# Initial Clinical Assessment – Clients age 21 and Over

NAME / MRN ______________________

## Billing Information

Program Name: ______________________________________ Fac/Prog: _____________ Date: ________________

Staff #: _________________ Hours: __________ Min(s): __________ Code Activity ☐ **331** Assessment ☐ **580** Lockout

*Is Client Pregnant?* ☐ **Yes** ☐ **No** *Travel Time To/From included in above (if applicable) Hrs ______ Mins ______*

**Location of Services:** (Please check one)

| | | | | |
|---|---|---|---|---|
| ☐ Office | ☐ School | ☐ Faith-Based | ☐ LicCommCarefac (adult) | ☐ Telehealth – Pt Home |
| ☐ Field | ☐ Cor Fac | ☐ Healthcare | ☐ Mobile Service | ☐ Telehealth – Other than Pt Home |
| ☐ Phone | ☐ Inpatient | ☐ Age-spec Com ctr | ☐ Non Trad Svc Loc | ☐ Other ______________________ |
| ☐ Home | ☐ Homeless/shelter | ☐ Client's job site | ☐ Res Tx Ctr (child) | ☐ Unknown |

**Service Strategies:** (Please check up to three, if applicable)

| | | | |
|---|---|---|---|
| ☐ 50 Peer/Fam Deliv Svcs | ☐ 53 Supportive Education | ☐ 56 Ptnrshp: Soc Svcs | ☐ 59 Integrated Svcs: MH-Dvlp Disabled |
| ☐ 51 Psych Education | ☐ 54 Prtnrshp: Law Enfcmt | ☐ 57 Ptnrshp: Subs Abuse | ☐ 60 Ethnic-Specific Service Strategy |
| ☐ 52 Family Support | ☐ 55 Ptnrshp: Health Care | ☐ 58 IntSvcs : MH / Aging | ☐ 61 Age-Spec Svc Strategy ☐ 99 Unknown |

Referred By: ____________________________________________________

**Identifying Information:**

Legal Name: ______________________________________________ Age: _____ DOB: ________________

Preferred Name: ______________________________________________________________________

Gender: ☐ Male ☐ Female ☐ Transgender F-M ☐ Transgender M-F ☐ Intersex ☐ Other ________________

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Widowed

Address: ______________________________________________________________________

Phone #: ____________________________

Emergency Contact: ______________________________ ______________________________
Name Phone number

**Language:**

Primary Language:________________________ Other Languages spoken in home:______________________________________

☐ Interpreter Name of Interpreter: ____________________________________________

Language service provided in other than English: ☐ Spanish ☐ Other ______________________

**Client Information:**

Entitlements: ☐ M/C ☐ Medicare ☐ BHC ☐ Other Health Care Info ___________________________
☐ No Health Insurance Coverage
☐ SSI ☐ SSDI Payee: ___________________________________

Monthly Income _____________ Refer to a Financial Counselor? ☐ Yes ☐ No

Living Situation: ☐ Independent Living ☐ Immediate Family ☐ Extended Family ☐ Shared Housing
☐ Board & Care ☐ Residential Care Facility ☐ **Homeless** ☐ Other

Support System Contacts: ______________________________________________________________

Other Agencies Involved: ☐ CC Provider Network ☐ CFS/APS ☐ Voc Services
☐ AOD ☐ Regional Center ☐ Homeless Services
☐ Other ___________________________

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**Presenting Problem:** (What is the primary reason for current referral? Describe current precipitating event, primary stressors, primary symptoms and functional impairment.) ***Continue on Page 9 if needed.***

**Relevant Family/Social History:** (Summarize relevant data regarding significant interpersonal relationships, including parents and marital status, children, siblings, living situations, education, work, history, military history, current support system, family history of mental illness or substance abuse and major traumatic events/losses, adverse childhood experiences.)

**CHECK THIS BOX IF CLIENT IS HOMELESS** ☐

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**Treatment History: (Check all appropriate and comment below.)**

☐ Yes ☐ No Previous outpatient mental health services? Where/When? ☐ Transfer

______________________________________________________________________

☐ Obtain Release of Information for records from above (as needed)
☐ Yes ☐ No Previous crisis contact?
Number of crisis unit visits without hospitalization in past 6 months ☐ 0 ☐ 1 ☐ 2 or more
Most recent date: ________________________________

☐ Yes ☐ No Previous psychiatric hospitalization(s)? #: __________ Most recent date: ________________

☐ Yes ☐ No Previous residential treatment? Name of Program _________________________ Length of Stay: __________
☐ Yes ☐ No Previous day treatment/partial hospitalization program? Name of Program _________________________ Length of Stay: __________

☐ Yes ☐ No Use of nontraditional or alternative healing practices? If yes, list:

**Risk Assessment:**
Danger to self (Intent, Plan Means): ______________________________________________

Past: ______________________________________________________________

Danger to others (Intent, Plan Means): ____________________________________________

Past: ______________________________________________________________

Grave Disability (Unable to make use of available Resources: ____________________________

☐ 5150 Initiated ☐ CPS Referral/Involvement ☐ APS Referral ☐ Tarasoff

Additional Risk Factors: Check all that apply. Document details.

☐ Family History of Suicide
☐ History of Domestic Violence
☐ Sexual Abuse
☐ Adverse Childhood
☐ Trauma or Loss in Family
☐ Physical Abuse/Emotional Abuse
☐ Inappropriate Sexualized Behavior
☐ Impulsivity/Threatening Behavior
☐ Other

☐ Animal Cruelty
☐ Fire Setting
☐ Emotional/Physical Neglect
☐ Substance Abuse
☐ Self-Injurious Behavior
☐ Access to Firearms (family, friends)
☐ Behavior Influenced by Delusions or Hallucinations
☐ Severe Hopelessness

Comments:

NAME / MRN

**Medical History:** ☐ Not available

Current Primary Medical Care Provider ______________________________________ ☐ None ☐ Unknown

Last Physical Exam: ☐ Within Past 12 months ☐ NOT within past 12 months ☐ Unknown

Last Dental Exam: ☐ Within Past 12 months ☐ NOT within past 12 months ☐ Unknown

Are there any health concerns (medical illness, medical symptoms)? ☐ No ☐ Yes (If so, please describe)

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Has client had ANY allergic/serious reactions to medication(s)? ☐ No ☐ Yes (If so, please describe)

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Does client have any NON medication allergies (Food, pollen, bee strings, etc.)? ☐ No ☐ Yes (If so, please describe)

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List name of any medication(s) client is taking at this time. (List all current medications including Psychiatric, OTC, herbal and homeopathic. Include Start date/Dose/Frequency.) ☐ No ☐ Yes (If so, please describe)

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Compliance issues? ☐ No ☐ Yes (If so, please describe)

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☐ Referral to Health Care Provider for further evaluation/assessment

NAME / MRN ____________________

**Criminal Justice History:**

☐ Probation ☐ Parole ☐ None

Probation/Parole Officer Contact: ____________________ ☐ Obtain Release (ROI)

Offense History (include jail/prison facility):

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**Substance Use:**
During the past 6 months:
1. Have you ever used alcohol or drugs (such as wine, beer, hard liquor, pot, coke, heroin, or other opiods, upper, downers, hallucinations, or inhalants)? ☐ Yes ☐ No

Check all substances that apply in the last 6 months:

| | FREQUENCY | | FREQUENCY |
|---|---|---|---|
| ☐ ALCOHOL | ________ | ☐ DESIGNER DRUGS (GHB, PCP, Ectasy) | ________ |
| ☐ AMPHETAMINE | ________ | ☐ INHALANTS (Paint, Gas, Aerosols) | ________ |
| ☐ COCAINE/CRACK | ________ | ☐ MARIJUANA | ________ |
| ☐ OPIATES (Heroin, Opium, Methadone) | ________ | ☐ TOBACCO | ________ |
| ☐ HALLUCINOGENS (LSD, Mushrooms, Peyote) | ________ | ☐ CAFFEINE (Energy Drinks, Sodas, Coffee, etc.) | ________ |
| ☐ PAIN KILLERS (Oxy, Norco, Vicodin) | ________ | ☐ OVER THE COUNTER ________ | ________ |

☐ Other ____________________

Has alcohol or drugs ever been a problem in your life? ☐ Yes ☐ No (If no, skip questions 2 – 9)

Frequency of use ____________________

2. Have you felt that you use too much alcohol or drugs? ☐ Yes ☐ No
3. Have you tried to cut down or quit drinking or using alcohol or drugs? ☐ Yes ☐ No
4. Have you gone to anyone for help because of your drinking or drug use (such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program)? ☐ Yes ☐ No
5. Have you had any of the following due to substance use?

| | |
|---|---|
| ☐ Had blackouts or other periods of memory loss? | ☐ Felt sick, shaky, or depressed? |
| ☐ Injured your head after drinking or using drugs? | ☐ Felt “coke bugs” or a crawling feeling under the skin? |
| ☐ Had convulsions or delirium tremens (“DTs”)? | ☐ Been injured after drinking or using drugs? |
| ☐ Had Hepatitis or other liver problems? | ☐ Used needles to shoot drugs? |

6. Has drinking or drug use caused problems between you and your family or friends? ☐ Yes ☐ No
7. Has your drinking or drug use caused problems at school or at work? ☐ Yes ☐ No
8. Have you been arrested or had other legal problems due to substance use (such as bouncing bad checks, driving while intoxicated, theft, or drug possession? ☐ Yes ☐ No

Describe:

NAME / MRN

9. Have you lost your temper or gotten into arguments or fights while drinking or using drugs? ☐ Yes ☐ No
10. Are you needing to drink more and more to get the effect you want? ☐ Yes ☐ No
11. Do you spend a lot of time thinking or trying to get the effect you want? ☐ Yes ☐ No
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone? ☐ Yes ☐ No
13. Do you feel bad or guilty about your drinking or drug use? ☐ Yes ☐ No
14. Have any of your family members ever had a drinking or drug problem? ☐ Yes ☐ No
15. Do you feel that you have a drinking or drug problem now? ☐ Yes ☐ No
16. What contributing factors/triggers do you have to drug/alcohol abuse?

17. Clean & Sober _______ Month(s) _______ Year(s)
    What has been most helpful to you in maintaining sobriety?

18. Are you currently or have you ever been in recovery?

19. What recovery models have you used?

Comments:

NAME / MRN ______________________

**Mental Status:**

| General (appearance, attitude, behavior, speech): |
|---|
| Orientation: |
| Mood/Affect: |
| Thought Process: |
| Memory/Thought Content: |
| Insight/Judgment/Impulsivity: |
| Additional Observation(s): |

**Diagnostic Impression:** DSM-5 Diagnosis and Narrative, ICD-10 Code

ICD-10 Code: ________________________ DSM-5 Diagnosis: ___________________ (Primary)

DSM-5 Narrative Diagnosis: __________________________________________________________________________

ICD-10 Code: ________________________ DSM-5 Diagnosis: ___________________ (Secondary)

DSM-5 Narrative Diagnosis: __________________________________________________________________________

DSM Diagnosis by: ______________________________________
*(Name of Diagnosing Clinician/Licensure)*

**Functional Impairment:**

| | None | Mild | Mod | Severe | | None | Mild | Mod | Severe |
|---|---|---|---|---|---|---|---|---|---|
| Family Relations | ☐ | ☐ | ☐ | ☐ | Social Relations | ☐ | ☐ | ☐ | ☐ |
| Employment / School Performance | ☐ | ☐ | ☐ | ☐ | Physical Health | ☐ | ☐ | ☐ | ☐ |
| Recreational / Leisure Activities | ☐ | ☐ | ☐ | ☐ | Substance Abuse | ☐ | ☐ | ☐ | ☐ |
| Food/Shelter | ☐ | ☐ | ☐ | ☐ | Activities of Daily Living | ☐ | ☐ | ☐ | ☐ |

Initial Treatment Plan (e.g. MHS, Medication Support, Day Treatment, etc.):

Clinical Summary / Additional Comments:

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**TARGETED CASE MANAGEMENT (TCM):**

Does client warrant the consideration for TCM? (May include moderate or above Functional Impairment and/or risk of losing placement/housing, needed for financial support, social support, prevocational/employment assistance, rehabilitation, or other programs or services considered as necessary.) ☐ No ☐ Yes

TCM Initial Treatment Plan (e.g. Referrals to medical services, AOD, Voc, Social Security, community agencies, etc.):

Preliminary Discharge Plan:

| Staff Signature/License | Printed Name | Date |
|---|---|---|
| Co-Signature of Licensed Clinician | Printed Name | Date |

Data Entry Clerk Initials

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Presenting Problem: ***(Continued from page 2)***

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## ASSESSMENT OF STRENGTHS

Check all that apply:

- ☐ Optimism / Hope
- ☐ Sense of Meaning
- ☐ Faith / Spirituality
- ☐ Empathy
- ☐ Compassion
- ☐ Resourcefulness
- ☐ Academic Accomplishments
- ☐ Daily Living Skills
- ☐ Flexibility
- ☐ Sense of Humor
- ☐ Support Relationship
- ☐ Friendships
- ☐ Open to Change
- ☐ Exercises Regularly
- ☐ Nutritional Awareness
- ☐ Understands Mental Illness / Needs
- ☐ Participates in 12 Step Program
- ☐ Participates in Self-Help Groups
- ☐ Able to voice Mental Health life needs
- ☐ Wellness Recovery Action Plan
- ☐ Able to Recognize Mental Health / Life Choices
- ☐ Hobbies / Special Interests
- ☐ Goal-Directed / Motivated
- ☐ Stable Family Life
- ☐ Communication
- ☐ Sense of Empowerment
- ☐ Work History
- ☐ Employment Skills
- ☐ Living Environment
- ☐ Positive Self Identity
- ☐ Cultural Identity / Integration
- ☐ Resilience
- ☐ Planning
- ☐ Other ________________________________________

Completed by: ☐ Therapist ☐ Client