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|------------|----------------------|---------------------------|-------------------|------------------------|----------------------------|-----------------|
| 1 - Office | 4 - Home | 8 - Correctional Facility | 11 - Faith-based | 14 - Client's Job Site | 17 - Non-Traditional | 20 - Telehealth |
| 2 - Field | 5 - School | 9 - Inpatient | 12 - Health Care | 15 - Adult Residential | 18 - Other | 21 - Unknown |
| 3 - Phone | 6 - Satellite Clinic | 10 - Homeless | 13 - Age-Specific | 16 - Mobile Service | 19 - Childrens Residential | |

DATE: _____ BILLING TIME: _____ LOCATION: _____ SERVICE TYPE: ASSESSMENT

(If all parts are completed by the same person, all billing may be done above on this page.)
 ALL ITEMS BELOW MUST BE COMPLETED (EVEN WITH N/A OR "NOT AVAILABLE"). THE ASSESSMENT SHOULD ILLUSTRATE ALL MEDICAL NECESSITY PRESENT AND PROVIDE THE BASIS FOR THE DSM-4 DIAGNOSIS.

(PART 1) TRIAGE/SCREENING

Age: _____ Gender: M F Marital Status: S M D W Sep Lives In/With _____

Person Giving Tx Consent: Self _____ Referral Source: _____

PRESENTING PROBLEM/HISTORY OF CURRENT PROBLEMS (Include significant problems with regard to daily living, such as with responsibilities, social relations, living arrangement, and health. Include cultural explanations of problems if these are important to client.)

Previous Inpatient and Outpatient Mental Health Tx (include dates, providers, diagnosis, results, and when most recent meds taken):

Previous inpt tx: None _____

Previous outpt tx: None _____

Most Recent Psychotropic Meds and When: Never _____

Previous Suicide / Homicide History

Suicide Attempts: None _____

Previous Homicide None _____

Substance Problems (describe past and present use of tobacco, alcohol, caffeine, drugs, and medicines)

Substances used: None _____

Time of last use: Never used _____

Age when first used: N/A _____

Frequency and quantity of use: N/A _____

Use of drugs intravenously: Never Not currently _____

Hx of withdrawal symptoms (sick, shaky, depressed, etc.): None _____

Hx of tolerance (use of more of the substance to get same effect): Never _____

Unsuccessful efforts to cut down or stop: None Never tried N/A _____

Problems with family or friends because of substance use: None _____

Legal problems related to substance use: Never _____

Hx of substance tx: None _____

ADULT CLINICAL ASSESSMENT

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Current Health Problems: None _____

Current Health Conditions Placing Client at Special Risk: None _____

Currently Pregnant? Yes No _____

Allergies to Medicines or Other Substances: None _____

Other Agencies/Providers Client is Involved With: None _____

(CLINICAL MASTERS LEVEL OR ABOVE ONLY)

Risk For Abuse And/Or Victimization: Non-significant _____

Current Suicide, Homicide, Assaultive Behavior and Other Risks: None noted _____

INITIAL INDICATIONS OF DYSFUNCTION (consider work, school, home, peer, family, parenting, self-care, etc): None _____

ADDITIONAL ASSESSMENT ISSUES (including reasons for NOA, if issued): None _____

DISPOSITION: List actions taken, recommendations, and referrals made (mental health tx, drug/alcohol tx, community resources, medical care, etc). Include preferred language for services and provider gender and ethnicity if these are important to client: _____

SIGNATURE _____

PRINTED NAME _____

DATE _____

SIGNATURE _____

PRINTED NAME _____

DATE _____

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(PART 2) ADDITIONAL CLINICAL ASSESSMENT

Education (yrs): _____

Current and Past Meds (include over-the-counter, non-traditional - herbs, etc.) (include dosage if known): _____

Past: None _____

Current: None _____

Culture-related Healing Practices Used: _____

Past and Present Employment: Never employed _____

Developmental Information (optional for adults):

Develop. History/Develop. Milestones No unusual prenatal events Perinatal dev. within usual limits

Past and Current Arrests and Legal Problems: None _____

Sleep Problems: None _____

Eating Problems: None _____

Importance of Religion/Spirituality For Client Not important _____

Culture/Diversity: Assess unique aspects of the client, including culture, background, and sexual orientation, that are important for understanding and engaging the client and for care planning.

Preferred language for receiving our services _____ (If **not** English, complete all items in this section.)

Nature of services and staff assigned will need to be significantly culturally-related: Yes No How? _____ (If "yes", complete all items in this section.)

(If the above two items are answered "English" and "No", respectively, the remainder of this section is optional.)

Family's country of origin _____

No. of yrs. client and parents have been in this country: Client: All his/her life _____ Parents: All their lives _____

Culture client most identifies with _____

Problems client has had because of his/her cultural background: None _____

Additional cultural/diversity assessment (optional): None _____

Sexual Orientation Issues: None _____

Support/Involvement of Family in Client's Life: _____

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Desire of Client for Involvement of Family or Others in Tx: Desires _____

Client Strengths _____

Client Motives For Services / What Does Client Really Want From Services? _____

Why Is Client Coming For Help Now? _____

MENTAL STATUS (CLINICAL MASTERS LEVEL OR ABOVE ONLY)

(Consider what is within normal limits for the client's culture and background)

Appearance/Behavior: _____

Orientation: Oriented to Person Place Time Situation _____

Speech _____

Intellectual Functioning Estimate: Above avg. Average Below avg. M.R. _____

Memory: No problems _____

Thought Processes _____

Other Cognitive Deficits: None noted _____

Thought Content/Delusions: No problem _____

Perceptual Processes/Hallucinations: No problem _____

Insight _____

Judgment _____

Mood _____

Affect _____

ADDITIONAL ASSESSMENT ISSUES (including special needs with respect to receiving services and reasons for NOA, if issued): None _____

DYSFUNCTION REQUIRING TREATMENT (consider work, school, home, peer, family, parenting, self-care, etc): None
 Same as Part 1 _____

DISPOSITION List actions taken, recommendations, and referrals made (mental health tx, drug/alcohol tx, community resources, medical care, etc.). Include preferred language for services and provider gender and ethnicity if these are important to client Same as Part 1 _____

Formulation / Explanation of Problems (optional) _____

(All staff participating sign below.) (Outlines for more extensive assessments of cultural issues, sexual orientation/gender issues, assaultive behavior, and firesetting are available. Such assessments should be attached to this form.)

SIGNATURE _____ PRINTED NAME _____

DATE _____

SIGNATURE _____ PRINTED NAME _____

DATE _____

ADULT CLINICAL ASSESSMENT

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