Behavioral Health Assessment

Name: ______________________________ DOB: __________Age:__________
Address: ____________________________ Today's Date: __________________
____
SS#________________________________ Education: ____________________

Reason for Referral? ☐Stimulator Implant ☐ Intrathecal Pump ☐Spinal Surgery
☐ Depression/mood concerns ☐ Pain Management ☐other_______________________

Referring physician: ___________________________

History of Pain

____
____
____
____
Was pain caused by injury? If so, when and how were you injured? _______________________
____
____

Medical Treatment for Pain

Surgery related to pain? _______ When & what type? __________________________________
Outcome? ____
____
Steroid injections _____; Trigger point injections_____; Physical therapy_____;
Chiropractor_____; Acupuncture_____; Massage therapy_____; Water therapy_____;
Nerve Blocks_____; Radio frequency_____; Medications _____; TENS unit ______;
Other procedures? ____
____
Current pain medications: ____
Outcome: ____
Level of relief: poor (0%) ____ fair ____ moderate ____ good ____ very good (100%) ______

Other Medical Problems

High blood pressure ____ High Cholesterol______ Diabetes ______ Heart problems _____
Migraine headaches_____ CRPS/RSD_____ Fibromyalgia _____ Arthritis ______
Other problems ____
____
Other injuries, surgeries, accidents: ____
____
____
____
Other treating physicians/medications: ____
____
Have you ever had a head injury or concussion? _______ Details - ________________________
____

Pain Location/Intensity

Where is most of your pain localized? Lower back ___ upper back/neck ___ mid-back ____
right leg ___ left leg ___ right foot ___ both legs and feet ___ left arm ___ right arm ___
right shoulder ___ left shoulder ___ head ___ tailbone ___ headaches ____
Other:____
On a scale of 0 to 10, (0 being no pain, 10 being the worst pain imaginable) what level is your pain: Most of the time? ____ On a good day? ____ On the worst day? _____ Today? _____
The pain is most intense – When you get up in the morning? ____ As the day progresses? _____
Afternoon/Evening? _____ No change during the day? _____ Other? ______________________

Factors Influencing Pain

What *aggravates* your pain? movement ____ activity ____ standing _____ sitting _____
walking ____ lying down ____ weather changes ____ stress ____ conflict _____
Other____
What *alleviates* your pain? inactivity ____ resting ____ lying down ____ walking ____
massage ____ medication ____ stretching ____ exercise ____ relaxation ____ sleeping _____
changing posture/position ____ ice ____ heat ____ other________________________________

Level of Activity

Currently employed? _________ **OR** When were you last employed? ______________________
Daily activity? ____
Are you awake most of the day? _________ Time spent in bed during the day? ______________
Do you do household chores? ____
cook meals ___ dishwashing ____ laundry ____ fold clothes ____ yard work ____ dust _____
vacuum ____ dust ____ sweep ____ repairs ____ care for children ______
Other: ____
Current level of functioning as compared to before injury/onset of pain?
60%___ 50%___ 40%___ 30%___ 20%___ 10%___ 5%___
How do you spend most of your time? ____
TV ___ Reading ___ Playing games/puzzles ____ Computer ____ School ____
Volunteer ___ Hobbies ____ Distractions ____ Other ___________________________________

Sleep Patterns: Limited sleep (3/4 hrs) ______ Normal sleep ______
Excessive sleep _____ Sleep during the day _______
No sleep ______ Interrupted sleep _______
Use of sleep meds. ____
Comments: ____
How does sleep deprivation affect you? ____
____

Personal and Social History

With whom are you living? ________________ How long have you been married? __________
Do you have children? _______ How many? __________ Contact with the children?_________
Any other info. on family life? ____
____

Birthplace: _______________________ Where have you lived most of your life? _____________
____

Family of origin - How many **total children** in your family growing up? ______________
Where did you fit in the birth order? #______ How was family life? ________________________
Abuse or trauma? ____
____

Education and Work History

How far did you go in formal school? ____________ City/State? __________________________
How did you do in school? ____

College Experience? ____
Vocational Training? ____

What kind of work have you done? ____
____
How long have you been out of work? ____
Have you been able to return to work? ____
Work/Career concerns? ____

Psychological Functioning

How are you doing emotionally? ____
Depression______; Anxiety or stress______; Panic Attacks ______; Excessive anger________
Current symptoms?

___loss of sleep
___excessive sleep
___insomnia
___loss of appetite
___excessive appetite
___crying episodes
___social withdrawal/wanting to be alone
___loss of energy/motivation to do things
___loss of interest in enjoyable activities
___mood swings/rapid mood changes
___agitation/restlessness
___negative/pessimistic thoughts
___sense of worthlessness
___sense of hopelessness
___low self-esteem/self-confidence
___irritability/getting upset with people easily
___loss of enjoyment in life (anhedonia)
___fatigue/always tired
___loss of sexual interest/desire (decreased libido)
___concentration problems
___forgetfulness/memory problems
___manic behavior
___sad feelings
___excessive feelings of guilt
___weight loss/gain ______________
___indecisiveness/unable to make decisions
___inability/difficulty in thinking clearly
___thoughts of dying
___other mood problems____
___thoughts of suicide; if so, how frequently____
___passive death wishes; if so, how frequently____
___any suicide attempts in your lifetime? ______ If so, how many? _______________________
What did you do? ____
What happened? ____
___hospitalized ___ER visit ___stomach pumped ___charcoal ___sutures
How recently was the last suicide attempt? ____________ Details___________________________
Any serious consideration of suicide at this time? ____

*Anxiety/panic attacks? __________How often? _____________________________________

Symptoms of panic attacks:

___racing heart ___sweating ___trembling/shaking
___shortness of breath ___sense of choking ___fear of dying
___sense of terror ___chest pain/discomfort ___agitation
___nausea ___dizziness/lightheadedness ___chills
___fear of losing control ___hot flashes ___avoid people

Other symptoms____

How do you manage these episodes/attacks? ____

____

Diagnosis

What mental health diagnosis have you had? ____

____

Treatment

Have you ever seen a Psychiatrist? ____

Details - ____

Medications taken in the **past** for depression/anxiety___________________________________

Current medications for emotional difficulties ____________________________________

Are the medications helping? _____________ Are medications needed? _________________

Have you ever been hospitalized for emotional issues? ________________________________

Where? ____When? _______________________

For how long? ____________________Outcome______________________________________

Follow-up treatment? ____

Have you ever seen a therapist/counselor/psychologist? ________________________________

For how long? __________ Are you seeing anyone now? _______ Who? ________________

Psychosocial Stressors

What contributes to your depression and stress? ______________________________________

___chronic/constant pain ___physical restrictions ___slow/no medical progress
___change in the quality of life ___inactivity ___loss of health
___loss of employment ___loss of independence ___loss of career
___financial problems ___being unproductive ___dependence on others
___hassles with insurance co. ___denial of treatment ___employer termination
___no income ___denial of Social Security ___bankruptcy
___dependence on spouse ___uncertainty about future ___changes in the family
___limited mobility ___inability to drive ___restricted social life
___disappointment with surgical outcome ___dependence on medication for relief
___marital problems ___changes in parenting ___disabling condition
___social isolation ___people's reactions to pain ___loss of friends/support
___trauma of injury ___changes in intimacy ___death of a loved one
___unable to play with kids ___change of roles in family

Others____

Psychological Pain Management Strategies

Have you used relaxation techniques? ______________________ Biofeedback Therapy_______
Clinical Hypnosis ______ Pain Management Psychotherapy ______ Pain Groups___________
Yoga _____ Other ____
Were these strategies helpful? ____

Addiction/Dependence Issues

Current use of tobacco products? ________ How many, how often? _______________________
For how long? _______ History of use? ____

Current use of alcohol? ____
Any history of abuse of alcohol? ________ Have you ever been an alcoholic? _______________
Treatment______________ Outcome ____

Current use of street drugs? _________ Which drugs? __________________________________
How much, how often? ____
Treatment ___________________ Outcome ____

History of overuse or abuse of (pain) medications? ____________________________________
Details ____

Ever been arrested? __________ For what? ____
Details ____
Current status ____

Any current involvement in lawsuit/legal dispute? _____________________________________

OFFICE USE ONLY

CPT: ____90791 ______96101

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***REVISED 10/01/2015*