*Every item must be completed.*

## Date Provider Phone Provider Office Address

|  |
| --- |
| **Client Name D.O.B. SSN** **Consent to treat given by:** ☐ Self ☐ Parent/Guardian ☐ Conservator |
| **Referral** ☐ Self ☐ School ☐ Probation ☐ Court ☐ CPS ☐ APS ☐ Parent/Guardian/Conservator ☐ Access Unit |
| * Other
 |
| **Living Arrangement** ☐ Own House ☐ Bio Family ☐ Foster Family ☐ Group Home ☐ SNF ☐ B&C **Ethnicity Language Preferred for Services** **Emergency Contact Relationship Phone Address**  |

**Presenting Problem** (nature and history)

# Risk Assessment

Current harm to self-risk ☐ N/A ☐ Ideation ☐ Intent ☐ Plan ☐ Means Describe:

History of:

Current harm to others risk ☐ N/A ☐ Ideation ☐ Intent ☐ Plan ☐ Means: Describe:

History of:

Describe: (note if a particular person is at risk)

Assaultive/Combative ☐ No ☐ Yes If yes, describe:

At risk of abuse or victimization ☐ No ☐ Yes Describe:

Have all mandated reporting requirements been met?

* Yes, by this Provider Yes, by :
* No (Explain) Other:

## Client Strengths

Client Name:

|  |
| --- |
| Culture/Diversity: Assess unique aspects of the client, including culture, background, and sexual orientation, that are important for understanding and engaging the client and for care planning. |
| Preferred language for receiving our services: |
| Culture client most identifies with: |
| Problems client has had because his/her cultural background: | * None
 |
| Sexual orientation issues: | * None
 |  |  |
| Support/ involvement of family in client’s life: | ☐ |  |
|  |  |  |
| Desire of client involvement of family or others in treatment: | * Desires
 |

**Psychiatric History** (Medication(s) and dosage (current))

Medication(s) (past):

History of Mental Illness in Family ☐ No ☐ Yes If yes, describe:

Prior Hospitalization(s) ☐ No ☐ Yes If yes, when, where

Prior Outpatient Treatment ☐ No ☐ Yes If yes, when and with whom:

Client Name:

|  |
| --- |
| **Medical History** Health Problems (current) ☐ No ☐ Yes If yes, describe: |
|  |
| Height:  | Weight :  | (Mandatory if client is a MINOR) |
| Sleep Disturbance ☐ No ☐ Yes If yes, describe: |
| Appetite ☐ Too Little ☐ Too Much | Weight gain:  | lbs. | Weight Loss:  | lbs. |
| Disability ☐ Developmental ☐ Physical ☐ Cognitive Describe: |  |  |  |

Allergies ☐ No ☐ Yes Describe:

Adverse response to medications ☐ No ☐ Yes If yes, describe:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Substance Use/ Abuse** |  |  | Amount | Last Use |
| No Use | Frequency |
| Nicotine | ☐ |  |  |
| Caffeine | ☐ |  |  |  |
| Alcohol | ☐ |  |  |
| Marijuana | ☐ |  |  |
| Amphetamines | ☐ |  |  |
| Hallucinogens | ☐ |  |  |
| Cocaine/Crack | ☐ |  |  |
| Heroin | ☐ |  |  |
| Prescription Meds | ☐ |  |  |
| Other: | ☐ |  |  |

|  |
| --- |
| **Mental Status** |
| **Appearance:** | ☐ | Clean | ☐ | Well-groomed | ☐ | Dirty |
|  | ☐ | Disheveled | ☐ | Inappropriate clothing |  |
| **Orientation:** | ☐ | Person | ☐ | Place | ☐ | Time |
|  | ☐ | Situation | ☐ | Disoriented |  |  |
| **Speech:** | ☐ | Organized/Clear | ☐ | Coherent | ☐ | Rapid |
|  | ☐ | Slowed | ☐ | Mumbling |  |  |
| **Thought Process:** | ☐ | Organized | ☐ | Coherent | ☐ | Tangential |
|  | ☐ | Thought Blocking | ☐ | Flight of Ideas |  |  |
|  | ☐ | Poor Concentration | ☐ | Obsessive |  |  |
| **Thought Content:** | ☐ | Normal | ☐ | Delusional | ☐ | Grandiose |
|  | ☐ | Other |  |  |  |  |
| **Perceptual Process:** | ☐ | Normal | ☐ | Auditory hallucinations |  |
|  | ☐ | Visual hallucinations | ☐ | Other |  |  |
| **Insight:** | ☐ | Good | ☐ | Average | ☐ | Poor |
|  | ☐ | None |  |  |  |  |
| **Judgment:** | ☐ | Good | ☐ | Average | ☐ | Poor |
|  | ☐ | None |  |  |  |  |
| **Mood:** | ☐ | Normal | ☐ | Hopeless | ☐ | Irritable |
|  | ☐ | Elevated | ☐ | Labile | ☐ | Depressed |
|  | ☐ | Anxious | ☐ | Sad | ☐ | Manic |
| **Affect:** | ☐ | Appropriate | ☐ | Inappropriate | ☐ | Blunted |
|  | ☐ | Flat | ☐ | Tearful |  |  |
| **Memory:** | ☐ | Intact | ☐ | Immediate Memory Problem |
|  | ☐ | Recent MemoryProblem | ☐ | Remote Memory |  |  |
| **Estimated Intellectual Functioning:** | ☐ | Average | ☐ | Below Average | ☐ | Above Average |
| **Cognitive Deficits:** | ☐ | None | ☐ | Cognitive Deficits Present |
|  | ☐ | Concentration Deficits Present |  |  |

Client Name:

 Impairments requiring Mental Health Treatment:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Dysfunction Rating | ☐ | None | ☐ | Mild | ☐ | Moderate | ☐ | Severe |
| Describe how symptoms impair functioning: |  |  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| **Employment/ Education:** | **Occupation:** |  |
| ☐ | Competitive job market, 35 hours or more per week | ☐ | Rehabilitative work, less than 20 hours per week. | ☐ | Volunteer Work |
| ☐ | Competitive job market, less than 20 hours perweek | ☐ | School, full time |  | ☐ | Retired |
| ☐ | Full-time homemaking responsibility | ☐ | Job training, full time | ☐ | Resident/Inmate |
| ☐ | Rehabilitative work, 35 hours or more per week | ☐ | Part-time school/job training | ☐ | Unknown |
| ☐ | Not in Labor force | ☐ | Highest Grade completed |  |  |

|  |
| --- |
| **Medical Necessity** |
| \* | ☐ | Qualifying mental health diagnosis |
|  | ☐ | Qualifying impairment is an important area of life functioning |
|  | ☐ | Probability of a significant deterioration in an important area of life functioning |
|  | ☐ | (Children only) Probability that child will not progress developmentally as individually appropriate |
|  | ☐ | EPSDT – Qualified |
| \* | ☐ | Planned interventions will address impairment conditions |
| \* | ☐ | Client is reasonably expected to benefit and improve with respect to impairments |
| \* | ☐ | Condition would not be responsive to physical health care-based treatment |
|  |  | \*All asterisked items must be present, plus 1 more and must be supported by documentation in record |

 Other Providers/ Agencies client is involved with:

Signature of Provider Date Printed Name