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| **PROVIDER** | | | | | | | | | | | | | | **ADDRESS** | | | | | | | | | | | | | | | | | | | | | | | | **PHONE** | | | | | | | | | | | | | | | | | | | | | | | **FAX** | | | | | | | | | | | | | | | | | | | |
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| **CLIENT LAST NAME** | | | | | | | | | | | | | | | | | **CLIENT FIRST NAME** | | | | | | | | | | | | | | | | | | | | | **MIDDLE NAME** | | | | | | | | | | | | | | | | | | | | | | | **SUFFIX (Sr., Jr.)** | | | | | | | | | | | | | | | | | | | |
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| **PREFERRED LAST NAME** | | | | | | | | | | | | | | | | | | | | | **PREFERRED FIRST NAME** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **D.O.B.** | | | | | | | | | | | | | | | | | | |
| **Sex Assigned at Birth**: Male | | | | | | | | | | | | | | | | | Female | | | | | | | | | Intersex | | | | | | | | | | | | | | | | Other: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Gender Identity**: Male  Declined to State Other: | | | | | | | | | | Female  Other | | | | | | | | Intersex | | | | | | | € Gender Queer | | | | | | | | | | | | | Transgender: | | | | | | | | | | | | | | | Male to Female | | | | | | | | | | | | | | | | | | Female to Male | | | | | | | | | | |
| **SEXUAL ORIENTATION:** Unknown Heterosexual/Straight Lesbian Gay  Bisexual  Queer Gender Queer Questioning Declined to State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other: | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
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| **Emergency Contact** | | | | | | | | Relationship | | | | | | | | | | | | | | | | Contact address (Street, City, State, Zip) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Contact Phone number | | | | | | | | | | | | | | | | | |
| Release for Emergency Contact obtained for this time period: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Assessment Sources of Information (**Check All that Apply): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Client** | | | | | | | | | | **Family Guardian** | | | | | | | | | | | | | | | | | **Hospital** | | | | | | | **Other:** | | | | | | | | | | | | | | | | | | |
| **REFERRAL Source/ REASON FOR REFERRAL/ CHIEF COMPLAINT** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe precipitating event(s) for Referral; Current Symptoms and Behaviors (intensity, duration, onset, frequency); present/new precipitants/stressors; for episodic illnesses describe first episode, onset, precipitants, duration & Rx response; etc. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Narrative continued in Addendum | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PSYCHIATRIC HEALTH HISTORY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Inpatient & Outpatient Treatment, Trauma & Risk Factors including S/I and H/I (If any mandatory reports filed—discuss.)  Narrative continued in Addendum | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PSYCHOSOCIAL HISTORY & FUNCTIONING** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Include: Client’s Family History; *Family History* of mental illness, suicide, substance abuse, trauma, and neglect/abuse; Cultural factors; History of Educational, Vocational, and Income; Social & Legal or Criminal Justice; Living Situation; Income; etcOr, see attached MH Assessment dated: \_\_/\_\_/\_\_\_\_ **OR**  Also, see attached MH Assessment dated: \_\_/\_\_/\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Narrative continued in Addendum | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **This Section for YOUTH ONLY < 18 YRS OLD** | | | | | | | | | | | | | | | | | | | Or, see attached MH Assessment dated: \_\_/\_\_/\_\_\_\_ **OR**  Also, see attached MH Assessment dated: \_\_/\_\_/\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| LIVES WITH: | | | | | | First Name of others in home (children & adults) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Age | | | | | | Relationship | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Immediate Family | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Extended Family | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Foster Family | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DESCRIBE FAMILY OF ORIGIN: | | | | | | | | | | | | | Narrative continued in Addendum | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **EDUCATION** | | | | | Current School: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Spec Ed | | | | | | | | | | YES | | | | | | | | | NO | | | |
| Grade |  | | | | Contact/Teacher/ Ph#: | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Active IEP/Special Assessment/Services: | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | LD | | | | | | | | | DD/ID | | | | | | | | | SED | | | | |
| Last School Attended: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Vocational Activities: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **YOUTH (0 – 17 YRS.) DEVELOPMENTAL HISTORY (also include any significant culturally related rites of passage, rituals, ceremonies, etc.)**  Or, see attached MH Assessment dated: \_\_/\_\_/\_\_\_\_ **OR**  Also, see attached MH Assessment dated: \_\_/\_\_/\_\_\_\_  **0 – 6 yrs**: Include relevant prenatal/birth/childhood information including pregnancy, developmental milestones, environmental stressors and other significant events.  **7 – 11 yrs**: Include above and relevant latency (peer/sibling relations, extracurricular activities, delinquency, environmental stressors of other significant events).  **12 – 17 yrs**: Include above and relevant adolescence (onset of puberty, extracurricular activities, teen parenthood, delinquency, gang involvement, and environmental stressors of other significant events).  Narrative continued in Addendum | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ADULTS (18+ yrs.) DEVELOPMENTAL HISTORY (also include any significant culturally related rites of passage, rituals, ceremonies, etc.)**  Or, see attached MH Assessment dated: \_\_/\_\_/\_\_\_\_ **OR**  Also, see attached MH Assessment dated: \_\_/\_\_/\_\_\_\_  **Adults 19+ yrs**: Include relevant: childhood (where, who reared/lived in house where grew up, important/traumatic events, school experience and performance, history of physical/sexual abuse, placement history, etc.), adolescence (school and activities, friendships/relationships, sexual experiences, traumas, leaving home, placement history, etc.), adulthood (military service, marriage/divorce, children, geographical changes, traumas, current relationship with family/significant other, etc.), and aging issues (retirement, grandchildren, support systems, sleep changes, losses, etc.).  Narrative continued in Addendum | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medical History**  **Relevant Medical History: *Indicate or check only those that are relevant*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **General Information:**  Respiration: | | | | | | | | | | | | Weight:  General Appearance: | | | | | | | | | | Height: | | | | | | | | | | | Sitting BP: Standing BP: | | | | | | | | | | | | | | | | | | | | | | | | Supine BP: | | | | | | | | | | Temp: | | | | | | | |  | | | | | | |
| *Cardiovascular/Respiratory:* | | | | | | | | | | | | Chest Pain | | | | | | | | | | | Hypertension | | | | | | | | | | | | | Hypotension | | | | | | | | | | | | | | | | | | Palpitation | | | | | | | | | | | | | | | | | | | | Smoking | | | | | | | |
| *Genital/Urinary/Bladder:* | | | | | | | | | | | | Incontinence | | | | | | | | | | | Nocturia | | | | | | | | | | | | | Urinary Tract Infection | | | | | | | | | | | | | | | | | | Retention | | | | | | | | | | | | | | | | | | | | Urgency | | | | | | | |
| *Gastrointestinal/Bowel:* | | | | | | | | | | | | Heartburn | | | | | | | | | | | Diarrhea | | | | | | | | | | | | | Constipation | | | | | | | | | | | | | | | | | | Nausea | | | | | | | | | | | | | | | | | | | | Vomiting | | | | | | | |
| Ulcers | | | | | | | | | | | Laxative Use | | | | | | | | | | | | | Incontinence | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| *Nervous System:* | | | | | | | | | | | | Headaches | | | | | | | | | | | Dizziness | | | | | | | | | | | | | Seizures | | | | | | | | | | | | | | | | | | Memory | | | | | | | | | | | | | | | | | | | | Concentration | | | | | | | |
| *Musculoskeletal:* | | | | | | | | | | | | Back Pain | | | | | | | | | | | Stiffness | | | | | | | | | | | | | Arthritis | | | | | | | | | | | | | | | | | | Mobility/Ambulation | | | | | | | | | | | | | | | | | | |  | | | | | | | | |
| *Gynecology:* | | | | | | | | | | | | Pregnant | | | | | | | | | | | Pelvic Inflam. Disease | | | | | | | | | | | | | Menopause | | | | | | | | | | | | | | | | | | Breast Feeding | | | | | | | | | | | | | | | | | | | Last LMP: | | | | | | | | |
| *Skin:* | | | | | | | | | | | | Scar | | | | | | | | | | | Lesion | | | | | | | | | | | | | Lice | | | | | | | | | | | | | | | | | | Dermatitis | | | | | | | | | | | | | | | | | | | | Cancer | | | | | | | |
| *Endocrine:* | | | | | | | | | | | | Diabetes | | | | | | | | | | | Thyroid | | | | | | | | | | | | | Other: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Respiratory:* | | | | | | | | | | | | Bronchitis | | | | | | | | | | | Asthma | | | | | | | | | | | | | COPD | | | | | | | | | | | | | | | | | | Other | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| *Others (check if relevant and describe):* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other: | | Significant Accident/Injuries/Surgeries: | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Hospitalizations: | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Physical Disabilities: | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Chronic Illness: | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | HIV disease: | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Age of Menarche and Birth Control Method: | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | History of Head Injury: | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Cardiac screening questions (required to be documented prior to starting stimulants): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | History of cardiac diagnosis (including heart murmur): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | History of palpitations, chest pain, syncope: | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Family history of sudden death less than age 30: | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | If any of the three answered yes, EKG ordered. | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **CURRENT MEDICATIONS** (include all prescribed, over the counter, and holistic/complimentary/alternative remedies): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | **Rx Name** | | | | | | | | | | | | **Effectiveness/Side Effects** | | | | | | | | | | | | | | | | **Dosage** | | | | | | | | | | | **Date Started** | | | | | | | | | | | | | **Prescriber** | | | | | | | | | | | | | | **Current** | | | | | | | | **Past** | | | |
| *Psychotropic* | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | |  | | | |
| *Non-Psychotropic* | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | |  | | | |
| **PREVIOUS MEDICATIONS** (include all prescribed, over the counter, and holistic/complimentary/alternative remedies): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Psychtropic* | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | |  | | | |
| *Non-Psychtropic* | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | |  | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Medication Narrative continued in Addendum | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Allergies/Adverse Reactions/ Sensitivities** Check if Yes  and List Food  Drugs(Rx/OTC/ILLICT) Unknown Allergies Other: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Date of last physical exam:** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | **Date of last dental exam:** | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Referral made to primary care or specialty** | | | | | | | | | | | | | | | | | | | | **NO** | | | | | | | | **YES** | | | | | | | | | **If yes, list:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Providers (if known):** | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Additional Medical Information (Describe any relevant medical conditions above):** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Narrative continued in Addendum | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SUBSTANCE USE** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SUBSTANCE EXPOSURE **(indicate if ever used)** | | | | | | | | | | | | | | | | | | | | | | | | | | | **AGE AT FIRST USE** | | | | | | | **CURRENT SUBSTANCE USE/DEPENDENCE/ABUSE** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| None/  Denies | | | | | | | | | | Current  Use | | | | | | | Current  Abuse | | | | | | | Current  Dependence | | | | | | | | | | | | | | In Recovery | | | | | | | Client-perceived Problem? | | |
| ALCOHOL: | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | |  | | | | | | |  | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | Y | N | |
| ILLICIT DRUGS: | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | |  | | | | | | |  | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | Y | N | |
| OVER THE COUNTER MEDICATIONS: | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | |  | | | | | | |  | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | Y | N | |
| CAFFEINE (ENGERY DRINKS, SODAS, COFFEE, ETC.): | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | |  | | | | | | |  | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | Y | N | |
| COMPLIMENTARY/ALTERNATIVE MEDICATIONS: | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | |  | | | | | | |  | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | Y | N | |
| CANNABIS: | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | |  | | | | | | |  | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | Y | N | |
| TOBACCO/NICOTINE: | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | |  | | | | | | |  | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | Y | N | |
| OTHER SUBSTANCE: | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | |  | | | | | | |  | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | Y | N | |
| Is beneficiary receiving alcohol and drug services? | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes, from this provider | | | | | | | | | | | | | | | | | | | | | | Yes, from a different provider | | | | | | | | | | | | | | | | | | | | | | | | | | | NO | | | | | |
| If yes, type of alcohol and drug services: | | | | | | | | | | | | | | | | | | | | | | | | | | | Residential | | | | | | | | | | | | | | Outpatient | | | | | | | | | | | | | | | | | | | | | | | | | Community/ Support Group | | | | | | | | | | | | | | | |
| **COMMENTS:** Include Tox Screen results, if any. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Narrative continued in Addendum | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SUD REFERRALS** (From the ACBHCS SUD Treatment Referral Guide, [www.acbhcs.org/providers/SUD/resources.htm](http://www.acbhcs.org/providers/SUD/resources.htm) indicate the specific referrals provided to client). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Narrative continued in Addendum | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| **MENTAL STATUS:** *(Check and describe if abnormal or impaired)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Appearance/Grooming:* | | Unremarkable | | | | | | | | | | Remarkable for: | | | | | | | | | | | | | | | | | |
| *Behavior/Relatedness:* | | Unremarkable | | | | | | | | | | Motor Agitated | | | | | | | Inattentive | | | | Avoidant | | | | | | |
| Impulsive | | | | | | | | | | Motor Retarded | | | | | | | Hostile | | | | Suspicious/Guarded | | | | | | |
| Other: | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Speech:* | | Unremarkable | | | | | | | | | | Remarkable for: | | | | | | | | | | | | | | | | | |
| *Mood/Affect:* | | Unremarkable | | | | | | | | | | Depressed | | | | | | | Elated/Expansive | | | | Anxious | | | | | | |
| Labile | | | | | | | | | | Irritable/Angry | | | | | | | Other: | | | | | | | | | | |
| *Thought Processes:* | | Unremarkable | | | | | | | | | | Concrete | | | | | | | Distorted | | | | Disorganized | | | | | | |
| Odd/Idiosyncratic | | | | | | | | | | Blocking | | | | | | | Paucity of Content | | | | Circumstantial | | | | | | |
| Tangential | | | | | | | | | | Obsessive | | | | | | | Flight of Ideas | | | | Racing Thoughts | | | | | | |
| Loosening of Assoc | | | | | | | | | | Other: | | | | | | | | | | | | | | | | | |
| *Thought Content:* | | Unremarkable | | | | | | | | | | Hallucinations | | | | | | | Delusions | | | Ideas of Reference | | | | | | | |
| Other | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Perceptual Content:* | | Unremarkable | | | | | | | | | | Hallucinations | | | | | | | Homicidal Ideation | | | Paranoid Reference | | | | | | | |
| Flashbacks | | | | | | | | | | Depersonalization | | | | | | | Derealization | | | Dissociation | | | | | | | |
| Other: | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Fund of Knowledge:* | | Unremarkable | | | | | | | | | | Remarkable for: | | | | | | | | | | | | | | | | | |
| *Orientation:* | | Unremarkable | | | | | | | | | | Remarkable for: | | | | | | | | | | | | | | | | | |
| *Memory:* | | Unremarkable | | | | | | | | | | Impaired: | | | | | | | | | | | | | | | | | |
| *Intellect:* | | Unremarkable | | | | | | | | | | Remarkable for: | | | | | | | | | | | | | | | | | |
| *Insight/Judgment:* | | Unremarkable | | | | | | | | | | Remarkable for: | | | | | | | | | | | | | | | | | |
| ***REQUIRED:* Describe Mental Status Exam abnormal/impaired findings:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | Narrative continued in Addendum | | | | | | | | | | | | | | |
| **CIRCLE ALL TARGETED SYMPTOMS**  DEPRESSION (“Sigecaps”) MANIA (“DIGFAST”) PSYCHOSIS PANIC ATTACKS AUTISM SPECTRUM  Low/ irritable mood >2 weeks Grandiose Hallucinations/illusions Trembling Social deficits  Sleep Increased activity Delusions Palpitations Restrictive, repetitive  Interest goal-directed/high risk Self-reference: Nausea/chills patterns of Bx  Guilt/Worthlessness Decreased judgment people watching you Choking/chest pain  Energy Distractible talking about you Sweating  Concentration Irritability messages from media Fear:  Appetite/weight Need less sleep Thought blocking/Insertion Dying/going crazy  Psychomotor slowing Elevated mood Disorganization: anticipatory anxiety  Suicide: Speedy talking speech/behavior avoidance  hopelessness/plan/access Speedy thoughts agoraphobia  GENERALIZED ANXIETY OBSESSIVE-COMPULSIVE DISORDER PTSD  Excess worry Intrusive/persistent thoughts Experienced/witnessed event  Restless/edgy Recognized as excessive/irrational Persistent re-experiencing  Easily fatigued Repetitive behaviors: Dreams/flashbacks  Muscle tension washing/cleaning Avoidance behavior  ↓ sleep counting/checking Hyper-arousal:  ↓ concentration organizing/praying ↑ vigilance/↑ startle trauma reenactment in play  SOCIAL/ SPECIFIC PHOBIA OPPOSITIONAL DEFIANT DISORDER frightening dreams w/o recognizable content  Performance situations: Angry/irritable mood/ resentful  fear of embarrassment Argumentative/ actively defiant ADHD Inattention  fear of humiliation Deliberately annoys others Inattention  criticism Blames others for his/her behavior fails to complete work  Specific phobia: Vindictive at least 2x in past 6 months easily distracted  heights/crowds/animals loses necessary items  Hyperactivity/ Impulsivity  PANIC DISORDER EATING DISORDERS talks excessively/ blurts out  Anticipatory anxiety Binging/purging/restriction/amenorrhea fidgets/ can’t remain seated/  Panic attacks Perception of body image or weight acts as if driven by a motor | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **INDICATE ANY ADDITIONAL TARGETED SYMPTOMS NOT IDENTIFIED ABOVE:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | None | | Mild | | Mod | | | Severe | | | |  | | | | | | None | | | | Mild | | | Mod | | Severe |
| Cognition/Memory/Thought | | |  | |  | |  | | |  | | | | Perceptual Disturbance | | | | | |  | | | |  | | |  | |  |
| Attention/Impulsivity | | |  | |  | |  | | |  | | | | Oppositional/Conduct | | | | | |  | | | |  | | |  | |  |
| Socialization/Communication | | |  | |  | |  | | |  | | | | Destructive/Assaultive | | | | | |  | | | |  | | |  | |  |
| Depressive Symptoms | | |  | |  | |  | | |  | | | | Agitation/Lability | | | | | |  | | | |  | | |  | |  |
| Anxiety/phobia/Panic Attack | | |  | |  | |  | | |  | | | | Somatic Disturbance | | | | | |  | | | |  | | |  | |  |
| Affect Regulation | | |  | |  | |  | | |  | | | | Other: | | | | | |  | | | |  | | |  | |  |
| ***REQUIRED, describe Targeted Symptoms checked above:***  Narrative continued in Addendum | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **FUNCTIONAL IMPAIRMENTS:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | None | | Mild | | Mod | Severe | | | | | | |  | | | | | None | | | | | Mild | | Mod | Severe |
| Family Relations | | | |  | |  | |  |  | | | | | | | Substance Use/Abuse | | | | |  | | | |  | | |  |  |
| School Performance/Employment | | | |  | |  | |  |  | | | | | | | Activities of Daily Living | | | | |  | | | |  | | |  |  |
| Self-Care | | | |  | |  | |  |  | | | | | | | Episodes of decompensation & increase of symptoms, each of extended duration | | | | |  | | | |  | | |  |  |
| Food/Shelter | | | |  | |  | |  |  | | | | | | |
| Social/Peer Relations | | | |  | |  | |  |  | | | | | | | Other (Describe): | | | | |  | | | |  | | |  |  |
| Physical Health | | | |  | |  | |  |  | | | | | | | Narrative continued in Addendum | | | | | | | | | | | | | |
| ***REQUIRED, describe Impairments checked above:*** | | | | | | | | | | | | | | | |
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| **Impairment Criteria (must have one of the following):** | | | | | | | | | | | **AND:** | | | | | | **Intervention Criteria (proposed INTERVENTION will….):** | | | | | | | | | | | | |
|  | 1. Significant impairment in an important area of life function. | | | | | | | | | | | | **AND** | | | | | 1. Significantly diminish impairment | | | | | | | | | | | |
|  | 1. Probability of significant deterioration in an important area of functioning. | | | | | | | | | | | | **AND** | | | | | 1. Prevent significant deterioration in an important area of life functioning. | | | | | | | | | | | |
|  | 1. (Under 21) Without treatment will not progress developmentally as individually appropriate. | | | | | | | | | | | | **AND** | | | | | 1. (Under 21) Probably allow the child to progress developmentally as individually appropriate. | | | | | | | | | | | |
|  | 1. None of the above. | | | | | | | | | | | | **AND** | | | | | 1. None of the above | | | | | | | | | | | |

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| **DSM IV DIAGNOSIS—NOT BY HISTORY, MUST BE CURRENT DIAGNOSTIC FORMULATION** | | | | | | | | | | |
| **Axis I-III:** | **Code**  **DSM & ICD-10** | | | | **Description** | | | | | **Check ONE Primary below** |
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| Narrative continued in Addendum | | | | | | | | | | |
| **Axis IV** Psychological and Environmental Problems which may affect diagnosis, treatment, or prognosis. **Primary Problem#:**      . **Check ALL that apply:** | | | | | | | | | | |
| 1. Primary support group | | | 1. Social environment | | | 1. Education | 1. Occupational | | | |
| 1. Housing | | | 1. Economics | | | 1. Access to health care | 1. Involve with legal sys. | | | |
| 1. Other psychosocial/environmental | | | | | | 1. Inadequate information | | | | |
| **Axis V** | | Current GAF: | | Diagnosis est. by: | | | | | On date: | |
| **INITIAL PLAN (MEDICATION PRESCRIBED/LABS ORDERED/ETC.)** | | | | | | | | | | |
| ***My Signature below acknowledges having read and endorsed any prior MH Assessment referenced in this Psychiatric Assessment.***  Narrative continued in Addendum | | | | | | | | | | |
| |  |  | | --- | --- | | |  | | --- | | PRINT NAME OF MEDICAL PROVIDER COMPLETING PSYCHIATRIC MH ASSESSMENT | | | |  | | --- | | INDICATE M/C CREDENTIAL: MD, NP, etc. | | | | | | | | | | |  | | --- | | DATE: | | | |

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| |  | | --- | | SIGNATURE AND PRINTED NAME OF (if needed) SUPERVISOR | | |  | | --- | | DATE: | |
| |  | | --- | | INDICATE M/C CREDENTIAL: MD, NP, etc. | |  |

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| **ADDENDUM** |
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