you?
		<input type="checkbox"/> M <input type="checkbox"/> F	/		/	<input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> M <input type="checkbox"/> F	/		/	<input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> M <input type="checkbox"/> F	/		/	<input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> M <input type="checkbox"/> F	/		/	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are you or partner pregnant?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> M <input type="checkbox"/> F	Months Pregnant:	Anticipated Birth Date:		

**D. OTHERS LIVING IN HOME:**

Name (Last, First, Middle Initial)	SSN	Sex	Age / Date of Birth	Race	Relationship:
		<input type="checkbox"/> M <input type="checkbox"/> F	/		Mother / Father / Other:
		<input type="checkbox"/> M <input type="checkbox"/> F	/		Mother / Father / Other:

**SECTION II - MEDICAL SUPPORT TEAM**

Commander / First Sergeant / Platoon Sergeant:

**Nurse Case Manager:**

Physician:

Behavioral Health/**Social Work Care** Manager:

Other Providers:

Referral Source? Self Command Medical / Provider  
SRP Reverse SRP PHA/PDHRA Other:

**For Provider Use Only****SECTION III - MOBILIZATION & DEPLOYMENT**

Mob / Deployment Location	Departure Date	Return Date	Combat Exposure	Combat Related Injuries
			<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
			<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
			<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Perceived level of threat during any deployment: High Medium Low Explain if High or Medium:				
Do you expect: <input type="checkbox"/> MEB <input type="checkbox"/> REFRAD <input type="checkbox"/> ETS <input type="checkbox"/> Remain on Active Duty				
<b>Additional comments:</b>				

PATIENT IDENTIFICATION (Last, First, Middle Initial):

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**SECTION IV - PRESENTING PROBLEM(S)**

For Provider Use Only

**A. ISSUES & GOALS**

In order to help us determine the best treatment plan, please list the main issues or goals you would like assistance with:

- 1.
- 2.
- 3.
- 4.

**B. STRESSORS (Check all that apply)**

<p><b>Marital/Relationships:</b></p> <input type="checkbox"/> Recent or pending divorce <input type="checkbox"/> Separation <input type="checkbox"/> Infidelity <input type="checkbox"/> Abuse <input type="checkbox"/> Fighting/Disagreements <input type="checkbox"/> Alcohol/Drugs <input type="checkbox"/> Sexual <input type="checkbox"/> Death <input type="checkbox"/> Birth <input type="checkbox"/> Illness (EFMP)	<p><b>Social:</b></p> <input type="checkbox"/> Loss of friend(s) <input type="checkbox"/> Broken romance <input type="checkbox"/> Loneliness <input type="checkbox"/> Lack of Social Support <input type="checkbox"/> Transportation <input type="checkbox"/> Religious/Spiritual <input type="checkbox"/> Neighbor/Housing <input type="checkbox"/> Other (Describe)	<p><b>Military:</b></p> <input type="checkbox"/> Deployment <input type="checkbox"/> Recent Move <input type="checkbox"/> Pending Move <input type="checkbox"/> Job Related <input type="checkbox"/> ETS/Retirement <input type="checkbox"/> Chapter / Separation <input type="checkbox"/> Promotion issues <input type="checkbox"/> Weight/PT problems	<p><b>Legal:</b></p> <input type="checkbox"/> Letter of Reprimand <input type="checkbox"/> Article 15 <input type="checkbox"/> Court Martial <input type="checkbox"/> Arrested <input type="checkbox"/> Probation/ Parole <input type="checkbox"/> Criminal <input type="checkbox"/> Family <input type="checkbox"/> Child Custody <input type="checkbox"/> Protective Order <input type="checkbox"/> DUI
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**Personal:**

<input type="checkbox"/> Financial	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Illness	<input type="checkbox"/> Injury
<input type="checkbox"/> Physical Assault	<input type="checkbox"/> Sexual Assault	<input type="checkbox"/> Other: _____	

**Occupational:**

<input type="checkbox"/> Conflict with supervisor(s)	<input type="checkbox"/> Discrimination	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Excessive hours	<input type="checkbox"/> Harassment	
<input type="checkbox"/> Fired/Relieved	<input type="checkbox"/> Boring/Meaninglessness	

**SECTION V - BEHAVIORAL / MENTAL HEALTH**

**A. DEPRESSION**

What is your current level of **emotional pain or distress**? Rating: \_\_\_\_\_

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Pain Free      Mild                      Moderate                      Severe      Totally Disabling

F1-1

During the past month, have you often been bothered by feeling down, depressed, or hopeless?  
 ...  No  Yes

During the past month, have you often been bothered by little interest or pleasure in doing things?  
 ...  No  Yes

In the past have, you suffered any emotionally or physically traumatic event?  
 (If "Yes," please explain)  No  Yes

Have you experienced a recent loss (including separation / divorce)?  
 (If "Yes," please explain)  No  Yes

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SECTION V - BEHAVIORAL / MENTAL HEALTH (Continued)		For Provider Use Only
<b>B. SELF HARM</b>		
Are you having thoughts of <b>harming or killing yourself</b> ? <input type="checkbox"/> No <input type="checkbox"/> Yes		<b>F1-2</b>
Do you have a <b>plan to harm yourself</b> (shoot self, overdose, cut self with knife, hang self, etc.)? <input type="checkbox"/> No <input type="checkbox"/> Yes		<b>F1-3</b>
Do you have access to a means to carry out a plan to hurt yourself (knives, rope, gun, drugs/medications, etc.)? <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes		<b>F1-4</b>
Have you ever tried to harm yourself? <i>(If "Yes," please explain – include history of suicide thoughts, gestures, attempts, etc.)</i> <input type="checkbox"/> No <input type="checkbox"/> Yes		<b>F1-5</b>
Are you hopeful about your future? <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>F1-6</b>
How often do you perceive you have failures in your life? <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently		<b>F1-7</b>
Have you ever been diagnosed with a mental health condition/illness by a health care provider? <i>(If "Yes," please explain)</i> <input type="checkbox"/> No <input type="checkbox"/> Yes		<b>F1-8</b>
<b>IF YOU RESPONDED POSITIVELY TO ANY OF THE ABOVE BEHAVIORAL / MENTAL HEALTH QUESTIONS, COMPLETE THE DEPRESSION SCALE.</b>		<b>*DEPRESSION SCALE</b> <input type="checkbox"/>
		<b>*SUICIDE PREV PLAN</b> <input type="checkbox"/>
<b>C. MENTAL STATUS</b>		
During the past week, have you had thoughts "racing" through your head? <input type="checkbox"/> No <input type="checkbox"/> Yes		<b>F2-1</b>
Do you believe you have special powers? <input type="checkbox"/> No <input type="checkbox"/> Yes		<b>F2-2</b>
Do you hear voices or are you "seeing things"? <input type="checkbox"/> No <input type="checkbox"/> Yes		<b>F2-3</b>
Do you believe that people are watching you [paranoia]? <input type="checkbox"/> No <input type="checkbox"/> Yes		<b>F2-4</b>
<b>POSITIVE RESPONSES TO MENTAL STATUS QUESTIONS REQUIRE FULL ASSESSMENT-----</b>		<b>FULL MSE</b> <input type="checkbox"/>
<b>D. ANXIETY / PANIC</b>		
Do you have any problems with anxiety, "nerves" or panic attacks? <input type="checkbox"/> No <input type="checkbox"/> Yes		<b>F3-1</b>
Have you ever experienced a sudden surge of overwhelming discomfort or extreme "anxiety" that came on without any warning or for no apparent reason? <input type="checkbox"/> No <input type="checkbox"/> Yes		<b>F3-2</b>
Do you avoid certain people, places, conversations, or other non-combat situations because you are concerned that you may experience a sudden surge of overwhelming discomfort or "anxiety"? <input type="checkbox"/> No <input type="checkbox"/> Yes		<b>F3-3</b> <b>*ANXIETY SCREEN</b> <input type="checkbox"/>
<b>E. POST TRAUMATIC STRESS</b>		
<b>In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you...</b>		
1. Have had <b>nightmares</b> about it or thought about it when you did not want to? <input type="checkbox"/> No <input type="checkbox"/> Yes		<b>F3-4</b>
2. <b>Tried</b> hard not to think about it or went out of your way to avoid situations that reminded you of it? <input type="checkbox"/> No <input type="checkbox"/> Yes		<b>F3-5</b>
3. Were constantly on guard, watchful, or easily startled? <input type="checkbox"/> No <input type="checkbox"/> Yes		<b>F3-6</b>
4. Felt numb or detached from others, activities, or your surroundings? <input type="checkbox"/> No <input type="checkbox"/> Yes		<b>F3-7</b>
<b>IF YOU RESPONDED "YES" TO ANY OF THE QUESTIONS IN THIS SECTION, COMPLETE THE PTSD CHECKLIST.</b>		<b>*PTSD CHECKLIST</b> <input type="checkbox"/>

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F. ANGER / AGGRESSION INCLUDING DOMESTIC VIOLENCE				For Provider Use Only	
Are you currently angry at anyone or about any situation? <i>(If "Yes," please explain)</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes			<b>F4-1</b>
Do you have thoughts or plans to harm or kill another person? <i>(If "Yes," please explain)</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes			<b>F4-2</b>
Have you recently broken objects or hurt yourself, others (emotionally, physically, sexually), or an animal due to your anger?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			<b>F4-3</b>
Are you currently involved in physical, emotional or sexual abuse of anyone (including family members)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			<b>F4-4</b>
Do you currently have a restraining or protection order in place against you?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			<b>F4-5</b>
Have you ever been charged or convicted of an offense of assault, battery or abuse?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			<b>F4-6</b>
Do you have weapons in your home (firearms, switchblades, knife collections, etc.)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			<b>F4-7</b>
Have you recently had a relationship break-up, separation, or divorce due to you or your intimate partner's anger/aggressive behavior? <i>(If "Yes," are you in agreement with the break-up / separation / divorce?)</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No
G. SUBSTANCE USE					
1. Have you ever felt you should <u>cut</u> down on your drinking?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
2. Have people <u>annoyed</u> you by criticizing your drinking?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
3. Have you ever felt bad or <u>guilty</u> about your drinking?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover ( <u>eye opener</u> )? <small>Reference: Mayfield, D., McLeod, G. &amp; Hall, P. (1974)</small>	<input type="checkbox"/> No	<input type="checkbox"/> Yes			<b>F5-1</b> <b>F5-2</b> <b>F5-3</b> <b>F5-4</b>
5. Do you drink alcohol or use drugs to cope with stress?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			<b>F5-5</b>
Are you currently using any controlled or illegal substances (i.e., marijuana, cocaine, crack, stimulants, sedatives, tranquilizers, heroin, opiates, psychedelics)? <i>(If "Yes," please explain)</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes			<b>F5-6</b>
Are you currently misusing prescribed medications, herbal supplements/remedies, sports nutritional supplements?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			<b>F5-7</b>
Have you been involved in any alcohol or drug treatment?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
Have you ever dropped out or failed any prior alcohol or drug treatment?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			<b>F5-8</b>
<b>IF YOU RESPONDED "YES" TO ANY OF THE QUESTIONS IN THIS SECTION, COMPLETE THE AUDIT SCREEN.</b>					
H. BEHAVIORAL / MENTAL HEALTH HISTORY					
Have you ever received counseling or mental health services? <i>(If "Yes," please explain)</i>				<input type="checkbox"/> No	<input type="checkbox"/> Yes
Diagnosis	Location	Hospitalized?	Date Treatment Began	Date Treatment Ended	
		<input type="checkbox"/> No <input type="checkbox"/> Yes			
		<input type="checkbox"/> No <input type="checkbox"/> Yes			
		<input type="checkbox"/> No <input type="checkbox"/> Yes			
Have you ever been diagnosed with: Adjustment Disorder, Depression, Bi-Polar, Anxiety, PTSD, Acute Stress Reaction or Personality Disorder? <i>(Circle all applicable diagnoses)</i>				<input type="checkbox"/> No	<input type="checkbox"/> Yes

- DV RISK SCREEN**
- SAFETY PLAN**
- \*VICTIM IMPACT STMT**
- F5-1**
- F5-2**
- F5-3**
- F5-4**
- F5-5**
- F5-6**
- \*DRUG ABUSE /**
- DEPENDENCE SCREEN**
- F5-7**
- F5-8**
- \*ALCOHOL USE**
- SCREEN**

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**SECTION VI - PSYCHOSOCIAL HISTORY**

For Provider Use Only

**A. EARLY CHILDHOOD & FAMILY RELATIONSHIPS**

Where were you born?

Current age of mother: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Current age of father: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Either parent deceased? \_\_\_\_\_

Are your parents still married to one another?  Yes  No

If they are divorced, how old were you when they divorced?

Who raised you? \_\_\_\_\_ Where were you raised? \_\_\_\_\_

How many biological brothers do you have? \_\_\_\_\_ How many biological sisters do you have? \_\_\_\_\_

How many step-brothers do you have? \_\_\_\_\_ How many step-sisters do you have? \_\_\_\_\_

What number child are you in the birth order?

What was it like in your childhood home?  Loving  Comfortable  Supportive  
 Chaotic  Abusive  Other (please describe): \_\_\_\_\_

Was your family:  Poor  Lower Middle Class  Middle Class  
 Upper Middle Class  Wealthy

Were you adopted?  No  Yes If yes, at what age?

Did your parents physically fight?  Never  Rarely  Sometimes  Often

Were you emotionally, physically or sexually abused, neglected or sexually assaulted as a child or an adult?

(If "Yes," please explain)  No  Yes

F6-1

Please identify any mental health issues that seem to "run in the family" or have occurred in family members in the past:

- Alcoholism/Drug Addiction  Anxiety  Attention Deficit Hyperactivity Disorder
- Depression  Hyperactivity  Manic-Depression/Bi-Polar Disorder
- Schizophrenia  Sexual Abuse  Suicide  Other: \_\_\_\_\_

Please explain any identified issues:

**B. MARRIAGE & RELATIONSHIPS**

Are you currently married?  No  Yes How long have you been married?  
 (If "No," skip to "If not married" below) \_\_\_\_\_ Years \_\_\_\_\_ Months

Are you currently living with your spouse?  Yes  No

How many times have you been married? \_\_\_\_\_ Your Partner? \_\_\_\_\_

Date of marriage	Date of divorce or death of spouse	Reason the relationship ended

**If not married**, are you currently in a relationship?  No  Yes

If "Yes," how long have you been involved with that person? \_\_\_\_\_ Years \_\_\_\_\_ Months

Please rate your satisfaction with your marriage/relationship: Rating: \_\_\_\_\_

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10  
 Completely Satisfied Satisfied Dissatisfied

\*MARITAL SCREEN

F6-2

Are you experiencing any problems with your spouse or in your relationship?  No  Yes  
 (If "Yes," please explain)

F6-3

CHILD ABUSE RISK SCREEN

Has past deployment(s) impacted your marriage, relationship, and family?  
 (If "Yes," please explain)  No  Yes

SAFETY PLAN

Do you and your children feel safe from domestic abuse at home?  Yes  No

F6-4

PATIENT IDENTIFICATION (Last, First, Middle Initial): \_\_\_\_\_

FMP/SPONSOR SSN: \_\_\_\_\_

<b>C. CHILDREN &amp; HOME</b>	<b>For Provider Use Only</b>
Are you currently having any problems with your children? <span style="float: right;"><input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes</span> <i>(If "Yes," please explain)</i>	<b>F6-5</b>
<input type="checkbox"/> Abuse / Neglect <input type="checkbox"/> Behavior <input type="checkbox"/> Illness / Disability / EFMP <input type="checkbox"/> Child Care <input type="checkbox"/> School Problems <input type="checkbox"/> Special Issues <input type="checkbox"/> Parenting / Nurturing <input type="checkbox"/> Mental Health <input type="checkbox"/> Other: _____	
Have you, your family or a person you are currently in a relationship with ever been to counseling or had involvement with any agency such as Child Protective Services or Family Advocacy due to physical, sexual, or emotional abuse or neglect? <i>(If "Yes," who participated in the counseling; please explain)</i> <span style="float: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</span>	<b>F6-6</b>
Are you involved in the care of any family member for illness or otherwise? <span style="float: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</span> <i>(If "Yes," please explain)</i>	
<b>D. EDUCATION</b>	
Highest level of education completed: <input type="checkbox"/> Elementary <input type="checkbox"/> Junior High <input type="checkbox"/> High School <input type="checkbox"/> Technical School <input type="checkbox"/> Some college <input type="checkbox"/> 2-Year college degree <input type="checkbox"/> 4-Year college degree <input type="checkbox"/> Graduate school <input type="checkbox"/> Other:	
If you did not graduate from high school, did you get your GED? <span style="float: right;"><input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
Did you repeat any grades? <span style="float: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</span> <i>(If "Yes," please explain)</i>	
Were you ever in special education classes or did you have a learning disability? <span style="float: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</span> <i>(If "Yes," please explain)</i>	<b>F7-1</b>
Did you have any disciplinary problems in school? <span style="float: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</span>  Were you ever suspended or expelled? <span style="float: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</span> <i>(If "Yes" to either question, please explain)</i>	
<b>E. FINANCIAL</b>	
Do you currently have any financial problems? <span style="float: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</span> <i>(If "Yes," please explain)</i>	<b>F7-2</b>
Are you currently having any of the following problems? <i>(Select all that apply)</i> <input type="checkbox"/> Garnished wages <input type="checkbox"/> Filed bankruptcy <input type="checkbox"/> Bounced checks <input type="checkbox"/> No money for food <input type="checkbox"/> Late on payments or loans <input type="checkbox"/> Item repossession <input type="checkbox"/> Disciplined for debts or bad checks <input type="checkbox"/> Having "no pay due" <input type="checkbox"/> Pawning items to make ends meet <input type="checkbox"/> Other:	
Do you need a referral to an agency for financial assistance/counseling? <span style="float: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</span>	

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F. ENVIRONMENT / SUPPORT SYSTEMS		For Provider Use Only
Do you have good social support systems (friends, family, neighbors, co-workers, organizations, etc.)? List your support systems: <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	F7-3	
Are you having trouble in your relationships with family or friends? <span style="float: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</span>	F7-4	
Do those surrounding you have sufficient knowledge about your condition? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
Do you have adequate housing or a place to live? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
Who do you rely on for help with problems? (e.g. family, friends, extended family) Names:		
<b>Services you are currently receiving:</b> <input type="checkbox"/> Alcohol and Drug <input type="checkbox"/> Army Community Services <input type="checkbox"/> Chaplains <input type="checkbox"/> Child Care/CYS <input type="checkbox"/> Child and Adolescent Counseling <input type="checkbox"/> Child Protective Services <input type="checkbox"/> Community Health Nurse <input type="checkbox"/> Community Mental Health <input type="checkbox"/> Court Mandated Counseling <input type="checkbox"/> English as a Second Language <input type="checkbox"/> Family Readiness Group <input type="checkbox"/> Family Member Employment Assistance Program <input type="checkbox"/> Legal Services <input type="checkbox"/> Marriage and Family Counseling <input type="checkbox"/> New Parent Support Program <input type="checkbox"/> Respite Care <input type="checkbox"/> School Counselor <input type="checkbox"/> Social Work Service <input type="checkbox"/> Special Needs Assistance Program (SNAP) <input type="checkbox"/> Tri-Care (Counseling/Psychiatric Care) <input type="checkbox"/> Use of Shelter <input type="checkbox"/> Victim Advocate <input type="checkbox"/> Others:		
G. EMPLOYMENT		
Are there any problems with your civilian or military job? <span style="float: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</span> <i>(If "Yes," please explain)</i>	F7-5	
Do you need a referral for civilian employment or vocational rehabilitation? <span style="float: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</span>		
If Reservist or National Guard, what is your civilian occupation?		
Are you returning to your job? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> <i>(If "No," please explain)</i>		
What are your plans: <input type="checkbox"/> Stay in and re-enlist <input type="checkbox"/> Stay in until my ETS <input type="checkbox"/> Get out ASAP with a good discharge <input type="checkbox"/> Get out ASAP with any discharge <input type="checkbox"/> I don't know right now <input type="checkbox"/> Other: _____		
Partner's Occupation: Length of Employment: _____ Years _____ Months If unemployed, how long since last employment: _____ Years _____ Months		
H. LEGAL		
Do you presently have any legal problems? <span style="float: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</span> <i>(If "Yes," please explain)</i>	F7-6	
Have you ever had any administrative or legal action taken against you? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(If "Yes," please select all that apply)</i> <input type="checkbox"/> Letter of Reprimand <input type="checkbox"/> Article 15 <input type="checkbox"/> Court Martial <input type="checkbox"/> Chapter <input type="checkbox"/> Arrest <input type="checkbox"/> DUI <input type="checkbox"/> Other: _____ Reason for action:		

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**I. LEISURE AND RECREATION**

Please list activities which you enjoy or have enjoyed in the past, including hobbies, volunteer work, sports, etc.

**For Provider Use Only**

**J. SPIRITUAL AND CULTURAL**

What is your religious or spiritual affiliation?

Are you an active participant with your religious/spiritual affiliation?  Yes  No

What is your cultural affiliation/heritage (i.e., American Indian, Asian, Irish, Hispanic, etc.)?

Do you have any religious or spiritual practices that the provider needs to be aware of during treatment? (If "Yes," please explain)  No  Yes

**SECTION VII - HEALTH HISTORY**

**A. PHYSICAL HEALTH**

How would you describe your physical health?  Excellent  Good  Fair  Poor

**F8-1**

Current medical treatment:  None  Inpatient  
 Outpatient w/out Follow-up  Outpatient with Follow-up

**MEDICAL HISTORY:** List any medical conditions you have or have had:

Medical Diagnosis      Diagnosis Date      Treatment Completion Date      Provider

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were any of these illnesses/injuries combat or deployment related?  No  Yes  
(If "Yes," where and when?)

What physical limitations do you have as a result of your illness/injury(s)?

**B. MEDICATIONS**

List **ALL** medications, over-the-counter or herbal supplements/remedies you are currently using, the dosage and the prescribing provider, if applicable:  N/A

Medication      Dosage      Prescribing Provider

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you currently taking your prescribed medications as prescribed?  N/A  Yes  No  
(In "No," please explain): \_\_\_\_\_

**F8-2**

Are you satisfied with how your medications are working?  Yes  No  
(If "No," please explain): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**PATIENT IDENTIFICATION** (Last, First, Middle Initial):

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<b>C. TRAUMATIC BRAIN INJURY (TBI) &amp; CONCUSSION</b>	<b>For Provider Use Only</b>
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Did any injury received while you were deployed result in being dazed, confused or "seeing stars", not remembering the injury, losing consciousness (knocked out), having symptoms of concussion (headaches, dizziness, memory problems, balance problems, ringing in ears, irritability, sleep problems, etc.)? No Yes

Did you have any **concussions or open or closed head injuries** during deployment? No Yes

Have you had a **previous history of a TBI or concussion**? No Yes

**F8-3**  
**\*TBI SCREEN**

<b>D. PAIN</b>
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Are you experiencing physical pain today? (If "Yes," please explain) No Yes

**F8-4**

Please rate the severity of your pain: Rating Injury/Illness #1: \_\_\_\_\_ Rating Injury/Illness #2: \_\_\_\_\_  
 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10  
 Pain Free          Mild                  Moderate                  Severe                  Totally Disabling

**F8-5**

If you have physical pain, are you being treated for that pain? N/A Yes No  
 (If "Yes," where or by whom?)

**F8-6**  
If "NO," refer for pain management, if needed

<b>E. SLEEP</b>
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Are you experiencing difficulty sleeping? No Yes  
 (If "Yes," please explain) Falling Asleep Staying Asleep Waking During Sleep

**F8-7**

Are you taking medications (over-the-counter or prescribed) to help you sleep? No Yes

<b>F. NUTRITION</b>
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Have you ever had problems with your weight or eating habits? No Yes  
 (If "Yes," please explain – include weight gain and loss and body image issues)

Have you ever had problems with binge eating or compulsive overeating, or purging (making yourself vomit or using laxatives to excess)? No Yes  
 (If "Yes," please explain)

<b>SECTION VIII - ADDITIONAL INFORMATION</b>
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Please use this space to tell us anything else that you may feel is relevant or that may be important for your provider to know.

**\*To be completed by patient, when indicated. All other screens completed by provider based on assessment/intervention with patient.**

Person filling out this form:  
 Sponsor  Spouse  Caregiver  Other: \_\_\_\_\_  
 I have completed all information accurately and completely.  
**Signature of Patient/Family Member/Guardian or Caregiver:**  
  
**Date:**

**Provider Signature & Stamp:**  
  
  
 Installation Name:  
**Date:**

**THANK YOU -- PLEASE STOP HERE**  
**The remainder of this form is for Provider Use Only**

PATIENT IDENTIFICATION (Last, First, Middle Initial):	FMP/SPONSOR SSN:
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For Provider Use Only

## CASE MANAGEMENT COMPLEXITY WORKSHEET FOR BEHAVIORAL HEALTH SOCIAL WORK CARE MANAGERS

	Rating 0 to 10*	Complexity Rating Scale Key* / Examples
<b>Effort Scale**</b>		
<b>Injuries / Illnesses</b>	Unk	
-Number of	0 1 2 3 4 5 6 7 8 9 10	PTSD, Back, Neck & Shoulder = 7 Rating
-Complexity of	0 1 2 3 4 5 6 7 8 9 10	Several Surgeries Required = 5 Rating
<b>Medications</b>	0 1 2 3 4 5 6 7 8 9 10	Pain & Behavioral Health Meds = 5 Rating
<b>Requirements</b>		
-Appointments	0 1 2 3 4 5 6 7 8 9 10	Medical/Mental Health/Dental/Support/Social
-Resources	0 1 2 3 4 5 6 7 8 9 10	Patient & Family
-Information / Education	0 1 2 3 4 5 6 7 8 9 10	Patient & Family
<b>Functioning Scale</b>		
<b>Patient Functioning</b>	0 1 2 3 4 5 6 7 8 9 10	Fair Functioning = 7
<b>Patient As Own Advocate</b>	0 1 2 3 4 5 6 7 8 9 10	Good Functioning = 3
<b>Support System Strength</b>	0 1 2 3 4 5 6 7 8 9 10	Good = 2
<b>Provider Strength</b>	0 1 2 3 4 5 6 7 8 9 10	Strong Skills & Knowledge = 0
<b>Time Scale</b>		
<b>Care Coordination</b>	0 1 2 3 4 5 6 7 8 9 10	Amount of Time (Patient & Family) (Team meetings, consultations, scheduling appointments, contacting collaterals)
<b>Support Required</b>	0 1 2 3 4 5 6 7 8 9 10	Length of Time (Patient & Family)
Add columns for Total _____ Divided by 12 = _____		
<b>COMPLEXITY SCALE RATING:</b> <input type="checkbox"/> LOW <input type="checkbox"/> MODERATE <input type="checkbox"/> HIGH		
<b>PROVIDER FINAL RATING:</b> <input type="checkbox"/> LOW <input type="checkbox"/> MODERATE <input type="checkbox"/> HIGH		

### \*Complexity Rating Scale Key

Effort**	Functioning	Rating & Rating Total	Amount of Time	Length of Time
None	Excellent	0	None	None
Low	Good	Low – 0-4	30-60 minutes/week	<30 days
Moderate	Fair / Limited	Mod – 5-7	60-180 minutes/week	30-120 days
High	Poor	High – 8-10	>180 minutes/week	>120 days

\*\*Based on effort to support patient including level of coordination and advocacy required. Score all "unknown" responses as 5.

**EXAMPLE:** Patient with PTSD, back and neck pain, & shoulder injury; multiple medications (>5); requires multiple appointments; requires financial assistance, vocational rehabilitation referral and information on diagnosis and symptoms.

**SCORING:** Effort-7+5+4+4+5+4=29; Function-4+3+3+1=11; Time-6+9=15; Total-55/12=5 (MOD).

**Items to consider:** Appointments for medical, dental, behavioral health (depression, self-harm, anxiety, anger, grief, PTSD, alcohol & drugs, mental health, marital/relationship/family issues, domestic violence, child abuse, psychological assessments); rehabilitative care; home health supplies and assistance (TBI, prosthetics, blind, spinal cord injury); pain management; nutrition; lack of support (family, guardian, social); child issues (child care, exceptional needs); financial; employment; housing; legal (family, guardian, UCMJ, administrative); educational; leisure activities; spiritual; cultural; vocational rehabilitation; community resource referrals (local support groups); Veteran's Administration; Social Security Administration; family/guardian support; etc.      MEDCOM BHD SWP 28 Jan 09

PATIENT IDENTIFICATION (Last, First, Middle Initial):	FMP/SPONSOR SSN:
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**BEHAVIORAL HEALTH INTAKE-PSYCHOSOCIAL HISTORY & ASSESSMENT  
(BHI-PHA)**

**ASSESSMENT TOOLS**

**FOR BEHAVIORAL HEALTH SOCIAL WORK CARE MANAGERS  
IN MTFs, WTUs AND CBWTUs**

PATIENT IDENTIFICATION (Last, First, Middle Initial):

FMP/SPONSOR SSN:

**ALCOHOL USE**

Date: \_\_\_\_\_

**ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT)**

*Please circle the answer that is correct for you.*

1. How often do you have a drink containing alcohol?  
 Never      Monthly or less      Two to four times a month      Two to three times a week      Four or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?  
 1 or 2      3 or 4      5 or 6      7 to 9      10 or more
3. How often do you have six or more drinks on one occasion?  
 Never      Less than monthly      Monthly      Weekly      Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?  
 Never      Less than monthly      Monthly      Weekly      Daily or almost daily
5. How often during the last year have you failed to do what was normally expected from you because of drinking?  
 Never      Less than monthly      Monthly      Weekly      Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?  
 Never      Less than monthly      Monthly      Weekly      Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?  
 Never      Less than monthly      Monthly      Weekly      Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?  
 Never      Less than monthly      Monthly      Weekly      Daily or almost daily
9. Have you or someone else been injured as a result of your drinking?  
 No      Yes, but not in the last year      Yes, during the last year
10. Has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?  
 No      Yes, but not in the last year      Yes, during the last year

**SCORING:** Questions 1-8 are scored 0, 1, 2, 3 or 4. Questions 9 and 10 are scored 0, 2 or 4 only. The response is as follows:

Question	0	1	2	3	4
1	Never	Monthly or less	Two to four times per month	Two to three times per week	Four or more times per week
2	1 or 2	3 or 4	5 to 6	7 to 9	10 or more
3-8	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
9-10	No		Yes, but not in the last year		Yes, during the last year

*The minimum score (for non-drinkers) is 0 and the maximum possible score is 40. A score of 8 or more indicates a strong likelihood of hazardous or harmful alcohol consumption.*

**REFERENCE:** Saunders, J. B., Aasland, O. G., Babor, F., et al. (1993). Development of the alcohol use disorders screening test (AUDIT). WHO collaborative project on early detection of persons with harmful alcohol consumption, II. Addiction, 88, 791-804.

PATIENT IDENTIFICATION (Last, First, Middle Initial):

FMP/SPONSOR SSN:

**ANXIETY SCREEN****OVERALL ANXIETY SEVERITY  
AND IMPAIRMENT SCALE (OASIS)**

The following items ask about anxiety and fear. For each item, circle the number for the answer that best describes your experience over the past week.

1. In the past week, how often have you felt anxious?
  - 0 = No anxiety in the past week.
  - 1 = Infrequent anxiety. Felt anxious a few times.
  - 2 = Occasional anxiety. Felt anxious as much of the time as not. It was hard to relax.
  - 3 = Frequent anxiety. Felt anxious most of the time. It was very difficult to relax.
  - 4 = Constant anxiety. Felt anxious all of the time and never really relaxed.
  
2. In the past week, when you have felt anxious, how intense or severe was your anxiety?
  - 0 = Little or None: Anxiety was absent or barely noticeable.
  - 1 = Mild: Anxiety was at a low level. It was possible to relax when I tried. Physical symptoms were only slightly uncomfortable.
  - 2 = Moderate: Anxiety was distressing at times. It was hard to relax or concentrate, but I could do it if tried. Physical symptoms were uncomfortable.
  - 3 = Severe: Anxiety was intense much of the time. It was very difficult to relax or focus on anything else. Physical symptoms were extremely uncomfortable.
  - 4 = Extreme: Anxiety was overwhelming. It was impossible to relax at all. Physical symptoms were unbearable.
  
3. In the past week, how often did you avoid situations, places, objects, or activities because of anxiety or fear?
  - 0 = None: I do not avoid places, situations, activities, or things because of fear.
  - 1 = Infrequent: I avoid something once in a while, but will usually face the situation or confront the object. My lifestyle is not affected.
  - 2 = Occasional: I have some fear of certain situations, places, or objects, but it is still manageable. My lifestyle has only changed in minor ways. I always or almost always avoid the things I fear when I'm alone, but can handle them if someone comes with me.
  - 3 = Frequent: I have considerable fear and really try to avoid the things that frighten me. I have made significant changes in my life style to avoid the object, situation, activity, or place.
  - 4 = All the Time: Avoiding objects, situations, activities, or places has taken over my life. My lifestyle has been extensively affected and I no longer do things that I used to enjoy.
  
4. In the past week, how much did your anxiety interfere with your ability to do the things you needed to do at work, at school, or at home?
  - 0 = None: No interference at work/home/school from anxiety.
  - 1 = Mild: My anxiety has caused some interference at work/home/school. Things are more difficult, but everything that needs to be done is still getting done.
  - 2 = Moderate: My anxiety definitely interferes with tasks. Most things are still getting done, but few things are being done as well as in the past.
  - 3 = Severe: My anxiety has really changed my ability to get things done. Some tasks are still being done, but many things are not. My performance has definitely suffered.
  - 4 = Extreme: My anxiety has become incapacitating. I am unable to complete tasks and have had to leave school, have quit or been fired from my job, or have been unable to complete tasks at home and have faced consequences like bill collectors, eviction, etc.
  
5. In the past week, how much has anxiety interfered with your social life and relationships?
  - 0 = None: My anxiety doesn't affect my relationships.
  - 1 = Mild: My anxiety slightly interferes with my relationships. Some of my friendships and other relationships have suffered, but, overall, my social life is still fulfilling.
  - 2 = Moderate: I have experienced some interference with my social life, but I still have a few close relationships I don't spend as much time with others as in the past, but I still socialize sometimes.
  - 3 = Severe: My friendships and other relationships have suffered a lot because of anxiety. I do not enjoy social activities. I socialize very little.
  - 4 = Extreme: My anxiety has completely disrupted my social activities. All of my relationships have suffered or ended. My family life is extremely strained.

**SCORING:** Add the numbers of the 5 items circled. Score of 8 and above indicates probable anxiety disorder; pending further evaluation by Dr. Norman, et al. in 2007.

**REFERENCE:** Norman, Sonya B., Ph.D., et al. (2006) and Laura Campbell-Sills, Ph.D.

PATIENT IDENTIFICATION (Last, First, Middle Initial):

FMP/SPONSOR SSN:

**CHILD ABUSE/NEGLECT RISK SCREEN****CHILD ABUSE/NEGLECT  
RISK LEVEL - QUICK SCREEN**

**Patient/Child's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Interviewed:** Mother / Father / Children: \_\_\_\_\_ /  
 Other: \_\_\_\_\_ (May include provider/screener observations)

**Instructions:** Check applicable boxes to indicate "yes" as to the presence of the risk factors below:

	<b>Mother / Father / Children / Other</b>			
1. Child(ren) is under 36 months old.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Poor parent-child bonding / attachment/nurturing skills.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Parent(s) is experiencing moderate to severe anxiety or depression.*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Parent(s) is suicidal / homicidal.*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Parent(s) is suffering from post-partum depression or psychosis.*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Parent(s) abuses alcohol and/or other substances.*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Parent(s) reports feeling overwhelmed / stressed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Parent(s) displays anger/hostility during visit / assessment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Parent(s) is socially isolated / lonely or lacks support systems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Parent(s) has thoughts of harming child.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**ESTIMATED RISK** (Circle one): LOW / MODERATE / HIGH RISK /

UNABLE TO DETERMINE

**This checklist is provided for use as a guide to identify factors which place a victim at "high risk" of abuse and is not inclusive of all risk factors. All suspected child abuse including cases estimated to be at high risk requires referral to Social Work Service. Consult with Social Work Service for further guidance, if needed.**

**\*Requires referral to Behavioral Health Service and/or Substance Abuse Services, as applicable.**

**MEDCOM FAP Update: 28 Jan 09**

PATIENT IDENTIFICATION (Last, First, Middle Initial):

FMP/SPONSOR SSN:

**DEPRESSION SCALE - PHQ-9**

**PATIENT HEALTH QUESTIONNAIRE (PHQ-9)**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Over the last 2 weeks, how often have you been bothered by any of the following problems?  
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

add columns:  +  +

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) TOTAL:

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at [rs9@columbia.edu](mailto:rs9@columbia.edu). Use of the PHQ-9 may only be made in accordance with the Terms of Use available at <http://www.pfizer.com>. Copyright ©1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.

ZT274388

PATIENT IDENTIFICATION (Last, First, Middle Initial):

FMP/SPONSOR SSN:

# DEPRESSION SCALE - PHQ-9 SCORING

## INSTRUCTIONS FOR USE

*for doctor or healthcare professional use only*

### PHQ-9 QUICK DEPRESSION ASSESSMENT

#### For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment on accompanying tear-off pad.
2. If there are at least 4 ✓s in the blue highlighted section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.
3. **Consider Major Depressive Disorder**  
—if there are at least 5 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)  
**Consider Other Depressive Disorder**  
—if there are 2 to 4 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician and a definitive diagnosis made on clinical grounds, taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

#### To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1      More than half the days = 2      Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying PHQ-9 Scoring Card to interpret the TOTAL score.
5. Results may be included in patients' files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

### PHQ-9 SCORING CARD FOR SEVERITY DETERMINATION

*for healthcare professional use only*

#### Scoring—add up all checked boxes on PHQ-9

For every ✓: Not at all = 0; Several days = 1;  
More than half the days = 2; Nearly every day = 3

#### Interpretation of Total Score

Total Score	Depression Severity
0-4	None
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

PATIENT IDENTIFICATION (Last, First, Middle Initial):

FMP/SPONSOR SSN:

**DOMESTIC VIOLENCE SCREEN****DOMESTIC VIOLENCE  
RISK LEVEL - QUICK SCREEN**

Date: \_\_\_\_\_

**Patient's Name:** \_\_\_\_\_ **Victim or Alleged Offender** (Circle One)  
**Interviewed:** Victim / Alleged Offender / Other: \_\_\_\_\_

**Instructions:** Check applicable boxes to indicate the presence of the risk factors below. All questions apply to both victim and alleged offender, unless otherwise specified.

Yes / No / Unk / N/A

- |   |                          |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Recent separation/divorce from partner against partner's wishes.     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Perceived infidelity.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Victim has imminent fear of their partner.                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Any threat to kill self or others.*                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. High/intense family conflict.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Harassing or stalking victim.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Escalation in severity, frequency and intensity of abuse by partner. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Strangled or attempted to strangle partner in the past.              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Access to or threatened use of a weapon.                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Destroyed property in any relationship conflict.                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Current injuries to the victim.                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. High levels of anger/hostility.*                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Experiencing moderate to severe anxiety or depression.*             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Abuse of alcohol and/or other substances.*                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**ESTIMATED RISK** (Circle one): LOW / MODERATE / HIGH RISK  
 / UNABLE TO DETERMINE

**This checklist is provided for use as a guide to identify factors which place a victim at "high risk" of abuse and is not inclusive of all risk factors. All intimate partner abuse including cases estimated to be at high risk requires referral to Social Work Service. Consult with Social Work Service for further guidance, if needed.**

**\*Requires referral to Behavioral Health Service and/or Substance Abuse Services, as applicable.**  
**MEDCOM FAP Update: 28 Jan 09**

PATIENT IDENTIFICATION (Last, First, Middle Initial):

FMP/SPONSOR SSN:

**DRUG ABUSE / DEPENDENCE SCREENER**

Here is a list of drugs:

- Marijuana, hashish, pot, grass
- Amphetamines, stimulants, uppers, speed
- Barbiturates, sedatives, downers, sleeping pills, seconal, quaaludes
- Tranquilizers, Valium, Librium
- Cocaine, coke, crack
- Heroin
- Opiates, codeine, Demerol, morphine, methadone, Darvon, opium
- Psychedelics, LSD, Mescaline, peyote, psilocybin, DMT, PCP

**1. Have you ever used one of these drugs on your own more than 5 times in your life? By "on your own," I mean to get high or without a prescription or more than was prescribed.**

Yes = 1;  No = 0

**2. Did you ever find you needed larger amounts of these drugs to get an effect or that you could no longer get high on the amount you used to use?**

Yes = 1;  No = 0

**3. Did you ever have emotional or psychological problems from using drugs - such as feeling crazy or paranoid or depressed or uninterested in things?**

Yes = 1;  No = 0

**Scoring:** Consider screen positive for lifetime drug abuse/dependence if item 1 = Yes and either item 2 or 3 = Yes

---

REFERENCES

Rost, K., Burnam, A., & Smith, G. R. (1993). Development of screeners for depressive disorders and substance disorder history. Medical Care, 31, 189-200.

Schorling, J. B., & Buchsbaum, D. G. (1997). Screening for alcohol and drug abuse. Medical Clinics of North America, 81, 845-65.

PATIENT IDENTIFICATION (Last, First, Middle Initial):

FMP/SPONSOR SSN:

## MARITAL QUALITY SCREEN

## Quality of Marriage Index (QMI)

Please rate the following statements about your spouse or significant other by circling the appropriate number:

	<u>Strongly Disagree</u>	<u>Somewhat Disagree</u>	<u>Neutral</u>	<u>Somewhat Agree</u>	<u>Strongly Agree</u>
1. We have a good relationship.	1	2	3	4	5
2. My relationship with my partner is very stable.	1	2	3	4	5
3. Our relationship is strong.	1	2	3	4	5
4. My relationship with my partner makes me happy.	1	2	3	4	5
5. I really feel like a part of a team with my partner.	1	2	3	4	5
6. Everything considered, I am happy in my relationship.	1	2	3	4	5

**REFERENCE**

Norton, R. (1983). Measuring marital quality. A critical look at the dependent variable. *Journal of Marriage and the Family*.

**SCORING:** There is no scoring mechanism for this assessment tool.

PATIENT IDENTIFICATION (Last, First, Middle Initial):

FMP/SPONSOR SSN:



## POST TRAUMATIC STRESS

Date: \_\_\_\_\_

### PTSD CheckList (PCL-17)

**Instruction to Patient:** Below is a list of problems and complaints that veterans sometimes have in response to stressful life experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem *in the last month*.

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing <i>memories, thoughts, or images</i> of a stressful experience from the past?					
2.	Repeated, disturbing <i>dreams</i> of a stressful experience from the past?					
3.	Suddenly <i>acting or feeling</i> as if a stressful experience <i>were happening again</i> (as if you were reliving it)?					
4.	Feeling <i>very upset</i> when <i>something reminded</i> you of a stressful experience from the past?					
5.	Having <i>physical reactions</i> (e.g., heart pounding, trouble breathing, or sweating) when <i>something reminded</i> you of a stressful experience from the past?					
6.	Avoid <i>thinking about or talking about</i> a stressful experience from the past or avoid <i>having feelings</i> related to it?					
7.	Avoid <i>activities or situations</i> because <i>they remind</i> you of a stressful experience from the past?					
8.	Trouble <i>remembering important parts</i> of a stressful experience from the past?					
9.	Loss of <i>interest in things that you used to enjoy</i> ?					
10.	Feeling <i>distant or cut off</i> from other people?					
11.	Feeling <i>emotionally numb</i> or being unable to have loving feelings for those close to you?					
12.	Feeling as if your <i>future</i> will somehow be <i>cut short</i> ?					
13.	Trouble <i>falling or staying asleep</i> ?					
14.	Feeling <i>irritable</i> or having <i>angry outbursts</i> ?					
15.	Having <i>difficulty concentrating</i> ?					
16.	Being " <i>super alert</i> " or watchful on guard?					
17.	Feeling <i>jumpy</i> or easily startled?					

PCL for DSM-IV (11/1/94). Weathers, Litz, Huska, & Keane, National Center for PTSD – Behavioral Science Division. Correlates highly with PTSD if at least 1 symptom from q. 1-5; 3 symptoms from q. 6-12; and 2 symptoms from q. 13-17 are endorsed "moderately" or above.

PATIENT IDENTIFICATION (Last, First, Middle Initial):

FMP/SPONSOR SSN:

## PTSD CHECKLIST SCORING

### **PCL: Post-Traumatic Stress Disorder (PTSD) Checklist**

The PCL is a standardized self-report rating scale for PTSD comprising 17 items that correspond to the key symptoms of PTSD. Two versions of the PCL exist:

- 1) PCL-M is specific to PTSD caused by military experiences
- 2) PCL-C is applied generally to any traumatic event

The PCL can be easily modified to fit specific time frames or events. For example, instead of asking about “the past month,” questions may ask about “the past week” or be modified to focus on events specific to a deployment.

#### ***How is the PCL completed?***

- The PCL is self-administered
- Respondents indicate how much they have been bothered by a symptom over the past month using a 5-point (1–5) scale, circling their responses. Responses range from **1 Not at All** – **5 Extremely**

#### ***How is the PCL Scored?***

- 1) Add up all items for a total severity score
- or*
- 2) Treat response categories **3–5** (*Moderately* or above) as symptomatic and responses **1–2** (below *Moderately*) as non-symptomatic, then use the following DSM criteria for a diagnosis:
    - Symptomatic response to at least 1 “B” item (Questions 1–5),
    - Symptomatic response to at least 3 “C” items (Questions 6–12), and
    - Symptomatic response to at least 2 “D” items (Questions 13–17)

PATIENT IDENTIFICATION (Last, First, Middle Initial):

FMP/SPONSOR SSN:

**SAFETY PLAN for ANGER / AGGRESSION / DOMESTIC VIOLENCE**

Date: \_\_\_\_\_

Patient informed of level of risk and/or potential lethality? No YesPatient informed of safety alternatives available (911, Shelter, etc.)? No YesVictim Advocate/counselor involved? No YesArrangements made for safety of children? No Yes N/AChild Protective Services notified? No Yes N/ACommander notified: No YesProtective measures discussed and in place (i.e., protective orders, no contact order, restricted to barracks, restricted to post, escort assigned, removal of weapons, and removal of children)? No Yes *(If yes, describe measures)*Law enforcement notified? No Yes N/AOffender compliant with Protective Orders? No Yes N/AWeapons Secured? N/A No Yes, Where:Victim referred to additional resources? No Yes, list referrals:

Additional Considerations:

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**SUICIDE PREVENTION PLAN**

I will take the following actions if I am ever suicidal:

1) CALL 911 if I believe that I am in immediate danger of harming myself.

2) CALL FAMILY MEMBER OR FRIENDS:

\_\_\_\_\_ Name and Phone Number

\_\_\_\_\_ Name and Phone Number

\_\_\_\_\_ Name and Phone Number

3) GO TO my local Emergency Room for immediate care needed.

4) CALL MY COUNSELOR:

\_\_\_\_\_ Name and Phone Number

5) CALL 1-800-SUICIDE (24-hour suicide prevention line), if having suicidal thoughts or need to speak with someone to prevent me from harming myself.

6) I will continue talking on the phone with as many people as necessary for as long as necessary until the suicidal thoughts have subsided.

7) Other coping strategies: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

My Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Buddy Support Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PATIENT IDENTIFICATION (Last, First, Middle Initial):

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### 3 Question DVBIC TBI Screening Tool

1. **Did you have any injury(ies) during your deployment from any of the following? (check all that apply):**

- A.  Fragment
- B.  Bullet
- C.  Vehicular (any type of vehicle, including airplane)
- D.  Fall
- E.  Blast (Improvised Explosive Device, RPG, Land mine, Grenade, etc.)
- F.  Other specify: \_\_\_\_\_

2. **Did any injury received while you were deployed result in any of the following? (check all that apply):**

- A.  Being dazed, confused or "seeing stars"
- B.  Not remembering the injury
- C.  Losing consciousness (knocked out) for less than a minute
- D.  Losing consciousness for 1-20 minutes
- E.  Losing consciousness for longer than 20 minutes

**NOTE:** Endorsement of A-E meets criteria for positive TBI Screen

- F.  Having any symptoms of concussion afterward (such as headache, dizziness, irritability, etc.)
- G.  Head Injury

**NOTE:** Confirm F and G through clinical interview

H.  None of the above

3. **Are you currently experiencing any of the following problems that you think might be related to a possible head injury or concussion? (check all that apply):**

- |  |  |
|--|--|
| A. <input type="checkbox"/> Headaches        | E. <input type="checkbox"/> Ringing in the ears  |
| B. <input type="checkbox"/> Dizziness        | F. <input type="checkbox"/> Irritability         |
| C. <input type="checkbox"/> Memory problems  | G. <input type="checkbox"/> Sleep problems       |
| D. <input type="checkbox"/> Balance problems | H. <input type="checkbox"/> Other specify: _____ |

Schwab, K. A., Baker, G., Ivins, B., Sluss-Tiller, M., Lux, W., & Warden, D. (2006). The Brief Traumatic Brain Injury Screen (BTBIS): Investigating the validity of a self-report instrument for detecting traumatic brain injury (TBI) in troops returning from deployment in Afghanistan and Iraq. *Neurology*, 66(5)(Supp. 2), A235.

Telephone: 1-800-870-9244      For more information contact:      Web: [www.DVBIC.org](http://www.DVBIC.org)  
Email: [info@DVBIC.org](mailto:info@DVBIC.org)

PATIENT IDENTIFICATION (Last, First, Middle Initial):

FMP/SPONSOR SSN:

**TRAUMATIC BRAIN INJURY (TBI) INSTRUCTIONS**

## 3 Question DVBIC TBI Screening Tool Instruction Sheet

### Purpose and Use of the DVBIC 3 Question TBI Screen

The purpose of this screen is to identify service members who may need further evaluation for mild traumatic brain injury (MTBI).

### Tool Development

The 3 Question DVBIC TBI Screening Tool, also called The Brief Traumatic Brain Injury Screen (BTBIS), was validated in a small, initial study conducted with active duty service members who served in Iraq/Afghanistan between January 2004 and January 2005.

Schwab, K. A., Baker, G., Ivins, B., Sluss-Tiller, M., Lux, W., & Warden, D. (2006). The Brief Traumatic Brain Injury Screen (BTBIS): Investigating the validity of a self-report instrument for detecting traumatic brain injury (TBI) in troops returning from deployment in Afghanistan and Iraq. *Neurology*, 66(5)(Supp. 2), A235.

### Who to Screen

Screen should be used with service members who were injured during combat operations, training missions or other activities.

### Screening Instructions

**Question 1:** A checked [] response to any item A through F verifies injury.

**Question 2:** A checked [] response to A-E meets criteria for a positive (+) screen. Further interview is indicated. A positive response to F or G does not indicate a positive screen, but should be further evaluated in a clinical interview.

**Question 3:** Endorsement of any item A-H verifies current symptoms which may be related to an MTBI if the screening and interview process determines a MTBI occurred.

### Significance of Positive Screen

A service member who endorses an injury [Question 1], as well as an alteration of consciousness [Question 2 A-E], should be further evaluated via clinical interview because he/she is more highly suspect for having sustained an MTBI or concussion. The MTBI screen alone does not provide diagnosis of MTBI. A clinical interview is required.

Telephone: 1-800-870-9244

For more information contact:

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Web: [www.DVBIC.org](http://www.DVBIC.org)

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**To be completed by Patient**

## VICTIM IMPACT STATEMENT

	VICTIM NAME (Last, First):	Example*:	DTA Summary
<b>A C T</b>	<b>DESCRIBE THE INCIDENT and identify the level of force (LOF) used on a scale of 1 to 10 (1=lowest; 10=highest):</b>	Twisted my left arm (LOF: 4) and pushed me into the car (LOF: 8) causing my head to hit the car.	YES / NO FORCE #1:
		(e.g., Yelling, Name Calling, Threatening, Throwing Objects, Pushing, Grabbing, Shaking, Throwing, Scratching, Pinching, Biting, Slapping, Hitting, Stabbing, Kicking, Cutting Off Air Supply, Choking; Applying Force to the Throat, Holding Under Water, Using a Weapon, Sexual Abuse/Assault/Grooming, Stalking, Neglect)	FORCE #2:
<b>I M P A C T</b>	<b>DESCRIBE PHYSICAL INJURIES, duration of injuries, and duration of pain from the injuries:</b>	Red marks which remained on my arm for two days and a bruise to my left arm which lasted a week; the pain lasted at least four hours.	YES / NO
		Red mark and bump on my head which lasted for a week; the pain lasted over four hours	
	If no injuries, do you believe there was <b>potential for injury or harm?</b> Yes or No		YES / NO
	<b>DESCRIBE PSYCHOLOGICAL IMPACT:</b>	I was scared and anxious and could not sleep that night because I was afraid and kept thinking about the incident. I had to go to the doctor because I was depressed and anxious and keep thinking that the incident might happen again. I cannot sleep at night sometimes and am frequently late to work because I cannot get up in the morning. My doctor diagnosed me with Adjustment Disorder and I'm on medication	YES / NO
	<i>Scale: 0=No Fear and 10=Very Fearful. (Circle appropriate number.)</i>		
	<b>DURING THE INCIDENT, what was your LEVEL OF FEAR?</b> 0----1----2----3----4----5----6----7----8----9----10	Level of Fear (During): 8 Fear of harm to self or others	LEVEL OF FEAR:
	<b>48 HOURS after the INCIDENT, what was your LEVEL OF FEAR?</b> 0----1----2----3----4----5----6----7----8----9----10	Level of Fear (48 hours after): 6 (e.g., Persistent recollections of the incident, avoidance of cues or the abuser, hyper-arousal, anxiety, anger, exaggerated startle response, etc.)	LEVEL OF FEAR:
	<b>DESCRIBE PHYSICAL COMPLAINTS (somatic) due to the incident:</b>	My stomach has been hurting and I have a lot of back pain now; I have been having headaches  (Stress-related physical ailments, i.e., aches and pains, migraines, stomach problems, etc.)	YES / NO
	<b>DESCRIBE IMPACT OF ACT/INCIDENT(S) on your lifestyle (social - family/friends, employment, education, community activities, etc.).</b>	Yes, I am afraid to ask for money and to use the car. I feel afraid to tell my family what is going on because my spouse will get angry; therefore, I have isolated myself from my friends and family. I lost my job because my spouse kept calling or interfering with my work.	YES / NO
	<b><i>Child Incidents Only:</i> Has the act/incident(s) or failure to act interfered with child's physical or mental health, development, socialization, education/school, ability to relate to others, etc.?</b>	Yes, my child had multiple medical appointments due to his injury and was failing school due to the emotional stress caused by the abuser.	YES / NO
		*Applies to either male or female victim.	

**FAP VICTIM IMPACT STATEMENT INSTRUCTIONS:**

Victim completes the left side of the form, the Assigned Worker completes the right side. The right side of the form has to do with the Decision Tree response. A "yes" response means that the Act or Impact met criteria for the act or impact. A "no" response means that the Act or Impact did not meet criteria for act or impact.

<b>PATIENT IDENTIFICATION</b> (Last, First, Middle Initial):	<b>FMP/SPONSOR SSN:</b>
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