INITIAL ASSESSMENT

Date of first assessment contact: _____

Assessing Practitioner (Name and Discipline): _____

Client/Others Interviewed: _____

I. Demographic Data & Special Service Needs:

DOB: _____ **Gender:** _____ **Ethnicity:** _____ **Marital Status:** _____

Referral Source:

☐ Non-English Speaking, specify language used for this interview: _____

Were Interpretive Services provided for this interview? Yes ☐ No ☐

☐ Cultural Considerations, specify _____

☐ Physically challenged (wheelchair, hearing, visual, etc.) specify: _____

☐ Access issues (transportation, hours), specify: _____

II. Reason for Referral/Chief Complaint:

Describe precipitating event(S)/Reason for Referral,

Current Symptoms and Behaviors (intensity, duration, onset, frequency) and Impairments in Life Functioning cause by the symptoms/behaviors perspective of client and others):

Client Strengths (to assist in achieving treatment goals)

Name: Provider:

INITIAL ASSESSMENT

III. Mental Health History:

History of Problem to Precipitating Event: *Include treatment & non-treated history.*

Impact of treatment and non-treatment history: *on the client's level of functioning. E.g., ability to maintain residence, daily living and social activities, health care, and/or employment.*

Psychiatric Hospitalizations: ☐ Yes ☐ No ☐ Unable to Access.
If yes, describe dates, locations, and reasons.

Outpatient Treatment: ☐ Yes ☐ No ☐ Unable to Access.
If yes, describe the dates, locations, and reasons.

Past Suicidal/Homicidal Thoughts/Attempts including dates, threat, intent, plan, target(s), access to letha means, method used:

History of Trauma or Exposure to Trauma: ☐ Yes ☐ No ☐ Unable to Access.
Has client ever (1) been physically hurt or threatened by another (2) been raped or had sex against their will, (3) lived through disaster, (4) been combat veteran or experienced an act of terrorism, (5) been in a severe accident, or been close to death from any cause, (6) witnessed death or violence to someone else, or (7) been the victim of crime?

Name: Provider:

INITIAL ASSESSMENT

IV. Medications.

List "all" past and present psychotropic medications used, prescribed/non-prescribed, by name, dosage, frequency. Indicate from client's perspective what seems to be working and not working.

Medication:	Dosage/Frequency	Period Taken	Effectiveness / Si

General Medication Comments: (include significant non-psychotic medication issue/history):

V. Substance Use/Abuse:

Does the client currently appear to be under the influence of alcohol or drugs?

☐ Yes ☐ No ☐ Unable To Assess.

If yes, when was the last time the client used alcohol or drugs?

Has the client ever received professional help for his/her use of alcohol or drugs?

☐ Yes ☐ No ☐ Unable To Assess.

Comments on alcohol/drug use:

How is Mental Health impacted by substance use (Clinician Perspective)? *Must be completed if any services will be directed towards Substance Use/Abuse.*

Name: Provider:

INITIAL ASSESSMENT

VI. Medical History.

MD Name: **MD Phone:** **Date of Last Physical Exam:**

Major medical problem (treated or untreated) *(indicate problems with check: Y or N for client, FAM for family history.*

FAM	Y	N		FAM	Y	N	
☐	☐	☐	Seizure/neuro disorder.	☐	☐	☐	Cardiovascular disease/symp.
☐	☐	☐	Head Trauma	☐	☐	☐	Thyroid disease/symp.
☐	☐	☐	Sleeping Disorder				
☐	☐	☐	Weight/appetite chg.	☐	☐	☐	Asthma/Lung Disease
☐	☐	☐	Allergies (if Y, specify)	☐	☐	☐	Blood Disorder
☐	☐	☐	Sensory/Motor impairment (if Y,specify)				
☐	☐	☐	Pap Smear	☐	☐	☐	Liver Disease
			If Yes, date:	☐	☐	☐	Renal Disease/symp
				☐	☐	☐	Hypertension
☐	☐	☐	Mammogram:	☐	☐	☐	Diabetes
			If yes, date	☐	☐	☐	Cancer
				☐	☐	☐	Sexual Dysfunction
☐	☐	☐	HIV Test:				
			If yes, date:				
☐	☐	☐	Pregnant				
			If yes, due date:				

Comments on above medical problems, other medical problems, any hospitalizations, including dates and reasons:

VII. Pyschosocial History

Please state how Mental Health status directly impacts each area below; Be sure to include the client's strengths in each area.

Education:

Special Education: ☐ Yes ☐ No ☐ Unable to Assess

Learning Disability: ☐ Yes ☐ No ☐ Unable to Assess

Motivation, education goals, literacy skills, level, general knowledge skill level, math skill level, school problems, etc:

Employment History, Readiness for Employment and Means of Financial Support:

Current Paid Employment: ☐ Yes ☐ No ☐ Unable to Assess **Military Service:** ☐ Yes ☐ No ☐ Unable to Assess

Work related problems, volunteer work, money management, source of income, longeriod period of employment, etc:

Name: Provider:

INITIAL ASSESSMENT

Legal History and Current Legal Status
Arrests/DUI, probation, convictions, divorce, conservatorship, parole, child custody, etc.

Current Living Arrangement and Social Support System
Type of living setting, problems at setting, community, religious, government agency, or other types of support, etc.

Dependent Care Issues
Number of Dependent Adults: _____ Number of Dependent Children: _____
Ages of children, school attendance/behavior problems of children, special needs of dependents, foster care/groups home placement issues, child support, etc:

Family and Relationships
History of mental Illness in Immediate Family: ☐ Yes ☐ No ☐ Unable to Assess
Alcohol/Drug Abuse in Immediate Family: ☐ Yes ☐ No ☐ Unable to Assess
Family constellation, family of origin, family dynamics, cultural factors, nature of relationships, domestic violence, physical or sexual abuse, home safety issues, family medical history, family legal/criminal issues.

Name: Provider:

INITIAL ASSESSMENT

VIII. Mental Status Evaluation

Instructions: Check all descriptions that apply.

General Description.

Grooming and Hygiene
☐ Well groomed ☐ Average ☐ Dirty
☐ Odorous ☐ Disheveled ☐ Bizarre

Eye Contact
☐ Normal for culture
☐ Little ☐ Avoids ☐ Erratic
Comments:

Motor Activity:
☐ Calm ☐ Restless ☐ Agitated
☐ Retarded ☐ Akathesis ☐ Posturing
☐ Rigid ☐ E.P.S
Comments:

Speech:
☐ Unimpaired ☐ Soft ☐ Slowed
☐ Mute ☐ Pressured ☐ Loud
☐ Excessive ☐ Slurred ☐ Incoherent
☐ Poverty of Content
Comments:

Interactional Style:
☐ Culturally congruent
☐ Cooperative ☐ Sensitive
☐ Guarded/Suspicious
☐ Overly Dramatic
☐ Negative ☐ Silly
Comments:

Orientation:
☐ Oriented
☐ Disoriented to:
☐ Time ☐ Place ☐ Person ☐ Situation
Comments:

Intellectually Functioning:
☐ Unimpaired ☐ Impaired
Comments:

Memory:
☐ Unimpaired
☐ Impaired ☐ Immediate ☐ Remote
☐ Recent ☐ Amnesia

Mood and Affect:

Mood:
☐ Euthymic ☐ Dysphoric ☐ Tearful
☐ Hopeless ☐ Lack of Pleasure
☐ Known Stressor ☐ Unknown Stressor

Affect
☐ Appropriate ☐ Labile ☐ Expansive
☐ Constricted ☐ Blunted ☐ Flat ☐ Sad
☐ Worried
Comments:

Perceptual Disturbance:
☐ None Apparent

Hallucinations:
☐ Visual ☐ Olfactory
☐ Tactile ☐ Auditory ☐ Command
☐ Persecutory ☐ Other
Comments:

Self Perception:
☐ Depersonalizations
☐ Idea of Reference
Comments:

Thought Process Disturbance:
☐ None apparent

Associations:
☐ Unimpaired ☐ Loose
☐ Tangential ☐ Circumstantial
☐ Confabulous ☐ Flight of Ideas
☐ Word of Salad
Comments:

Abstractions: ☐ Intact ☐ Concrete
Comments:

Judgments: ☐ Intact
☐ Impaired re: ☐ Minimum ☐ Moderate
☐ Severe
Comments:

Insights: ☐ Adequate
☐ Impaired re: ☐ Minimum ☐ Moderate
☐ Severe
Comments:

Thoughts of Content Disturbance

None apparent

Delusions:
☐ Persecutory ☐ Paranoid ☐ Grandios
☐ Somatic ☐ Religious ☐ Nihilistic
☐ Being Controlled:
☐ Comments:

Ideations:
☐ Bizarre ☐ Phobic ☐ Suspicious
☐ Obsessive ☐ Blames Others
☐ Persecutory
☐ Assaultive Ideas ☐ Magical Thinking
☐ Irrational/Excessive Worry
☐ Sexual Preoccupation
☐ Excessive/Inappropriate Religiosity
☐ Excessive/Inappropriate Guilt
Comments:

Behavioral Disturbance:

Behavioral Disturbances:
☐ None ☐ Aggressive ☐ Uncooperative
☐ Demanding ☐ Demeaning
☐ Belligerent
☐ Violent Destructive
☐ Self-Destructive ☐ Poor Impulse Control
☐ Excessive/Inappropriate Display of Anger
☐ Manipulative ☐ Antisocial
Comments:

Suicidality/Homocidality:
Suicidal: ☐ Denies ☐ Ideation Only
☐ Threatening ☐ Plan
Comments:

Homicidal: ☐ Denies ☐ Ideation Only
☐ Threatening ☐ Target ☐ Plan
Comments:

Name: Provider:

INITIAL ASSESSMENT

IX. Summary and Diagnosis

I. Diagnostic Summary: (Be sure to include assessment for risks of suicidal/homicidal behaviors, significant strengths/weaknesses, observations/descriptions, symptoms/impairments in life functioning, i.e., Work, School, Home, Community, Living Arrangements, etc, and justification for Diagnosis.

II. Admission Diagnosis (Check one Principle and one Secondary)

Axis I Prin Sec Code_____ Nomenclature _____
(Medications cannot be prescribed with a deferred diagnosis)
Sec Code_____ Nomenclature _____
Code_____ Nomenclature _____
Code_____ Nomenclature _____
Code_____ Nomenclature _____

Axis II Prin Sec Code_____ Nomenclature _____
Sec Code_____ Nomenclature _____
Code_____ Nomenclature _____

Axis III _____ Code _____
_____ Code _____
_____ Code _____

Axis IV

Psychological and Environmental Problems which may affect diagnosis, treatment, or prognosis.
Primary Problem #: _____
Check as many that apply:

1. Primary support group. 2. Social environment 3. Educational 4. Occupational
5. Housing 6. Economics 7. Access to Healthcare
8. Involve w/Legal Sys. 9. Other psychosocial/environmental

Axis V Current GAF: _____ DMH Dual Diagnosis Code: _____

III. Specialty Mental Health Services Medical Necessity Criteria:

1. Medi-Cal Specialty Mental Health Included Diagnosis
2. Significant impairment in life functioning due to the Included Diagnosis
3. Expectation that proposed interventions can impact the client's condition
4. Mental Health Condition will not be responsive to physical health care based treatment.

IV. Disposition/Recommendation/Plan

V. Signatures

Assessor's Signature & Discipline	Date	Co-Signature & Discipline	Date

Name: Provider:

INITIAL ASSESSMENT

Sex Hx Section:
I. What was your first introduction to sex?
II. How old were you?
III. How/Where were you introduced to Porn?
IV. How old were you when you were introduced to Porn?
V. How would you describe your relationship to sex and sexuality?

This confidential information is provided to you in accord with State and Federal laws, and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorization representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.	Name: Provider: