SOW'S MENTAL HEALTH INTAKE ASSESSMENT FORM

A. Identifying Information

Name: _____

Referred by: _____

Date of Birth: _____

Date of Assessment: _____

Informed Consent

Was the client advised that mental health services are voluntary, results are not guaranteed, and of the limits to confidentiality? ☐ Yes ☐ No

Was the client informed of the mental health services provided by SOW? ☐ Yes ☐ No

B. Incarceration or probation (Circle one): ☐ Yes ☐ No

C. Reason for Referral (e.g., precipitants, referral questions): **Referral form included?** ☐ Yes ☐ No

D. Relevant Psychosocial History (e.g., note any of the following: family history of mental illness/substance abuse, cultural factors, academic history, spiritual/religious history, legal history, gang affiliation, trauma history, abuse history as victim or perpetrator)**:**

E. Mental Health Treatment History (e.g., outpatient or inpatient treatment, previous counseling; **was it helpful**?):

F. Psychotropic Medications (current and previous): ☐ None

Medication/Dose	Indication	Now	Past
		☐	☐
		☐	☐
		☐	☐
		☐	☐

G. Substance Use History: ☐ No ☐ Yes (explain below)

H. Relevant Medical History (e.g., current and previous significant health conditions, hospitalizations)**:**

I. High Risk Screening History (e.g., current and previous suicidal/homicidal ideation, self-injury, thrill-seeking behaviors, history of assault and/or violence):

☐ Present: (Explain) _____

☐ Previous: (Explain) _____

☐ Denied

J. Current Mental Status (check all that apply):

Rapport	Mood	Affect	Speech	Behavior	Insight	Judgment
☐ Appropriate	☐ Normal	☐ Appropriate	☐ Normal	☐ Normal	☐ Good	☐ Good
☐ Poor eye contact	☐ Depressed	☐ Inappropriate	☐ Delayed	☐ Restless	☐ Fair	☐ Fair
☐ Evasive	☐ Anxious	☐ Depressed	☐ Pressured	☐ Pacing	☐ Poor	☐ Poor (Based on history and/or observation)
☐ Distant	☐ Angry	☐ Expansive	☐ Excessive	☐ Compulsive	☐ Motivated	
☐ Mistrustful	☐ Irritable	☐ Blunted	☐ Loud	☐ Psychomotor retardation	☐ Ambivalent	
☐ Resistant	☐ Euphoric	☐ Flat	☐ Soft	☐ Psychomotor agitation	☐ Apathetic	
☐ Hostile	☐ Elated	☐ Labile				

Other Significant Mental Status Findings (e.g., cognitive impairment or psychotic symptoms):

_____

_____

_____

Student Strengths

_____

_____

_____

K. Brief Clinical Summary: _____

_____

_____

L. DSM Diagnosis: ☐ Formal ☐ Provisional

Diagnostic Code and Name: _____

_____

_____

M. If clients condition rises to a level of a care that is not treatable by SOW, a referral will be provided for assistance. Has this been completed? ☐ Yes ☐ No

If NO, explain why: _____

_____

Referral Interested In Services at This Time

Is client interested in services or follow-up at this time? ☐ Yes ☐ No

Follow-up

☐ Scheduled for follow-up sessions ☐ Care Management Form

☐ Mental health referral ☐ None at this time ☐ Other: _____

N. Mental Health Treatment Plan, if applicable: (Employability Focus)

Issue/Behavior/Symptom	Plan	Follow-up Date

O. I understand the terms of treatment (3-6 sessions at no cost to me) and terms of confidentiality ?

☐ Yes ☐ No

Signatures

Clients name (Printed)	Signature	Date
Licensed Supervisor (if different)	Signature	Date