

## Intake Forms: NICOE Intrepid Spirit One

Name: [Click here to enter text.](#) DOB: [Click here to enter text.](#) Last four of SSN: [Click here to enter text.](#)

Do you have any of the following?:

Special Duty Clearances:  PRP or PSP  Secret/Top Secret Clearance  Regular Weapons Duties  
 FLY  Other Special Clearance: \_\_\_\_\_

Are you enrolled at a Warrior Transition Unit/Battalion? Yes  No

If yes, who is your WTU/WTB Case Manager? \_\_\_\_\_

If not WTU/WTB, your Unit: \_\_\_\_\_

Do you have an Advance Directive? *Check all that apply:*  Medical  Behavioral Health  None

If yes: where is a copy and who has access to it? [Click here to enter text.](#)

*Please note, it is recommended that a copy of this form be scanned into your military health record. You can bring a copy of this form to PAD and they will scan the form.*

If no: would you like information on how to obtain an advance directive? *Check all that apply:*

Yes, for Mental Health  Yes, for medical  Not interested

### **Deployment (please skip if you are a dependent):**

Are the issues which brought you to the TBI Clinic related to deployment experiences?  Yes  No

Are you currently scheduled for Deployment?  Yes, in 0-2 months  Yes, in 2-6 months  Maybe  No

Are you currently 'in the window' or vulnerable to receive a deployment tasking?

Yes, in 0-2 months  Yes, in 2-6 months  Yes, in 6+ months  At any time  Maybe  No

Primary Care Manager (PCM): [Click here to enter text.](#)

### **Stressors:**

What are the top three stresses or problems in your life?

1. [Click here to enter text.](#) 2. [Click here to enter text.](#)

3. [Click here to enter text.](#)

### **Problems and Symptoms**

**Pain:** Do you currently have pain problems (physical pain):  Yes  No.

If yes, is your pain...  All headaches  Mostly headaches  50/50  Mostly other pain  All other pain

If not all headaches, where is your pain? [Click here to enter text.](#)

How often do you have pain problems? Daily 3-5 times weekly 1-3 times weekly 1-3 times monthly

Describe the type of pain: Sharp Dull/Achy Throbbing Sore Only when move Other

Who is treating your pain problem? PCM Pain Clinic Internal Med Flight Doc No One

Do you have regular nightmares or bad dreams which really bother you or interfere with sleep: Yes No.

If yes, how often per month? Once 2-3 times 4-6 times Half the nights Most nights

### **Energy:**

Do you currently have regular energy problems (can't get going, too tired, fatigued): Yes No.

If yes:

What part of the day? Mostly in AM Off and On Mostly Afternoon Mostly evening

Is it mostly sleepiness or mostly low physical energy? Mostly sleepiness Mixed Mostly low energy

Are you able to do necessary tasks? Mostly yes 50/50 Mostly no It's so bad I can't do what need to

### **Concentration Problems:**

Do you have regular concentration problems: Yes No.

If yes, how often? Daily Most of the time Half the time Several times a week

How long ago did your concentration problems start? Weeks Few months Several months Years ago

Are your concentration problems: Staying the same Getting worse over time Better over time

How distractible are you? Same as always Somewhat worse Much worse Horrible

For what activities is your concentration the best? [Click here to enter text.](#)

For what activities is your concentration the worst? [Click here to enter text.](#)

### **Memory Problems:**

Do you have regular memory problems? Yes No.

If yes, how often? Daily Most of the time Half the time Several times a week

How long ago did your memory problems start? Weeks Few months Several months Years ago

Are your memory problems: Staying the same Getting worse over time Better over time

For what activities is your memory the best? [Click here to enter text.](#)

For what activities is your memory the worst? [Click here to enter text.](#)

### **Visual Problems:**

Do you have regular visual problems (aside from prescription glasses)? Yes No.

If yes, what type of visual problems? [Click here to enter text.](#)

Do you have double vision? Yes No.

Do you have blurry vision? Yes No.

Do you have difficulties reading or other near work activities?  Yes  No.

Do you currently wear glasses or contact lenses?  Yes  No.

Have you ever been diagnosed with a “Lazy eye”?  Yes  No.

Do you have any history of eye disease or trauma to the eye?  Yes  No.

If yes, explain: [Click here to enter text.](#)

### **Balance, Dizziness or Fainting Problems:**

Do you have regular balance issues, dizziness or fainting?  Yes  No.

If yes, what type of problems? [Click here to enter text.](#)

### **Mood Problems:**

Do you have regular mood problems?  Yes  No.

If yes, mark all which are regular problem for you.

Calm  Down  Sad  Depressed  Anxious  Worried  Angry  Frustrated

Hopeless  Lonely  Helpless  Guilty  Too Variable  Too Intense

Too Little Emotion  Don't Care  Grief or Loss  Other: [Click here to enter text.](#)

Which 1-2 feelings do you have most often? [Click here to enter text.](#)

Your mood problems began, how long ago?  Days  Weeks  Few months  Several months  Years

Are you currently or recently seeing a mental health provider?  Yes  No.

If yes, please list name(s) and where: [Click here to enter text.](#)

### **Nutrition & Medications**

Do you have **Nutrition** related concerns, special diet, weight problem, eating problems)?  Yes  No.

Do you have any physical limitations/barriers/handicaps?  Yes  No.

If yes, please briefly explain: [Click here to enter text.](#)

Do you have any communication barriers?  Yes  No.

If yes, please briefly explain: [Click here to enter text.](#)

**Medications:** Please list any **over-the-counter medications, supplements** or **herbals** you are currently taking:

[Click here to enter text.](#)

### **Social Life and History**

Birth/Delivery: Were there serious problems during your birth/delivery?  Yes  No  Don't know

Did you walk, talk and learn toileting at the same time as others?  Yes  No  Don't know

Childhood/Teen Years:

I was raised mostly in:  Inner City  Large City  Small City  Small Town  Rural/Farming Area  Other

Mostly my family had:  1 or  2 wage earners and  he  she  they usually worked as: [Click here to enter text.](#)

The highest level of education for the wage earner(s) in my family was:

GED  High School  Some College  College Grad

Lack of money was a stressor in my family:  Rarely  Occasionally  50 / 50  Frequently  Usually

Overall, my childhood was (*happy, chaotic, normal, troubled, abusive, neglected, etc*): [Click here to enter text.](#)

**Assessment of Life Priorities and Values**

Overall, are you satisfied with your quality of life:

Very Unsatisfied  Unsatisfied  50 / 50  Satisfied  Very Satisfied

What do you do when you want to relax? [Click here to enter text.](#)

What are your personal interests / hobbies / talents? [Click here to enter text.](#)

Recently, do you do the above activities:  Usual frequency  Less than usual  More than usual

Recently, do you enjoy the above activities:  As Usual  Less than usual  More than usual

**Spirituality:**

Are you satisfied with your current spirituality practice?

Very Unsatisfied  Unsatisfied  50 / 50  Satisfied  Very Satisfied

How important is the spiritual side of your life at this time?

Very  Somewhat  In the middle  Little  Not important

What is your religious preference? (*Answering is Optional*) [Click here to enter text.](#)

Any specific spiritual beliefs & values you want your provider to know? [Click here to enter text.](#)

Any spiritual difficulties or worries?  None or please list: [Click here to enter text.](#)

How often do you attend church or other religious or spiritual meetings?

More than once a week  Once a week  A few times a week  A few times a year  Once a year or less  Never

How often do you spend time in private religious or spiritual activities such as prayer, meditation, or the study of religious texts?  More than once a day  Daily  Two or more times a week  Once a week  A few times a month

Rarely or Never

**In my life, I experience the presence of the Divine (e.g. God).**

Definitely true  Tends to be true  Unsure  Tends NOT to be true  Definitely NOT true

**My religious beliefs are what really lie behind my whole approach to life.**  Definitely true  Tends to be true

Unsure  Tends NOT to be true  Definitely NOT true

**I try hard to carry religion over into all other dealings in life.**  Definitely true  Tends to be true  Unsure  Tends NOT to be true  Definitely NOT true

**I don't know who I am, where I came from, or where I'm going.**  Strongly Agree  Moderately agree  Agree

Disagree  Moderately disagree  Strongly disagree

**I feel that life is a positive experience.**  Strongly Agree  Moderately agree  Agree  Disagree  Moderately disagree  Strongly disagree

**I feel unsettled about my future.**  Strongly Agree  Moderately agree  Agree  Disagree  Moderately disagree  Strongly disagree

**I feel very fulfilled and satisfied with life.**  Strongly Agree  Moderately agree  Agree  Disagree  Moderately disagree  Strongly disagree

**I feel a sense of well-being about the direction my life is headed in.**  Strongly Agree  Moderately agree  Agree  Disagree  Moderately disagree  Strongly disagree

**I don't enjoy much about life.**  Strongly Agree  Moderately agree  Agree  Disagree  Moderately disagree  Strongly disagree

**I feel good about my future.**  Strongly Agree  Moderately agree  Agree  Disagree  Moderately disagree  Strongly disagree

**I feel that life is full of conflict and unhappiness.**  Strongly Agree  Moderately agree  Agree  Disagree  Moderately disagree  Strongly disagree

**Life doesn't have much meaning.**  Strongly Agree  Moderately agree  Agree  Disagree  Moderately disagree  Strongly disagree

**I believe there is some real purpose for my life.**  Strongly Agree  Moderately agree  Agree  Disagree  Moderately disagree  Strongly disagree

**I have wondered whether God has abandoned me.**  Not at all  Occasionally  Frequently  A great deal

**I have felt punished by God for my lack of devotion.**  Not at all  Occasionally  Frequently  A great deal

**I have wondered what I did for God to punish me.**  Not at all  Occasionally  Frequently  A great deal

**I have questioned God's love for me.**  Not at all  Occasionally  Frequently  A great deal

**I have wondered if my church has abandoned me.**  Not at all  Occasionally  Frequently  A great deal

**I have decided the Devil is responsible for bad things that happen to me.**  Not at all  Occasionally  Frequently

A great deal

**I have questioned the power of God.**  Not at all  Occasionally  Frequently  A great deal

**If I get sick, it is my own behavior that determines how soon I get well again.**  Strongly Agree  Moderately agree  
 Agree  Disagree  Moderately disagree  Strongly disagree

**I am in control of my health.**  Strongly Agree  Moderately agree  Agree  Disagree  Moderately disagree  
 Strongly disagree

**When I get sick, I am to blame.**  Strongly Agree  Moderately agree  Agree  Disagree  Moderately disagree  
 Strongly disagree

**The main thing that affects my health is what I myself do.**  Strongly Agree  Moderately agree  Agree  Disagree  
 Moderately disagree  Strongly disagree

**If I take care of myself, I can avoid illness.**  Strongly Agree  Moderately agree  Agree  Disagree  Moderately  
disagree  Strongly disagree

**If I take the right actions, I can stay healthy.**  Strongly Agree  Moderately agree  Agree  Disagree   
Moderately disagree  Strongly disagree

### **Education History:**

Degrees Completed: [Click here to enter text.](#)

Were you held back or did you fail any grades?  Yes  No.

Did you have any Special Educational services/classes?  Yes  No.

Were you considered Learning Disabled or Special Needs?  Yes  No.

Were you treated or evaluated for ADD or ADHD?  Yes  No.

Were you suspended in school for behavior problems?  Yes  No.

Did you get into trouble for physical fights at school?  Yes  No.

During High School, your usual grades were?  As  Bs  Cs  Ds  Fails.

Is English your primary language?  Yes  No.

**If no**, would you feel more comfortable using an interpreter?  Yes  No.

Are you currently enrolled in college classes?  Yes  No.

If yes, what classes? [Click here to enter text.](#)

### **Legal History:**

Have you had serious legal problems?  Yes  No. If yes, is this recent?  Yes  No.

If yes:  Charged  Under investigation  Pending court action  Was victim  Other: [Click here to enter text.](#)

Do you currently have (or recently had) serious military discipline action against you?  Yes  No.

If yes:  UCMJ violation  Written Reprimand  Formal counselings  Other: [Click here to enter text.](#)

### **Other Job History:**

How many full-time jobs have you held (aside from military)?

None  1-2  3-4  5-6  7+ How many jobs been fired from? [Click here to enter text.](#)

What kind of work did you do? [Click here to enter text.](#)

### **Habits:**

1. How often do you exercise most weeks?  Zero  1-2 times  3-4 times  4-5 times  Almost Daily

Preferred Exercise: [Click here to enter text.](#)

2. Do you have other potentially harmful or negative habits you want to change?  Yes  No.

Briefly describe: [Click here to enter text.](#) or  I prefer to discuss in private.

**Goals for Treatment at TBI Clinic:**

What are your goals for treatment or what things would you like to change / be different about yourself?

1. Click here to enter text.
2. Click here to enter text.
3. Click here to enter text.

**Long Term Goals:**

What are your goals for the next 3-5 years?

1. Click here to enter text.
2. Click here to enter text.
3. Click here to enter text.

**Strengths:**

Please list the good things in your life or what you see as your strengths: Click here to enter text.

**Any Other Information:**

Please list any other information you think might help your provider understand your concerns or situation.

Click here to enter text.

Please read the following statements. To the right of each you will find seven numbers, ranging from "1" (Strongly Disagree) on the left to "7" (Strongly Agree) on the right. Circle the number which best indicates your feelings about that statement. Please indicate your experience on average over the past MONTH.

	Strongly Disagree			Strongly Agree			
1. When I make plans, I follow through with them.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
2. I usually manage one way or another.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
3. I am able to depend on myself more than anyone else.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
4. Keeping interested in things is important to me.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
5. I can be on my own if I have to.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
6. I feel proud that I have accomplished things in life.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
7. I usually take things in stride.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
8. I am friends with myself.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
9. I feel that I can handle many things at a time.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
10. I am determined.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
11. I seldom wonder what the point of it all is.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
12. I take things one day at a time.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
13. I can get through difficult times because I've experienced difficulty before.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
14. I have self-discipline.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
15. I keep interested in things.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
16. I can usually find something to laugh about.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
17. My belief in myself gets me through hard times.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
18. In an emergency, I'm someone people can generally rely on.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
19. I can usually look at a situation in a number of ways.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
20. Sometimes I make myself do things whether I want to or not.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
21. My life has meaning.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
22. I do not dwell on things that I can't do anything about.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
23. When I'm in a difficult situation, I can usually find my way out of it.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
24. I have enough energy to do what I have to do.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
25. It's okay if there are people who don't like me.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
26. I am resilient.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>

**INSTRUCTIONS:**

The questions in this scale ask you about your feelings and thoughts during THE LAST MONTH. In each case, please indicate your response by placing an “X” over the circle representing HOW OFTEN you felt or thought a certain way

1. In the last month, how often have you been upset because of something that happened unexpectedly? Never Almost Never Sometimes Fairly Often Very Often
2. In the last month, how often have you felt that you were unable to control the important things in your life? Never Almost Never Sometimes Fairly Often Very Often
3. In the last month, how often have you felt nervous and “stressed”? Never Almost Never Sometimes Fairly Often Very Often
4. In the last month, how often have you felt confident about your ability to handle your personal problems? Never Almost Never Sometimes Fairly Often Very Often
5. In the last month, how often have you felt that things were going your way? Never Almost Never Sometimes Fairly Often Very Often
6. In the last month, how often have you found that you could not cope with all the things that you had to do? Never Almost Never Sometimes Fairly Often Very Often
7. In the last month, how often have you been able to control irritations in your life? Never Almost Never Sometimes Fairly Often Very Often
8. In the last month, how often have you felt that you were on top of things? Never Almost Never Sometimes Fairly Often Very Often
9. In the last month, how often have you been angered because of things that were outside your control? Never Almost Never Sometimes Fairly Often Very Often
10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them? Never Almost Never Sometimes Fairly Often Very Often

Below is a collection of statements about your everyday experience.

Using the 1-6 scale below, please indicate how frequently or infrequently you currently have each experience. Please answer to what *really reflects* your experience rather than what you think your experience should be. Please treat each item separately from every other item.

**1 – Almost Always**

**2- Very Frequently**

**3- Somewhat Frequently**

**4- Somewhat Infrequently**

**5- Very Infrequently**

**6-Almost Never**

I could be experiencing some emotion and not be conscious of it until sometime later.

1 2 3 4 5 6

I break or spill things because of carelessness, not paying attention, or thinking of something else.

1 2 3 4 5 6

I find it difficult to stay focused on what's happening in the present.

1 2 3 4 5 6

I tend to walk quickly to get where I'm going without paying attention to what I experience along the way.

1 2 3 4 5 6

I tend not to notice feelings of physical tension or discomfort until they really grab my attention.

1 2 3 4 5 6

I forget a person's name almost as soon as I've been told it for the first time.

1 2 3 4 5 6

It seems I am "running on automatic" without much awareness of what I'm doing.

1 2 3 4 5 6

I rush through activities without being really attentive to them.

1 2 3 4 5 6

I get so focused on the goal I want to achieve that I lose touch with what I'm doing right now to get there.

1 2 3 4 5 6

I do jobs or tasks automatically, without being aware of what I'm doing.

1 2 3 4 5 6

I find myself listening to someone with one ear, doing something else at the same time.

1 2 3 4 5 6

I drive placed on "automatic pilot" and then wonder why I went there.

1 2 3 4 5 6

I find myself preoccupied with the future or the past.

1 2 3 4 5 6

I find myself doing things without paying attention.

1 2 3 4 5 6

I snack without being aware that I'm eating.

1 2 3 4 5 6