Mental Health Assessment Form

Client Name: _____ **Medicaid ID#:** _____

Date of Birth:			
Address:			
City, State, Zip:			
Parent/Guardian (if applicable)**:**			
Primary Phone #:			
Name of Emergency Contact (EC):			
Relationship to EC:			
Emergency Contact Phone #:			
Referral Source:			
Cultural and Linguistic Factors:			
Race:	**Ethnicity:**	**Language:**	
☐Black or African American ☐Asian ☐White ☐Native Hawaiian or Other Pacific Islander ☐American Indian or Alaska Native	☐Other Hispanic/Latino ☐Not Hispanic/Latino	☐English ☐Spanish ☐Other (*specify*):	
Date of Service:		**Time of Service:**	
Duration of Service:			

Presenting Concern/Chief Complaint (include symptoms, intensity and duration):

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Interpersonal/Family Relationships:	
Assessment of Strengths (check all that apply):	
☐Supportive Family, Friends, etc ☐Attendance to 12 Step Meetings ☐Effective Financial Management Skills ☐Maturity ☐Intelligence ☐Effective Communication Skills ☐Assertive ☐Open Minded ☐Honesty ☐Determination ☐Resiliency ☐Self-Confidence/Good Self-Esteem ☐Patience ☐Strong Religious Connection ☐Hopefulness ☐Stable Employment ☐Effective Coping Skills	☐Other (*please specify*):

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Mental Status Exam:			
General Appearance: ☐Normal ☐Disheveled ☐Emaciated ☐Obese ☐Poor Hygiene ☐Other: **Motor Activity:** ☐Normal ☐Agitation ☐Decrease Amount ☐Increased Amount ☐Peculiar Posturing ☐Repetitive Actions ☐Tics ☐Tremors ☐Unusual Gait ☐Other: **Judgment:** ☐Good ☐Fair ☐Poor **Memory:** ☐Intact ☐Confabulation ☐Poor Distant ☐Poor Recent ☐Other: **Concentration/ Attention:** ☐Good ☐Distractible ☐Variable ☐Other:	**Dress:** ☐Appropriate Attire ☐Eccentric ☐Seductive ☐Other: **Insight:** ☐Good ☐Fair ☐Poor **Cognitive Ability:** ☐Intact ☐Impaired ☐Retarded **Speech:** ☐Normal ☐Hesitant ☐Pressured ☐Slurred ☐Soft ☐Stuttering ☐Tense ☐Verbose ☐Other: **Sensorium/Orientation:** ☐Orientated X3 ☐Orientated X2 ☐Orientated X1 ☐Orientated X0 Specify:	**Flow of Thought:** ☐Normal ☐Blocking ☐Circumstantial ☐Flight of Ideas ☐Loose Associations ☐Perseveration ☐Tangential **Affect/Mood:** ☐Appropriate ☐Anxious ☐Blunted ☐Constricted ☐Depressed/Flat ☐Euphoric ☐Irritable ☐Labile ☐Other: **Daily Patterns:** ☐Normal Sleep ☐Poor Sleep Quality ☐Decreased Sleep Quality ☐Increased Sleep ☐Nightmares ☐Fatigue ☐Increased Sex Drive ☐Decreased Sex Drive ☐Social Withdrawal ☐Normal Appetite ☐Decreased Appetite ☐Increase Appetite ☐Binging ☐Purging ☐Decreased Work Performance	**Content of Thought:** ☐Normal ☐Delusions ☐Excessive Religiosity ☐Guilt Focused ☐Hallucinations ☐Hopelessness ☐Impaired Reality ☐Obsessions ☐Paranoia ☐Sexual Preoccupation ☐Somatic Preoccupations ☐Worthlessness ☐Other: **Interview Behavior:** ☐Appropriate ☐Aggressive ☐Angry ☐Apathetic ☐Argumentative ☐Callous ☐Childish/Silly ☐Cooperative ☐Demanding ☐Dramatic ☐Evasive ☐Hostile ☐Impulsive ☐Irritable ☐Manipulative ☐Naïve ☐Negativistic ☐Passive ☐Sensitive ☐Uncooperative ☐Withdrawn

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Alcohol/Drug Assessment:					
Substance	**Age of 1st Use**	**Years of Continuous Use**	**Days Use in Last 30 Days**	**Frequency**	**Method (i.e. – oral, nasal, etc)**
Tobacco					
Alcohol					
Crack/Cocaine					
Marijuana					
Heroin					
Oxycodon/Oxycotin					
Percocet/Percodan					
PCP					
Benzodiazepines					
Other (*specify*):					

Prior Substance Use Treatment History:		
Detox History: Facility	**Dates of Service:**	**Disposition/Client Compliance:**
Residential/Rehab History: Facility	**Dates of Service:**	**Disposition/Client Compliance:**
OP/IOP/PHP History: Facility	**Dates of Service:**	**Disposition/Client Compliance:**

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Mental Health/Risk Assessment:		
Previous Psychiatric Diagnoses (by a medical professional):		
Condition (check all that apply):		
☐Depression ☐Anxiety Disorder ☐Panic Disorder ☐Bipolar Disorder	☐PTSD ☐Phobia (specify): ☐Schizophrenia ☐Attention Disorder	☐Other:

Symptomatology (check all that apply):				
Symptom	**Never**	**Current**	**Ever**	**If Ever, when was the symptom last experienced:**
Suicide Attempt	☐	☐	☐	
Suicidal Plan	☐	☐	☐	
Suicidal Ideation	☐	☐	☐	
Impaired Thinking	☐	☐	☐	
Homicidal Ideation	☐	☐	☐	
Violent outbursts/aggression	☐	☐	☐	
Hopelessness	☐	☐	☐	
Depression	☐	☐	☐	
Obsessive Thoughts	☐	☐	☐	
Compulsive Behavior	☐	☐	☐	
Panic Attacks	☐	☐	☐	
Hallucinations	☐	☐	☐	**Specify type (i.e. – audio, visual)**
Anxiety	☐	☐	☐	
Flashbacks	☐	☐	☐	
Paranoia	☐	☐	☐	
Binging/Purging	☐	☐	☐	
Other (*specify*)	☐	☐	☐	

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If "current" or "ever" was checked off above for suicidal ideation, suicidal plan, suicidal attempt and/or homicidal ideation, please complete the following:			
Check all that apply regarding past suicide:	☐Ideation	☐Plan	☐Attempt
Please describe the events as follow:	What were the precipitating factors that led to the event?	What were the stressors that led to the event?	What were the interpersonal triggers that led to the event?
What helped in the past that could help alleviate and/or prohibit these symptoms from re-occurring?			
What changes in current treatment could help to manage/support the member in avoiding engagement in such behaviors in the future?			
Do you have access to weapons by which to harm yourself?	☐Yes ☐No		
If Yes, please specify:			
What are your current protective factors?			
Internal (i.e. – ability to cope, tolerance, etc)	**External (i.e. – responsibility to children, etc)**		

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If homicidal thoughts were identified above "ever" or "current", please complete the following:			
Who was the identified target?		**Notified/Duty to warn?**	
Past assault/legal history?	☐Yes	☐ No	
If yes, please specify			
Access to weapons/plan/intent?	☐Yes	☐ No	
If yes, please specify:			
Psychotic disorder?	☐Yes	☐ No	
If yes, please specify:			
TBI?	☐Yes	☐ No	
Cluster B Traits/Conduct?	☐Yes	☐ No	
Substance use?	☐Yes (*if yes, refer to AOD sxn*)	☐ No	
Are you currently taking any psychiatric medications?	☐Yes	☐No	

Current Psychiatric Medications	**Dosage & Frequency**	**Route of Administration**	**Prescribing Physician**

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Overall Risk Level (*based on clinical judgment*):	☐High	☐Medium	☐Low
In the space below, please specify the Crisis Plan. If a Crisis Plan is not needed, please write "Not Applicable" or "NA"			
Do you have any grave disabilities (GD)?	☐Yes ☐No		
If yes, what medical concerns are directly related to the GD?			
What level of support is needed to complete ADLs?			
Able to have this level at home through supports?	☐Yes ☐No (*if no, why?*)		

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Do you have any current medical conditions?		☐Yes ☐No	
If yes, please specify below:			
Present medical conditions:			
Medical history (*please specify any past medical conditions i.e. – cancer, etc*):			
Are you on any medications for the above noted medical conditions?		☐Yes ☐No	
If yes, please specify below:			
Current medications for medical conditions	**Dosage & Frequency**	**Route of Administration**	**Prescribe Physician**
Do you have any allergies?		☐Yes ☐No	
If Yes, please specify below:			

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Social History:	
Early Childhood Development:	
Current Psychosocial Situation:	
Abuse History (i.e. – physical, emotional, sexual)	
Crime Victimization:	

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Social History (cont'd):	
Family History of Mental Illness/Drug use:	
Educational History:	
Current Occupational Assessment:	
Military History:	
Legal Status:	

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Diagnostic Impressions:		
Primary	**Code:**	
	Description:	
	Rationale/ICD10:	
Secondary	**Code:**	
	Description:	
	Rationale/ICD10:	
Tertiary	**Code:**	
	Description:	
	Rationale/ICD10:	
Other	**Code:**	
	Description:	
	Rationale/ICD10:	
Disposition Plan:		
Clinical Impressions:		
Referred to/Recommendations:		
Additional Referrals/Recommendations:		

Signatures:		**Date**
Clinician Name and Credentials (printed):		
Clinician Signature:		