CONTRA COSTA
HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

INITIAL PSYCHIATRIC ASSESSMENT

_____

_____

NAME / MRN

Date of Service:_____ RU:_____

Staff #: _____ **Hours**: _____ **Mins**: _____

Code Activity: ☒ 361 EVAL/RX Location: ☐ 1 Office ☐ 2 Field ☐ 4 Home ☐ 5 School Satellite ☐ 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 Disbled
☐ **51** Psych Education	☐ **54** Prtnrshp:LawEnfcmt	☐ **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

Assessment in language other than English: ☐ Spanish ☐ Other _____

☐ **Interpreter** **Name of Interpreter:** _____

Is Client Pregnant? ☐ Yes ☐ No

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/Significant Other: _____ _____

Name Phone number

Primary concerns per consumer:

Presenting Problem/ Recent Course of Illness:

Consumer and Family Strengths (Positive factors to facilitate treatment e.g. faith, resilience, etc.):

Psychiatric History (include hospitalizations and dates, suicide attempts, history of intervention):

Psychiatric Medication History (Current and Past, side effects, adherences & outcomes) Current: ☐None Past: ☐None

Alcohol/ Drug Use History: (Check all appropriate and provide details.)

☐Unknown ☐No Current Substance Abuse ☐No Past Substance Abuse ☐Currently Clean & Sober for: ☐>3 Mos. ☐>1 Yr

Alcohol	☐ Past	☐ Present	Nicotine	☐ Past	☐ Present	Caffeine	☐ Past	☐ Present
Cocaine	☐ Past	☐ Present	Marijuana	☐ Past	☐ Present	Amphetamines	☐ Past	☐ Present
Opiates	☐ Past	☐ Present	Ecstasy	☐ Past	☐ Present	Hallucinogens	☐ Past	☐ Present
Sedatives	☐ Past	☐ Present	Inhalants	☐ Past	☐ Present	Energy Drinks	☐ Past	☐ Present
Other:	☐ Past	☐ Present						

Specify:

Medical History (include illnesses, surgeries, CNS, head injuries):

Date of Last Physical: _____ Physician(s)/clinic: _____

Phone #: _____ Weight: _____ Height: _____ BMI: _____

Allergies (Meds & Other) / Adverse Reaction: _____
Active Medical Concerns, History of Hospitalizations/Surgeries:

Non-Psych Med/OTC _____

Review of Systems: ☐ No Significant issues revealed

☐ CV ☐ Renal ☐ GI ☐ Hepatic ☐ CNS ☐ GU ☐ Metabolic ☐ CA ☐ PULM ☐ Gyn ☐ ID/HIV

☐ Sexually Active Contraceptive Method _____ ☐ Risk of Pregnancy ☐ Pregnant

☐ Breast-Feeding LMP: _____

Pregnancy and Birth History (<18): _____

Developmental History (<18): _____

NAME/MRN

Family Psychiatric History:

Psychosocial History (e.g. education, family, vocational, military, legal):

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

☐ Victim of Physical Abuse	☐ History of Self-injurious Behavior
☐ Victim of Sexual Abuse	☐ History of Suicidal Behavior
☐ Trauma or Loss in the Family	☐ Family History of Suicide
☐ Domestic Violence: Victim ☐ Perpetrator ☐	☐ Access to Firearms (family, friends, self)
☐ History of Substance Abuse	☐ Access to Other Means of Suicide
☐ History of Assaultive Behavior	☐ Lack of Social Support
☐ History of Threatening Behavior	☐ History of Foster Care
☐ History of Inappropriate Sexual Behavior	☐ Homelessness
☐ Behavior Influences by Delusions or Hallucinations	☐ Other

Comments:

MENTAL STATUS EXAMINATION

APPEARANCE/GROOMING	☐ Unremarkable	☐ Remarkable for: _____
PSYCHO-MOTOR ACTIVITY	☐ Unremarkable	☐ Remarkable for: _____
ATTITUDE/RELATEDNESS	☐ Unremarkable	☐ Remarkable for: _____
SPEECH	☐ Unremarkable	☐ Remarkable for: _____
MOOD	☐ Unremarkable	☐ Remarkable for: _____
AFFECT	☐ Unremarkable	☐ Remarkable for: _____
THOUGHT PROCESS	☐ Unremarkable	☐ Remarkable for: _____
THOUGHT CONTENT	☐ Unremarkable	☐ Remarkable for: _____
PERCEPTUAL DISTURBANCE	☐ Unremarkable	☐ Remarkable for: _____
ORIENTATION	☐ Unremarkable	☐ Remarkable for: _____
MEMORY/CONCENTRATION	☐ Unremarkable	☐ Remarkable for: _____
FUND OF KNOWLEDGE	☐ Unremarkable	☐ Remarkable for: _____
INTELLECT/ABSTRACT THINKING	☐ Unremarkable	☐ Remarkable for: _____
INSIGHT/ JUDGEMENT	☐ Unremarkable	☐ Remarkable for: _____
IMPULSE CONTROL	☐ Unremarkable	☐ Remarkable for: _____

Additional Observations:

NAME/MRN

Current Risk Assessment:

Danger to SELF (Intent, Plan Means): _____

Danger to OTHER (Intent, Plan Means): _____

Grave Disability: _____

Clinical Summary (Optional):

Diagnostic Impression: DSM Code and Narrative – Designate diagnosis which is primary focus of treatment with a "P"

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: _____

FUNCTIONAL IMPAIRMENT: (IF MODERATE OR ABOVE, MAY WARRANT TARGETED CASE MANAGEMENT)

	None	Mild	Mod	Severe		None	Mild	Mod	Severe
Family Relations	☐	☐	☐	☐	**Peer Relations**	☐	☐	☐	☐
Academic/Vocational Performance	☐	☐	☐	☐	**Physical Health**	☐	☐	☐	☐
Self Care	☐	☐	☐	☐	**Substance Abuse**	☐	☐	☐	☐

TARGETED SYMPTOMS:

	None	Mild	Mod	Severe		None	Mild	Mod	Severe
Cognition/Memory/Thought	☐	☐	☐	☐	**Perceptual Disturbance**	☐	☐	☐	☐
Attention/Impulsivity	☐	☐	☐	☐	**Antisocial Behavior**	☐	☐	☐	☐
Socialization/Communication	☐	☐	☐	☐	**Destructive/Assaultive**	☐	☐	☐	☐
Depressive Symptoms	☐	☐	☐	☐	**Mania/Agitation/Lability**	☐	☐	☐	☐
Anxiety/Phobia/Panic Attack	☐	☐	☐	☐	**Somatic Disturbance**	☐	☐	☐	☐
Affect Regulation	☐	☐	☐	☐	**Other:**	☐	☐	☐	☐

NAME/MRN

Initial Treatment Plan/Targeted Case Management:

Does consumer meet the criteria for TCM? (May include moderate or above Functional Impairment and/or risk of losing placement/housing, need for financial support, social support, prevocational/employment assistance, rehabilitation, AOD services, or other programs or services considered necessary.) ☐ No ☐ Yes
Explain:

Referral to Coordination of Care with:

☐ PCP ☐ Case Management ☐ Therapist ☐ Family/ Other Support ☐ Substance Abuse Tx

☐ Housing ☐ Community Agencies ☐ Vocational Rehab ☐ Social Security

Details:

Labs Ordered:

Medications Prescribed / Dosage / Frequency:

☐ Drug Information Sheet for each medication was given to consumer and family.
☐ Benefits/Risks/Possible adverse effects of medication and Alternatives to medication have been discussed.
☐ An opportunity was given to ask questions.
☐ The consumer and/or family appear to understand the information on the form.
☐ If appropriate, discuss the interaction of psychiatric medication with the following: Pregnancy, Lactation, Alcohol, Nutrition, and Non-Psychiatric Medications
☐ An Informed Consent was signed within the past two years.

Consumer (Family) is able to manage own medication: ☐ Yes ☐ No

If not, explain: _____

Additional Information:

MD/DO/NP Signature: _____ **Date:** _____

PRINT FULL NAME AND TITLE _____

_____
Data Entry Clerk Initials