SAMPLE
CTOD MENTAL HEALTH INTAKE & EVALUTION FORM

Patient Name: Click here to enter text.

CTOD Subscription Plan: (create a drop down) UM1, UMP, UUM, CTM, FTC

Medical Record #: Click here to enter text.

Date of Birth: select month select day select year

Current Age: Click here to enter text.

Primary Language: Click here to enter text.

Date Service Provided: Click here to enter a date.

Primary Care Provider: Click here to enter text.

Faith Journey: Open Ended Long Paragraph

Reason for Referral: Open Ended Long Paragraph

Service(s) Provided: Short Open Ended

Evaluation Procedures:

☐Interview with select an option
☐Review of records
☐Psychological testing: select an option
Click here to enter text.

Background Information

Medical History:

☐see medical chart for details	☐diabetes	☐per patient history is significant for chronic pain
☐addiction	☐sleep disorder	☐nutrition/obesity/eating disorder
☐cardiac illness	☐fertility issues	☐other
☐hypertension		

Additional Comments:

Current Medications per patient: Click here to enter text.

Current Functioning

Orientation: select an option

Appearance/Personal Hygiene: select an option

Eye Contact: select an option

Psychosis: select an option

Hallucinations: ☐None ☐Auditory ☐visual ☐olfactory ☐gustatory
Delusions: ☐Bizarre ☐Grandiose ☐Jealousy ☐Nihilistic ☐Persecutory ☐Reference ☐Somatic

Homicidal Ideation/Intentions: select an option
☐**Duty to Protect process completed**

Insight: select an option

Intelligence: select an option

Memory/Cognition: select an option

Mood/Affect:

☐Angry	☐Expressing Guilt	☐Suspicious
☐Anxious	☐Hopeful	☐Tearful
☐Appropriate	☐Being Irritable	☐Having Trouble Concentrating
☐Bright	☐Labile	☐Withdrawn
☐Distressed	☐Expressing Loss of Pleasure	☐Expressing Worthlessness
☐Fatigued	☐Being Sad	☐Expressing Worry
☐Flat		☐Difficult or Unable to Assess

Suicidal Ideation/Intentions: select an option
Frequency of occurrence: Click here to enter text.
How long does it last: Click here to enter text.
Intensity of suicidal thoughts: Click here to enter text.
Reasons individual would rather die than live: Click here to enter text.
Detailed Plan: select an option
Plan location: Click here to enter text.
How lethal is the method: Click here to enter text.
Access to lethal methods: Click here to enter text.
If firearms, are they being removed from patient access: select an option
Steps taken to enact plan: select an option
Rehearsal behaviors: Click here to enter text.
Obtained access: Click here to enter text.
Details: Click here to enter text.

Thought Process:

☐Blocking	☐Evasive	☐Neologisms
☐Circumstantial	☐Flight of ideas	☐Perseveration
☐Clang Associations	☐Incoherent, Logical	☐Rational
☐Coherent	☐Loose Associations	☐Tangential
☐Egocentric	☐Magical thinking	☐Word Salad

Test Results and Interpretation:
(add as needed)

Problem List:

☐No HTN	☐learning/cognitive impairment	☐Prior TIA / stroke	☐Cognitive impairment
☐DM	☐compliance difficulties	☐Coronary heart disease	☐Seizure disorder
☐Lipids	☐Hypertension	☐Smoking history	☐Compliance issues
☐heart disease	☐Diabetes mellitus	☐Obesity	☐Mood disorder
☐smoking	☐Hyperlipidemia	☐Sedentary lifestyle	☐Personality disorder
☐mental illness			☐Thought disorder

Additional Comments:

Diagnosis: select an option select an option

select an option select an option

select an option select an option

select an option select an option

select an option select an option

select an option select an option

Treatment Plan/Recommendations:

Type you name here as a signature
Insert Clinician's Name Here

Click here to enter a date.
Date