Assessment/Evaluation

Client Name: | Record No.:

Type of Admission Priority: ☐ **Emergency/1 Hour** ☐ **Urgent/48 Hours** ☐ **Routine/7 Days**

Reason for Admission:

Medical/Dental/History: (pregnancy status, nutritional/dietary needs, seizures, anti-convulsant treatment, family physician, family dentist, Previous/current medical conditions, surgeries):

If Not Receiving Medical Care, Referral to:

Medication Name	Strength	Administration Directions	Prescribing Physician

**** Allergies:**

Family History: (MH history of family, immediate family constellation, support provided by family; birth order; client satisfaction with Family and support system):

Client Name:	Record No:

History of Traumatic Events: (consider abuse/neglect, significant loss, etc.)

** Prior MH/DD/SAS History (Previous Hospitalization):

**Past Mental Health History:

- ☐ State MH Hospital
- ☐ Private Hospital
- ☐ Private MH Professionals
- ☐ Private Practitioner
- ☐ VA Hospital
- ☐ Other
- ☐ None

**Outpatient Prior MH:

- ☐ CPS
- ☐ Self-Help
- ☐ Community MH Centers
- ☐ Alcohol Center
- ☐ MR Facility
- ☐ None

Present Life Circumstances: (current living situation, religion, culture, custody issues, safety issues, supervision needed, current psychosocial stressors, etc.)

STRENGTHS:

STRESSORS:

Client Name:	Record No.:

Vocational History: (military, employment history, last employment, handicaps, application for disability, etc.)

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Educational History: (any special education programs, suspensions, grade level, school, behaviors, inattentiveness, hyperactivity, etc.)

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Social History: (friendships, relationships, religious affiliation, support provided by friends, etc. – client satisfaction with family and support Systems)

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Legal History: (include contact names and numbers if applicable-probation, parole, previous arrests/incarceration, past and current charges)

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Other Agencies Currently Working with Client: (including names and phone numbers of contact persons)

☐ DSS ☐ Health Department ☐ VR ☐ Soc. Sec. Admin. ☐ Probation

☐ Other ____ ☐ None

Special Needs/Problems with Activities of Daily Living (ADL's): (disability, assistive technology, prosthetic devices, language b or cultural concerns, bathing, dressing, etc.)

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Client Name:	Record No.:

Problems with Independent Living Skills (ILS's): (i.e. balancing checkbook, using public transportation, etc.)

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Developmental/Childhood History: ☐ Not Applicable

Estimated Age: Started Walking: Started Talking: Toilet Trained: Birth Weight:

Developmental Disabilities: ☐ Not Applicable Age of Onset: ________________

☐ Mental Retardation (☐ Mild ☐ Moderate ☐ Severe ☐ Profound) ☐ Traumatic Brain Injuries

☐ Cerebral Palsy ☐ Blind ☐ Deaf ☐ Epilepsy

Additional Information concerning developmental history: (speech, hearing, DEC involvement, PT, OT, ECI involvement, Prenatal, Postnatal complication):

SUBSTANCE ABUSE HISTORY NOT APPLICABLE

	*Primary Drug	*Secondary Drug	*Tertiary Drug
*Major substance(s) abused prior to admission.			
Age of first drug use or alcohol intoxication.			
Usual route of administration.			
Frequency of substance abuse			
Average use/day			
Last Used			

Nicotine Usage:

Type: ______________________ Age of onset: ________________ Frequency/Amount: ____________________________

Describe past periods of abstinence: (when, how, previous admissions to detox, hospitalizations for substance abuse, recovery history, recovery environment, etc.)

☐ None Reported

Additional History and Comments: (previous treatment, etc.)

☐ DWI ☐ Blackouts ☐ Absenteeism ☐ Seizures ☐ Job Loss ☐ IV Drug Use

Substance Abuse Related Withdrawal Symptoms: (sweating, cravings, tremulousness, rapid heart rate, hallucinations, nausea, Paranoia):

Past:____

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Present:____

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Non-Substance Abuse Addictive Behaviors: (i.e. gambling, over spending, etc.) ______________________________

Client Name:	Record No.:

General Appearance: ☐ Well-groomed ☐ Unkempt ☐ Cosmetics (none, light, heavy) ☐ Unshaven ☐ Posture: stooped, stiff, bizarre ☐ Poor Hygiene ☐ Overweight ☐Underweight ☐ Poor eye contact

Orientation: ☐ Person ☐ Place ☐ Date

Level of Consciousness: ☐ Alert ☐ Drowsy ☐ Stupor ☐ Coma

Insight: ☐ Poor ☐ Average ☐ Good

Judgment: ☐ Poor ☐ Average ☐ Good

Fund of Information: ☐ Poor ☐ Average ☐ Good

Abstract Thinking: ☐ Poor ☐ Average ☐ Good

Memory Intact: ☐ Immediate ☐ Recent ☐ Remote

Psychotic-Like Behaviors: ☐ None ☐ Illusions ☐ Flight of Ideas ☐ Delusions ☐ Suspicions ☐ Paranoia

☐Hallucinations(visual/auditory) ☐Withdrawn ☐ Incoherent ☐Loose Associations ☐Unmanageable ☐Inability to care for self

☐ Obscene acts ☐ Wanders off ☐ Poor personal hygiene ☐ Tangential Thinking ☐ Confused ☐ Forgetfulness

☐ Disoriented (time, people, place) ☐ Other: ____

Danger to Self: ☐ None ☐ Thoughts of suicide ☐ Threats of suicide ☐ Plan for suicide ☐ Preoccupation with death

☐ Suicide gesture ☐ Suicide attempts ☐ Family history of suicide ☐ Inability to care for self ☐ History

☐ Other: ____ ☐ No current intent or plan

Danger to Others: ☐ None ☐ Thoughts to harm others ☐ Threats to harm others ☐ Plan to harm others

☐ Felt like killing someone ☐ Attempts to harm others ☐ Inability to care for dependents ☐ Has harmed others

☐ History ☐ Other: ______________________________________ ☐ No current intent or plan

Change in Biological Functions: ☐ Sleep ↑↓ ☐ Nightmares ☐ Appetite ↑↓ ☐ Weight ↑↓

☐ Multiple Somatic Complaints ☐ Other: ____

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Total Sleep Time: ____

Motor Activity: ☐ Not Remarkable ☐ Tremulous (hands, arms, trunk, legs, whole body) tic(s) ☐ Mannerism

☐ Paralysis ☐ Restlessness ☐ Slurred Speech ☐ Mute ☐ Loquacious ☐ Pacing ☐ Agitation ☐ Ataxia

☐ Hyperactivity ☐ Other: ____

Affect: ☐ Appropriate ☐ Euphoric ☐ Depressed ☐ Fearful ☐ Anxious ☐ Flattened ☐ Labile ☐ Angry

☐ Inappropriate ☐ Blunted

Client Name:	Record No.:

Antisocial Behavior: ☐ None ☐ Frequent Lying ☐ Stealing ☐ Running Away From Home ☐ Excessive Fighting

☐ Destroys Property ☐ Fire Setting ☐Arrest ☐ Convictions ☐ Imprisoned ☐ Promiscuity ☐ Exhibitionism

☐ Family Desertion ☐ Uses Assumed Name ☐ Other: ______________________________

Depressive-Like Behavior: ☐ None ☐ Sadness ☐ Fatigue ☐ Hypoactive ☐ Loss of Interest

☐Feelings of Worthlessness ☐ Feelings of Guilt ☐ Crying ☐ Poor Concentration

☐ Other: ____________________ ☐ Length of Symptoms: ____________________

Manic-Like Behaviors: ☐ None ☐ Euphoria ☐ Hyper sexuality ☐ Over-talkativeness ☐ Grandiosity

☐ Extravagance with money

☐ Other: ____

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Client Name:			Record No.:
	DSM IV		**DIAGNOSIS**
Axis	Code	Description	
Axis I	____________________	____________________	
	____________________	____________________	
	____________________	____________________	
	____________________	____________________	
Axis II	____________________	____________________	
	____________________	____________________	
	____________________	____________________	
	____________________	____________________	
Axis III	____________________	____________________	
	____________________	____________________	
	____________________	____________________	
	____________________	____________________	
Axis IV	____________________	____________________	
	____________________	____________________	
	____________________	____________________	
	____________________	____________________	
Axis V	__GAF______________	Rate: (1-10 with 10 the best) _______Client ______CAFAS	
LOC	_______________	________ASAM _______SNAP	

Client Name:	Record No.:

** Competency Status (CHOOSE ONE): ☐ Competent ☐ Incompetent ☐ Minor ☐ Unknown

Services Recommended for Client Treatment: ☐ None ☐ Individual Outpatient Treatment

☐ Outpatient Group Therapy ☐ In-Home/Family Therapy Services ☐ Community Support

☐ MR/MI Services ☐ CAP/MR Services ☐ Residential Services ☐ Other: ______________________

Client's Preferences: ____

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Client's Strengths: ____

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Client's Needs: ____

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Client in need of: ☐ Short-term care ☐ Long-term care

______________________	____________	______________________	____________
Physician's Signature	Date	Clinician's Signature	Date

Disposition:

IPRS Categories: 1) _______________ 2) _______________ 3)_______________ 4) _______________