



Initial Clinical Assessment for Adults

NAME / MRN _____

Billing Information

Program Name: _____ RU: _____ Date: _____

Staff #: _____ Hours: _____ Min(s): _____ Code Activity 331 Assessment 580 Lockout

Is Client Pregnant? Yes No *Travel Time To/From included in above (if applicable) Hrs _____ Mins _____*

Location of Services: (Please check one)

<input type="checkbox"/> 1 Office	<input type="checkbox"/> 5 School	<input type="checkbox"/> 11 Faith-based	<input type="checkbox"/> 15 LicCommCareFac (Adult)	<input type="checkbox"/> 19 Res Tx Ctr (Child)
<input type="checkbox"/> 2 Field	<input type="checkbox"/> 8 Cor Fac	<input type="checkbox"/> 12 Healthcare	<input type="checkbox"/> 16 Mobile Service	<input type="checkbox"/> 20 TeleHealth
<input type="checkbox"/> 3 Phone	<input type="checkbox"/> 9 Inpatient	<input type="checkbox"/> 13 Age-spec Comm Ctr	<input type="checkbox"/> 17 NonTradSvcLoc	<input type="checkbox"/> 21 Unknown
<input type="checkbox"/> 4 Home	<input type="checkbox"/> 10 Homeless/Shelter	<input type="checkbox"/> 14 Client's Job-site	<input type="checkbox"/> 18 Other	

Service Strategies: (Please check up to three, if applicable)

<input type="checkbox"/> 50 Peer/Fam Deliv Svcs	<input type="checkbox"/> 53 Supportive Education	<input type="checkbox"/> 56 Ptnrshp: Soc Svcs	<input type="checkbox"/> 59 Integrated Svcs: MH-Dvlp Disabled
<input type="checkbox"/> 51 Psych Education	<input type="checkbox"/> 54 Ptnrshp: Law Encfnt	<input type="checkbox"/> 57 Ptnrshp: Subs Abuse	<input type="checkbox"/> 60 Ethnic-Specific Service Strategy
<input type="checkbox"/> 52 Family Support	<input type="checkbox"/> 55 Ptnrshp: Health Care	<input type="checkbox"/> 58 IntSvcs : MH / Aging	<input type="checkbox"/> 61 Age-Spec Svc Strategy <input type="checkbox"/> 99 Unknown

Referred By: _____

Identifying Information:

Legal Name: _____ Age: _____ DOB: _____

Preferred Name: _____

Gender: Male Female Transgender F-M Transgender M-F Intersex Other _____

Marital Status: Single Married Divorced Partnered Widowed

Address: _____

Phone #: _____

Emergency Contact: _____
Name _____ Phone number _____

Language:

Primary Language: _____ Other Languages spoken in home: _____

Interpreter Name of Interpreter: _____

Language service provided in other than English: Spanish Other _____

Client Information:

Entitlements: M/C Medicare BHC Other Health Care Info _____

No Health Insurance Coverage SSDI

Monthly Income _____ Payee: _____

Refer to a Financial Counselor? Yes No

Living Situation: Independent Living Immediate Family Extended Family Shared Housing

Board & Care Residential Care Facility Homeless Other

Support System Contacts: _____

Other Agencies Involved: CC Provider Network CFS/APS Voc Services Regional Center

AOD Anka BHI Homeless Services

Other _____



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Presenting Problem: (What is the primary reason for current referral? Describe current precipitating event, primary stressors, primary symptoms and functional impairment.)

Relevant Family/Social History: (Summarize relevant data regarding significant interpersonal relationships, including parents and marital status, children, siblings, living situations, education, work, history, military history, current support system, family history of mental illness or substance abuse and major traumatic events/losses, adverse childhood experiences.)

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Treatment History: (Check all appropriate and comment below.)

- Yes No Previous outpatient mental health services? Where/When? Transfer
-
- Obtain Release of Information for records from above (as needed)
- Yes No Previous crisis contact? Number of crisis unit visits without hospitalization in past 6 months 0 1 2 or more
Most recent date: _____
- Yes No Previous psychiatric hospitalization(s)? #: _____ Most recent date: _____
- Yes No Previous residential treatment? Name of Program _____ Length of Stay: _____
- Yes No Previous day treatment/partial hospitalization program? Name of Program _____ Length of Stay: _____
- Yes No Use of nontraditional or alternative healing practices? If yes, list: _____

Risk Assessment:

Danger to self (Intent, Plan Means): _____

Past: _____

Danger to others (Intent, Plan Means): _____

Past: _____

Grave Disability (Unable to make use of available Resources: _____

- 5150 Initiated CPS Referral/Involvement APS Referral Tarasoff

Additional Risk Factors: Check all that apply. Document details.

- | | |
|--|---|
| <input type="checkbox"/> Family History of Suicide | <input type="checkbox"/> Animal Cruelty |
| <input type="checkbox"/> History of Domestic Violence | <input type="checkbox"/> Fire Setting |
| <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Emotional/Physical Neglect |
| <input type="checkbox"/> Adverse Childhood | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Trauma or Loss in Family | <input type="checkbox"/> Self-Injurious Behavior |
| <input type="checkbox"/> Physical Abuse/Emotional Abuse | <input type="checkbox"/> Access to Firearms (family, friends) |
| <input type="checkbox"/> Inappropriate Sexualized Behavior | <input type="checkbox"/> Behavior Influenced by Delusions or Hallucinations |
| <input type="checkbox"/> Impulsivity/Threatening Behavior | <input type="checkbox"/> Severe Hopelessness |

Other _____

Comments:



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Medical History: Not available

Current Primary Medical Care Provider _____ None Unknown

Last Physical Exam: Within Past 12 months NOT within past 12 months Unknown

Last Dental Exam: Within Past 12 months NOT within past 12 months Unknown

Are there any health concerns (medical illness, medical symptoms)? No Yes (If so, please describe)

Has client had ANY allergic/serious reactions to medication(s)? No Yes (If so, please describe)

Does client have any NON medication allergies (Food, pollen, bee strings, etc.)? No Yes (If so, please describe)

List name of any medication(s) client is taking at this time. (List all current medications including Psychiatric, OTC, herbal and homeopathic. Include Start date/Dose/Frequency.) No Yes (If so, please describe)

Compliance issues? No Yes (If so, please describe)

Referral to Health Care Provider for further evaluation/assessment



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Criminal Justice History:

Probation Parole None

Probation/Parole Officer Contact: _____

Obtain Release (ROI)

Offense History (include jail/prison facility):

Substance Use:

During the past 6 months:

1. Have you ever used alcohol or drugs (such as wine, beer, hard liquor, pot, coke, heroin, or other opioids, upper, downers, hallucinations, or inhalants)? Yes No

Check all substances that apply in the last 6 months:

	FREQUENCY		FREQUENCY
<input type="checkbox"/> ALCOHOL	_____	<input type="checkbox"/> DESIGNER DRUGS (GHB, PCP, Ecstasy)	_____
<input type="checkbox"/> AMPHETAMINE	_____	<input type="checkbox"/> INHALANTS (Paint, Gas, Aerosols)	_____
<input type="checkbox"/> COCAINE/CRACK	_____	<input type="checkbox"/> MARIJUANA	_____
<input type="checkbox"/> OPIATES (Heroin, Opium, Methadone)	_____	<input type="checkbox"/> TOBACCO	_____
<input type="checkbox"/> HALLUCINOGENS (LSD, Mushrooms, Peyote)	_____	<input type="checkbox"/> CAFFEINE (Energy Drinks, Sodas, Coffee, etc.)	_____
<input type="checkbox"/> PAIN KILLERS (Oxy, Norco, Vicodin)	_____	<input type="checkbox"/> OVER THE COUNTER	_____
<input type="checkbox"/> Other _____			

Has alcohol or drugs ever been a problem in your life? Yes No (If no, skip questions 2 – 9)

Frequency of use _____

- 2. Have you felt that you use too much alcohol or drugs? Yes No
- 3. Have you tried to cut down or quit drinking or using alcohol or drugs? Yes No
- 4. Have you gone to anyone for help because of your drinking or drug use (such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program)? Yes No
- 5. Have you had any of the following due to substance use?

<input type="checkbox"/> Had blackouts or other periods of memory loss?	<input type="checkbox"/> Felt sick, shaky, or depressed?
<input type="checkbox"/> Injured your head after drinking or using drugs?	<input type="checkbox"/> Felt "coke bugs" or a crawling feeling under the skin?
<input type="checkbox"/> Had convulsions or delirium tremens ("DTs")?	<input type="checkbox"/> Been injured after drinking or using drugs?
<input type="checkbox"/> Had Hepatitis or other liver problems?	<input type="checkbox"/> Used needles to shoot drugs?

- 6. Has drinking or drug use caused problems between you and your family or friends? Yes No
- 7. Has your drinking or drug use caused problems at school or at work? Yes No
- 8. Have you been arrested or had other legal problems due to substance use (such as bouncing bad checks, driving while intoxicated, theft, or drug possession)? Yes No

Describe:

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9. Have you lost your temper or gotten into arguments or fights while drinking or using drugs? Yes No
10. Are you needing to drink more and more to get the effect you want? Yes No
11. Do you spend a lot of time thinking or trying to get the effect you want? Yes No
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone? Yes No
13. Do you feel bad or guilty about your drinking or drug use? Yes No
14. Have any of your family members ever had a drinking or drug problem? Yes No
15. Do you feel that you have a drinking or drug problem now? Yes No
16. What contributing factors/triggers do you have to drug/alcohol abuse?

17. Clean & Sober _____ Month(s) _____ Year(s)
What has been most helpful to you in maintaining sobriety?

18. Are you currently or have you ever been in recovery?

19. What recovery models have you used?

Comments:



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Mental Status:

General (appearance, attitude, behavior, speech):

Orientation: _____

Mood/Affect: _____

Thought Process: _____

Memory/Thought Content: _____

Insight/Judgment/Impulsivity: _____

Additional Observation(s):

Diagnostic Impression: DSM-5 Diagnosis and Narrative, ICD-10 Code

DSM 5 Code: _____ (Primary) **AND** ICD-10 Code: _____

DSM-5
Diagnosis Title/Narrative: _____

DSM 5 Code: _____ (Secondary) **AND** ICD-10 Code: _____

DSM-5
Diagnosis Title/Narrative: _____

DSM Diagnosis by: _____
(Name of Diagnosing Clinician/Licensure)

Functional Impairment:

	None	Mild	Mod	Severe		None	Mild	Mod	Severe
Family Relations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Social Relations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employment / School Performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreational / Leisure Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food/Shelter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Activities of Daily Living	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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Initial Treatment Plan (e.g. MHS, Medication Support, Day Treatment, etc.):

Clinical Summary / Additional Comments:

TARGETED CASE MANAGEMENT (TCM):

Does client warrant the consideration for TCM? (May include moderate or above Functional Impairment and/or risk of losing placement/housing, needed for financial support, social support, prevocational/employment assistance, rehabilitation, or other programs or services considered as necessary.) No Yes

TCM Initial Treatment Plan (e.g. Referrals to medical services, AOD, Voc, Social Security, community agencies, etc.):

Preliminary Discharge Plan:

Staff Signature/License

Printed Name

Date

Co-Signature of Licensed Clinician

Date

Data Entry Clerk Initials



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Presenting Problem: (*Continued from page 2*)

ASSESSMENT OF STRENGTHS

Check all that apply:

- | | |
|---|---|
| <input type="checkbox"/> Optimism / Hope | <input type="checkbox"/> Participates in Self-Help Groups |
| <input type="checkbox"/> Sense of Meaning | <input type="checkbox"/> Able to voice Mental Health life needs |
| <input type="checkbox"/> Faith / Spirituality | <input type="checkbox"/> Wellness Recovery Action Plan |
| <input type="checkbox"/> Empathy | <input type="checkbox"/> Able to Recognize Mental Health / Life Choices |
| <input type="checkbox"/> Compassion | <input type="checkbox"/> Hobbies / Special Interests |
| <input type="checkbox"/> Resourcefulness | <input type="checkbox"/> Goal-Directed / Motivated |
| <input type="checkbox"/> Academic Accomplishments | <input type="checkbox"/> Stable Family Life |
| <input type="checkbox"/> Daily Living Skills | <input type="checkbox"/> Communication |
| <input type="checkbox"/> Flexibility | <input type="checkbox"/> Sense of Empowerment |
| <input type="checkbox"/> Sense of Humor | <input type="checkbox"/> Work History |
| <input type="checkbox"/> Support Relationship | <input type="checkbox"/> Employment Skills |
| <input type="checkbox"/> Friendships | <input type="checkbox"/> Living Environment |
| <input type="checkbox"/> Open to Change | <input type="checkbox"/> Positive Self Identity |
| <input type="checkbox"/> Exercises Regularly | <input type="checkbox"/> Cultural Identity / Integration |
| <input type="checkbox"/> Nutritional Awareness | <input type="checkbox"/> Resilience |
| <input type="checkbox"/> Understands Mental Illness / Needs | <input type="checkbox"/> Planning |
| <input type="checkbox"/> Participates in 12 Step Program | <input type="checkbox"/> Other _____ |

Completed by: Therapist Consumer