|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| **PROVIDER** | **ADDRESS** | **PHONE** | **FAX** |
|  |  |  |  |
| **CLIENT LAST NAME** | **CLIENT FIRST NAME** | **MIDDLE NAME** | **SUFFIX (Sr., Jr.)** |
|  |  |  |
| **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:      |  |  |  |
|  |  |  |  |
| **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; etc[ ] Or, see attached MH Assessment dated: \_\_/\_\_/\_\_\_\_ **OR**  [ ] Also, see attached MH Assessment dated: \_\_/\_\_/\_\_\_\_ |
| [ ] Narrative continued in Addendum |
|  |
| **This Section for YOUTH ONLY < 18 YRS OLD** |  [ ] Or, see attached MH Assessment dated: \_\_/\_\_/\_\_\_\_ **OR**  [ ] Also, see attached MH Assessment dated: \_\_/\_\_/\_\_\_\_ |
|  |  |
| 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 | CurrentUse | CurrentAbuse | CurrentDependence | 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 |

|  |
| --- |
| **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 SPECTRUMLow/ 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 BxGuilt/Worthlessness Decreased judgment people watching you Choking/chest painEnergy Distractible talking about you Sweating Concentration Irritability messages from media Fear:Appetite/weight Need less sleep Thought blocking/Insertion Dying/going crazyPsychomotor slowing Elevated mood Disorganization: anticipatory anxietySuicide: Speedy talking speech/behavior avoidance  hopelessness/plan/access Speedy thoughts agoraphobiaGENERALIZED ANXIETY OBSESSIVE-COMPULSIVE DISORDER PTSDExcess worry Intrusive/persistent thoughts Experienced/witnessed eventRestless/edgy Recognized as excessive/irrational Persistent re-experiencingEasily 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 workSpecific 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:*** |
|  |  |  |  |  |
|  |
| **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
 |

|  |
| --- |
| **DSM IV DIAGNOSIS—NOT BY HISTORY, MUST BE CURRENT DIAGNOSTIC FORMULATION**  |
| **Axis I-III:** | **Code****DSM & ICD-10** | **Description** | **Check ONE Primary below** |
|  |  | [ ]  |
|  |  | [ ]  |
|  |  | [ ]  |
|  |  | [ ]  |
| [ ] 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: |

 |

|  |  |  |  |
| --- | --- | --- | --- |
|

|  |
| --- |
| SIGNATURE AND PRINTED NAME OF (if needed) SUPERVISOR |

 |

|  |
| --- |
| DATE: |

 |
|

|  |
| --- |
| INDICATE M/C CREDENTIAL: MD, NP, etc. |

 |  |

|  |
| --- |
| **ADDENDUM** |
|  |