PSYCHIATRIC MH ASSESSMENT

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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 ☐Female ☐Intersex ☐ Gender Queer Transgender: ☐Male to Female ☐Female to Male ☐Declined to State Other: ☐ Other

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:		

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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:	Weight:	Height:	Sitting BP:	Standing BP:	Supine BP:	Temp:
Respiration:	General Appearance:					

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. ____________________

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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									
	AGE AT FIRST USE	**CURRENT SUBSTANCE USE/DEPENDENCE/ABUSE**							
SUBSTANCE EXPOSURE (**indicate if ever used**)		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 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:			

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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")
Low/ irritable mood >2 weeks
Sleep
Interest
Guilt/Worthlessness
Energy
Concentration
Appetite/weight
Psychomotor slowing
Suicide:
hopelessness/plan/access

MANIA ("DIGFAST")
Grandiose
Increased activity
goal-directed/high risk
Decreased judgment
Distractible
Irritability
Need less sleep
Elevated mood
Speedy talking
Speedy thoughts

PSYCHOSIS
Hallucinations/illusions
Delusions
Self-reference:
people watching you
talking about you
messages from media
Thought blocking/Insertion
Disorganization:
speech/behavior

PANIC ATTACKS
Trembling
Palpitations
Nausea/chills
Choking/chest pain
Sweating
Fear:
Dying/going crazy
anticipatory anxiety
avoidance
agoraphobia

AUTISM SPECTRUM
Social deficits
Restrictive, repetitive
patterns of Bx

GENERALIZED ANXIETY
Excess worry
Restless/edgy
Easily fatigued
Muscle tension
↓ sleep
↓ concentration

SOCIAL/ SPECIFIC PHOBIA
Performance situations:
fear of embarrassment
fear of humiliation
criticism
Specific phobia:
heights/crowds/animals

PANIC DISORDER
Anticipatory anxiety
Panic attacks

OBSESSIVE-COMPULSIVE DISORDER
Intrusive/persistent thoughts
Recognized as excessive/irrational
Repetitive behaviors:
washing/cleaning
counting/checking
organizing/praying

OPPOSITIONAL DEFIANT DISORDER
Angry/irritable mood/ resentful
Argumentative/ actively defiant
Deliberately annoys others
Blames others for his/her behavior
Vindictive at least 2x in past 6 months

EATING DISORDERS
Binging/purging/restriction/amenorrhea
Perception of body image or weight

PTSD
Experienced/witnessed event
Persistent re-experiencing
Dreams/flashbacks
Avoidance behavior
Hyper-arousal:
↑ vigilance/↑ startle
trauma reenactment in play
frightening dreams w/o recognizable content

ADHD Inattention
Inattention
fails to complete work
easily distracted
loses necessary items
Hyperactivity/ Impulsivity
talks excessively/ blurts out
fidgets/ can't remain seated/
acts as if driven by a motor

INDICATE ANY ADDITIONAL TARGETED SYMPTOMS NOT IDENTIFIED ABOVE:

	None	Mild	Mod	Severe
Cognition/Memory/Thought	☐	☐	☐	☐
Attention/Impulsivity	☐	☐	☐	☐
Socialization/Communication	☐	☐	☐	☐
Depressive Symptoms	☐	☐	☐	☐
Anxiety/phobia/Panic Attack	☐	☐	☐	☐
Affect Regulation	☐	☐	☐	☐
Perceptual Disturbance	☐	☐	☐	☐
Oppositional/Conduct	☐	☐	☐	☐
Destructive/Assaultive	☐	☐	☐	☐
Agitation/Lability	☐	☐	☐	☐
Somatic Disturbance	☐	☐	☐	☐
Other:	☐	☐	☐	☐

REQUIRED, describe Targeted Symptoms checked above:

☐Narrative continued in Addendum

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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	☐	☐	☐	☐					

***REQUIRED*, describe Impairments checked above:**

☐Narrative continued in Addendum

	Impairment Criteria (must have one of the following):	AND:	Intervention Criteria (proposed INTERVENTION will….):
☐	A. Significant impairment in an important area of life function.	**AND**	A. Significantly diminish impairment
☐	B. Probability of significant deterioration in an important area of functioning.	**AND**	B. Prevent significant deterioration in an important area of life functioning.
☐	C. (Under 21) Without treatment will not progress developmentally as individually appropriate.	**AND**	C. (Under 21) Probably allow the child to progress developmentally as individually appropriate.
☐	D. None of the above.	**AND**	D. 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
2. ☐ Social environment
3. ☐ Education
4. ☐ Occupational
5. ☐ Housing
6. ☐ Economics
7. ☐ Access to health care
8. ☐ Involve with legal sys.
9. ☐ Other psychosocial/environmental
10. ☐ 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 INDICATE M/C CREDENTIAL: MD, NP, etc.	DATE:

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ADDENDUM