Life Management Center
Of Northwest Florida Inc.

Interactive Core Assessment
Adult Version
Ages 18 years & older

Client Name: _____ **Today's Date:** _____ **Case#:** _____

Date of Birth: _____ **Social Security #:** _____ **Gender:** _____ **Race:** _____

Mailing Address: _____ **Phone Number:** _____

After you complete this information, you will be visiting with your service coordinator to talk about how best we can help you. If you need any help in completing this form, ask your service coordinator or someone at the front desk.

Why are you seeking services from Life Management Center at this particular point in time? _____

_____

What is your goal? _____

_____

PRESENTING PROBLEM

Please check any problem(s) you are having:

☐ depression	☐ violence	☐ anger	☐ social problems
☐ sleep problems	☐ domestic violence	☐ anxiety	☐ family problems
☐ tired/fatigue	☐ hearing/seeing things	☐ grief/loss	☐ marital/ divorce
☐ appetite/weight loss or gain	☐ physical pain	☐ sexual problems	☐ legal problems
☐ poor concentration	☐ repetitive thoughts	☐ gambling	☐ DUIs
☐ suicidal thoughts	☐ unemployment	☐ homelessness	☐ alcohol/drugs
☐ other (explain)			

Were you referred by someone to come to Life Management Center? ☐ No ☐ Yes, If yes, please identify:_____

☐ Another agency _____ **☐ Friend ☐ Teacher ☐ Pastor ☐ Emergency Services referral ☐ Other:** _____

PROBLEM HISTORY

Have you ever received counseling or behavioral health services in the past? ☐ Yes ☐ No
If yes, please list the following:

Provider	Reason	Dates	How Effective do you think it was?		
			Poor	Fair	Good
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

Have you experienced highly stressful events such as:

☐ Neglect	☐ Physical abuse	☐ Sexual abuse	☐ Loss of a loved One
☐ Other kind of loss? If so, explain			
☐ Witness to a highly disturbing situation? If so, explain			

FAMILY BACKGROUND

Marital Status: ☐ Single ☐ Never Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Married How many times? _____

Do you have children? ☐ Yes ☐ No, If yes, ages: _____

Please check any of the problems that you remember when you were growing up:

☐ Fighting between children	☐ Divorcing/Separating parents	☐ Religious differences
☐ Arguing between parents	☐ Violence between parents	☐ Parents emotional problems
☐ Parents disagreeing about kids	☐ Sexual/Physical abuse	☐ Expressing feelings
☐ Alcohol, drug misuse	☐ Emotional abuse	☐ Employment/Unemployment
☐ Financial problems	☐ Homelessness	☐ Sibling's emotional problems
☐ Mental Illness:	☐ Other, Explain:	

MEDICAL HISTORY

Who is your physician? _____ Date of last physical exam? _____

List any known current (or significant past) medical conditions:

_____

Have you ever been hospitalized? ☐ Yes ☐ No Have you ever had major surgery? ☐ Yes ☐ No

Please list any prescribed medications you currently take:

Medication Name	Dosage	Frequency	Prescribing Physician	Effectiveness		
				Poor	Fair	Good
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

Please list any over-the-counter medicine, vitamins or herbal remedies you currently take:

Name	Dosage	Frequency	Effectiveness		
			Poor	Fair	Good
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

Are you allergic to any medications? ☐ Yes ☐ No If so, what are they? _____

Any other allergies? _____

LEGAL INFORMATION

Any current legal problems? ☐ **Yes** ☐ **No** **Any past legal problems?** ☐ **Yes** ☐ **No**

If yes, please explain _____

EDUCATIONAL/VOCATIONAL INFORMATION

Highest level of education completed: _____ **Grades:** ☐ **above average** ☐ **average** ☐ **below average**

Have you been diagnosed with a learning problem? ☐ **Yes** ☐ **No**

Military Service: ☐ **Yes** ☐ **No** **If yes: Highest rank:** _____ **Branch of service:** _____

Dates of service: From: _____ **To:** _____ **Discharge status:** _____

Work History

What is your current job? _____

What other jobs have you held? _____

SUBSTANCE USE

The following information is important because alcohol and other substances can affect your mental health and influence decisions about types of medications and other treatments. Please be honest; this information is confidential.
Please check the boxes that best describe your alcohol use. **(Standard drink is: one beer, one glass of wine, one "shot" of liquor)**

Please answer the following:	***For Office Use***
1. How often do you have a drink containing alcohol?	
☐ **Never**	***(0)***
☐ **Once a month or less**	***(1)***
☐ **2-4 times a month**	***(2)***
☐ **2-3 times a week**	***(3)***
☐ **4 or more times a week**	***(4)***
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	
☐ **1 or 2**	***(0)***
☐ **3 or 4**	***(1)***
☐ **5 or 6**	***(2)***
☐ **7 to 9**	***(3)***
☐ **10 or more**	***(4)***
3. How often do you have five or more drinks on one occasion?	
☐ **Never**	***(0)***
☐ **Less than Monthly**	***(1)***
☐ **Monthly**	***(2)***
☐ **Weekly**	***(3)***
☐ **Daily or Almost Daily**	***(4)***
(For Office Use Only) ***AUDIT-C Score:***	

4. Have you had <u>problems</u> in the <u>past</u> resulting from your alcohol use? ☐ **Yes** ☐ **No**

If yes, describe: _____

5. Have you received treatment in the past for your alcohol use? □ Yes □ No

If yes, describe: _____

6. Family history of alcohol problems? □ Yes □ No

If "yes," describe: _____

Other Substances:

7. **Please complete the following table if you have used any of these substances:**

Substance	Date of First Use	Date of Last Use	Frequency	Amount
Tobacco				
Marijuana				
Cocaine (powder, crack)				
Hallucinogens (LSD, mushrooms)				
MDMA (ecstasy)				
Sedatives (downers, benzos.) Specify:				
Opiates (heroin, percodan) Specify:				
Stimulants (uppers, speed, meth) Specify:				
Prescriptions/Meds (not prescribed to you) Specify:				
Other				

8. Have you had problems in the past resulting from your drug use? □ Yes □ No

9. Have you received treatment in the past for your drug use? □ Yes □ No

10. Family history of drug problems? □ Yes □ No

OTHER NEEDS

Are you disabled? □ Yes □ No If yes, what is the nature of your disability? _____

Indicate whether you require any of the following equipment or resources to participate in services:

□ Wheelchair □ Equipment to assist hearing □ Signing services □ Materials for visual challenges

□ Interpreter, preferred language: _____

Are there cultural needs or considerations (e.g., ethnicity, language, religion, customs, or beliefs) that are important for us to know about to better enable us to work with you or your family? □ Yes □ No

Are there any other needs (in addition to mental health services) for which you need a referral? □ Yes □ No

If yes, specify: □ Educational □ Medical □ Speech □ Other (Specify): _____

STRENGTHS / ABIILITIES

Please check all that apply:

☐ Good Communication Skills	☐ Good Insight	☐ Readiness for change	☐ Past Treatment Success
☐ Good Health	☐ Family Support	☐ Adequate Finances	☐ Faith
☐ Safe Living Environment	☐ Shared Parenting	☐ Sense of Humor	☐ Leisure Time Opportunities
☐ Educational Achievement	☐ Friendships	☐ Harmonious Relationships	☐ Law Abiding
☐ Shared Family Beliefs	☐ Safe Neighborhood	☐ Cultural Heritage	☐ Good Support System
☐ Stable Employment	☐ Stable Housing	☐ Adequate Transportation	☐ Adequate Health Care
☐ Extended Family Support	☐ Stable Income	☐ Little Debt	
Other:			

RESOURCES

☐ Child Support	☐ SSI	☐ Medicaid	☐ Subsidized Housing
☐ Food Stamps	☐ TANF	☐ WIC	☐ SSA
☐ Other:			

ADVANCE DIRECTIVES (information regarding mental health advance directives is available upon request)

Have you ever prepared an Advance Directive for medical or mental health treatment? ☐ Yes ☐ No
If yes, check as applicable: ☐ Living Will ☐ Advance Directive for Medical Care ☐ Mental Health Advance Directive

If yes, who is your substitute decision-maker?

Name	Age	Address	Phone	Relationship

The above information is complete and accurate to the best of my knowledge.

_____ _____

Signature of client ***Date***