Adult Annual Clinical Update

NAME / MRN

Billing Information

Program Name:____ RU:__________________ Date: __________

Staff #: __________________ **Hours**: ______ **Mins**: _____ 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)

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

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

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

☐ **Interpreter** Name of Interpreter: ____

Language service provided in other than English: ☐ Spanish ☐ Other ________________

Identifying Information:

Name:____ Age:____ DOB:___________

Address:____ Phone__________________

Emergency Contact/Name & Phone: ____

MH Provider: ____

Marital Status
☐ Single
☐ Married
☐ Divorced
☐ Partnered
☐ Widowed

Current Mental Health Functioning: (Include current symptoms, improvements in functioning, on-going functional impairments, hospitalizations and other pertinent changes in past year.)

Strengths:

NAME/MRN

Family/Social/Economic Update: (Include living situation, income, socialization, work or educational activity, judicial involvement, support system and any changes in life circumstances.)

Current Medical Status:

Primary Care Provider: ___________________________	Last Physical Exam:_______________	Last Dental Exam: _______________

Psychiatrist_____________________________________ Location ____

List all Medical Conditions:

Allergies/Drug Reactions:

Med Compliant? ☐ Yes ☐ No ☐ Unknown

List name of medication(s) client is taking at this time.
(List all current meds including OTC, herbal, and homeopathic. Include start date/dose/frequency.)

Current Substance Use:

☐ No Substance use ☐ Actively Using Substances ☐ Currently Clean & Sober for: ____________

Please list all substance being used or list current treatment interventions.

NAME/MRN

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 ☐ APS Referral ☐ Tarasoff ☐ Arrests/Incarcerations in last 12 months

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

☐ Physical Abuse/Emotional Abuse
☐ Family History of Suicide
☐ Assaultive Behavior
☐ Inappropriate Sexualized Behavior
☐ History of Domestic Violence
☐ Impulsivity/Threatening Behavior
☐ Sexual Abuse
☐ Animal Cruelty
☐ Fire Setting
☐ Emotional/Physical Neglect
☐ Adverse Childhood Experience
☐ Substance Abuse
☐ Self-injurious Behavior
☐ Trauma or Loss in Family
☐ Access to Firearms (family, friends)
☐ Behavior Influences by Delusions or Hallucinations
☐ Severe Hopelessness
☐ Other ______________________________

Comments:

Mental Status:

General (Appearance, attitude, behavior, speech) : ______________________________

Orientation : ______________________________

Mood/Affect : ______________________________

Thought Process : ______________________________

Memory/Thought Content : ______________________________

Insight/ Judgment/ Impulsivity : ______________________________

Additional Observation :

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

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

DSM-5 Title/Narrative: ______________________________

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

Diagnosis Title/Narrative: ______________________________

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

Functional Impairment:

	None	Mild	Mod	Severe		None	Mild	Mod	Severe
Family Relations	☐	☐	☐	☐	Social Relations	☐	☐	☐	☐
Employment / School Performance	☐	☐	☐	☐	Physical Health	☐	☐	☐	☐
Recreational / Leisure Activities	☐	☐	☐	☐	Substance Abuse	☐	☐	☐	☐
Food/Shelter	☐	☐	☐	☐	Activities of Daily Living	☐	☐	☐	☐

Additional Comments:

NAME/MRN

Justification for Continued Care Services

Discharge Plan Update: (Clinical Presentation)

Staff Signature/License	Printed Name	Date
Co-Signature/License	Printed Name	Date

Data Entry Clerk Initials ________