Date: _____ Service: _____ Time: _____ Location _____ Preferred Language_____

Presenting Problems – *(Please provide specific symptoms by doing brief MSE and indicate onset. Include MHS 140 analysis)*

Indications of Dysfunction Due to Mental Illness Requiring DBH Treatment

Health/Self-Care ☐ No impairment reported

☐ Impairment/s =

Occupation ☐ No impairment reported

☐ Impairment/s =

Legal ☐ No impairment reported

☐ Impairment/s =

Financial ☐ No impairment reported

☐ Impairment/s =

Interpersonal ☐ No impairment reported

☐ Impairment/s =

Assessment of Risk (Clinical Masters Level Or Above Only) ☐ At risk without intervention

Danger to Self:	☐ None	☐ Ideation	☐ Plan	☐ Intent w/o means	☐ Intent w/ means
Danger to Others:	☐ None	☐ Ideation	☐ Plan	☐ Intent w/o means	☐ Intent w/ means ☐ identifiable victim/ victims (Tarasoff)
Grave Disability:	☐ No ☐ Yes	As evidenced by:			
Suicide HX:	☐ No ☐ Yes	Describe if yes			
Homicide HX:	☐ No ☐ Yes	Describe if yes			

Assessment of Risk (continued)

Substance Use ☐ Substance abuse ☐substance dependence ☐ Alcohol ☐Tobacco ☐ Caffeine ☐ none

Indicate concise specifier: ☐ None ☐ Sober <1 month ☐Sober 1-3 months ☐Sober 3-6 months ☐Sober >6 months

List any substances used within the last month, duration of use, amount, and the last time used

Medications – *List any medications currently being taken, duration of use, the last time taken, and supply on hand (Include over the counter, non-traditional-herbs, etc, and dosages if known)*

Current /Past Medication	Medication	Dosage	Duration of Use	Supply on Hand	Prescribed by or OTC, etc.
☐ Current ☐ Past					
☐ Current ☐ Past					
☐ Current ☐ Past					
☐ Current ☐ Past					
☐ Current ☐ Past					
☐ Current ☐ Past					
☐ Current ☐ Past					

Diagnosis: (see diagnosis sheet for full ICD-10-CM diagnosis)

Disposition: *Referrals:* *Intake scheduled date:*

CASE STATUS: ☐ Case opened ☐ Hospitalization ☐ NOA Issued ☐ Community Referral ☐ No Tx Required ☐ Homeless program

Rationale for NOA (Medi-Cal Only):

Signature _____ Print Name _____ Date _____

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

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

Person Giving Tx Consent: ☐ **Self** _____ **Referral Source:** ☐ _____

Previous inpt tx: ☐ **None** _____

Previous outpt tx: ☐ **None** _____

Current Health Conditions Placing Client at Special Risk: ☐ **None** _____

Currently Pregnant ☐**Yes** ☐**No** _____

Allergies to Medicines or Other Substances: ☐**None** _____

Sleep Problems: ☐ **None** _____

Eating Problems: ☐ **None** _____

Other Agencies/Providers Client is Involved With: ☐ **None** _____

Past and Present Employment: ☐ **Never employed** _____

Past and Current Arrests and Legal Problems: ☐ **None** _____

Education (yrs): _____

Culture-related Healing Practices Used: ☐ _____

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** _____

_____

Sexual Orientation Issues: ☐ **None** _____

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

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 ☐ **WNL** _____

Intellectual Functioning Estimate: ☐ **Above avg.** ☐ **Average** ☐ **Below avg.** _____

Memory: ☐ **No problems noted** _____

Thought Processes ☐ **No problems noted** _____

Cognition/Attention: ☐ **No problems noted** _____

Thought Content/Delusions: ☐ **None noted** _____

Perceptual Processes/Hallucinations: ☐ **None noted** _____

Insight _____

Judgment _____

Mood _____

Affect _____

DISPOSITION List actions taken, recommendations, and referrals made (mental health tx, drug/alcohol tx, community resources, medical care, etc.). Include _____

_____

_____

_____

Signature _____ **Print Name** _____ **Date** _____

Signature _____ **Print Name** _____ **Date** _____

ADULT CLINICAL ASSESSMENT (A-2) San Bernardino County DEPARTMENT OF BEHAVIORAL HEALTH Confidential Patient Information See W&I Code 5328	NAME: CHART NO.: DOB: PROGRAM:

ASSESSMENT ADDENDUM

Update entries may be made here of important background information or other assessment information about changes in the client's circumstances discovered during the course of services. All entries will be dated and signed as a regular chart note. If an interview takes place, it may be charted here and billed by adding the MHS-Assess. heading, the billing time, and the location code.

ADULT CLINICAL ASSESSMENT (A-2) San Bernardino County DEPARTMENT OF BEHAVIORAL HEALTH Confidential Patient Information See W&I Code 5328	NAME: CHART NO.: DOB: PROGRAM: