Patient Name	ID Number	Date of Assessment

EMPLOYED?	SEEKING TX FOR WORK RELATED ISSUES?
____________	____________
____________	____________

Referred By: ______________________________

What are the presenting problems? Medical necessity? Duration of chief complaint?

Include relevant psychological and social conditions affecting psychiatric and medical status.

____
____
____
____
____
____

☐ Any Special Status issues? ☐ Court Mandated-Criminal ☐ Court Mandated-Family Court ☐ On Probation ☐ On Parole
☐ Other Status? ______________________________

Why seeking treatment now?

____
____

Patient's expectation of treatment and treatment outcome

____
____
____

Symptoms currently experiencing:

- ☐ **Sleep Disturbance**
- ☐ **Appetite Disturbance**
- ☐ **Episodic Crying**
- ☐ **Low Energy**
- ☐ **Depressed Mood**
- ☐ **Psychomotor Agitation**
- ☐ **Psychomotor Retardation**
- ☐ **Obsessions/Compulsions**
- ☐ **Poor Concentration**
- ☐ **Mood Lability**
- ☐ **Irritability**
- ☐ **Anxiety**
- ☐ **Panic Attacks**
- ☐ **Phobias**
- ☐ **Sexual Dysfunction**
- ☐ ____________________
- ☐ **Delusions**
- ☐ **Paranoid Ideation**
- ☐ **Loose Associations**
- ☐ **Hallucinations**
- ☐ **Tangential/Circumstantial**
- ☐ **Oppositional/Defiant**
- ☐ **Aggressive Behavior**
- ☐ **Bingeing/Purging**
- ☐ **Anorexia**
- ☐ **Abusing**
  - ☐ **Alcohol**
  - ☐ **Laxative**
  - ☐ **Diuretics**
  - ☐ **Rx meds**
  - ☐ **St. Drugs**

Mental Status Exam (Circle as appropriate)						
Attention	Good (on-task 90%)	Fair (On-task 75%)	Easily Distracted	Highly Distractible		
Affect	Appropriate	Labile	Expansive	Constricted	Blunted	
Mood	Normal	Depressed	Anxious	Euphoric		
Appearance	Well-groomed	Disheveled	Bizarre	Inappropriate		
Motor Activity	Calm	Hyperactive	Agitated	Tremors	Tics	Muscle Spasms
Thought Process	Intact	Circumstantial	Tangential	Flight of Ideas	Loose Associations	
Hallucinations	None	Auditory	Visual	Olfactory	Command	
Delusions	None	Persecutory	Grandiose	Religious	Other ____________	
Memory	Intact	Impaired: (circle appropriate)	**Immediate**	**Recent**	**Remote**	
Judgment/Insight	Intact	Impaired: (circle appropriate)	**Mild**	**Moderate**	**Severe**	
Orientation	All Spheres	Impaired: (circle appropriate)	**Person**	**Place**	**Time**	**Purpose**
Suicidal	None	Ideation	Plan	Intent	Means	
Homicidal	None	Ideation	Plan	Intent	Means	
Speech	Normal	Slow	Slurred	Pressured	Rapid	

Functional Impairments				
Estimate the effect of behavioral problems or emotional distress on the following areas:				
Family	None	Mild	Moderate	Severe
Relationship with S/O and other Primary Relationships	None	Mild	Moderate	Severe
Physical Health	None	Mild	Moderate	Severe
Work	None	Mild	Moderate	Severe
School	None	Mild	Moderate	Severe
Spiritual/Sense of Meaning	None	Mild	Moderate	Severe
Social/Activity Level	None	Mild	Moderate	Severe

Addiction/Chemical Use & Dependency Assessment for 12 years and over

(include tobacco, alcohol, Rx abuse, over the counter and illicit drugs and relevant caffeine)

Tobacco	**Frequency:**	**Amount**	☐ **Currently**	☐ **By history**	☐ **Not Applicable**
Alcohol	**Frequency:**	**Amount**	☐ **Currently**	☐ **By history**	☐ **Not Applicable**
Caffeine	**Frequency :**	**Amount**	☐ **Currently**	☐ **By history**	☐ **Not Applicable**
________	**Frequency**	**Amount**	☐ **Currently**	☐ **By history**	
________	**Frequency**	**Amount**	☐ **Currently**	☐ **By history**	
________	**Frequency**	**Amount**	☐ **Currently**	☐ **By history**	

☐ Has received prior treatment for this issue ______________________________
Where, when, outcome

____

☐ Family History of Addiction/Chemical Abuse/Treatment?____________________

____

____

Mental Health Treatment History

☐ Prior or current psychotherapy? ______________________________
When, why, with whom, length and type of treatment, was treatment considered successful, why was it discontinued?
____
____

☐ Family History of Mental Health Treatment/Diagnosis? ______________________________
____

☐ Release of Information Discussed? ______________________________

☐ Prior or current psychiatric treatment?
☐ Current or history of psychotropic medication? Include doses, frequency, times
____
____

Prescribing Physician ______________________________
Name, address, telephone

☐ Release of Information discussed? ______________________________

☐ Ever hospitalized? ______________________________

☐ History of Suicide Attempts? ______________________________

☐ History of self-injury/self-mutilation? ______________________________

Medical History

☐ **Medical conditions?** ______________________________

What effect does medical condition have on patient's level of physical functioning and mental health? ______________________________

☐ **Allergies**: ______________________________ ☐ **NKA**

☐ **Current prescriptions?** ______________________________

☐ **Release of Information discussed**? ______________________________

Family Hx Issues: ______________________________

Community & Ancillary Resource Use

☐ **Patient has utilized community-based resources (include why used, when)**

1. ______________________________
2. ______________________________
3. ______________________________

☐ **Patient has never utilized community resources**

- ☐ Never referred
- ☐ Never required
- ☐ Refused ______________________________
  (Explain)

SIGNIFICANT OTHERS

Current Relationship ☐Married ☐Domestic Partner ☐Separated ☐Single ☐None
Length, history, status of relationship, supportive, problematic:

____
____
____

Last Relationship ended _____ , 19____due to ☐ Divorce/Break-Up ☐ Death of partner

Relationship History:

____
____
____

Children/ages: ____________ ____________ ____________
____________ ____________ ____________

Notes:

____
____
____

Personal History Data

Family History:

Birth Order: _______ of _______ children born to natural parents
_______ of _______ adopted by parents

Siblings (natural and blended family structures):

Name/Gender		Age		Name/Gender		Age	
Name/Gender	________	Age	____	Name/Gender	________	Age	____
Name/Gender	________	Age	____	Name/Gender	________	Age	____
Name/Gender	________	Age	____	Name/Gender	________	Age	____

Raised: ☐ in intact family ☐ in single parent home ☐ parents separated

Born and raised : ____
____

Parents: ____
Relationship, marital history, custody issues, parenting styles, occupation, health, other

____
____
____

Other Notes: ____
____
____

STRENGTHS/TEACHING NEEDS-that affect ability to respond to treatment and maintain stabilization

____
____
____

AGE RELATED/ LIFE CYCLE ISSUES	CULTURAL, ETHNIC, SOCIO-ECONOMIC CONSIDERATIONS	RELIGION: BACKGROUND/ CURRENT PRACTICES
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

NOTES:

DSM IV MULTI-AXIAL DIAGNOSIS

AXIS I : (Primary) ____________________

AXIS I : (Secondary) ____________________

AXIS II: ____________________

AXIS III: ____________________

AXIS IV: ____________________

AXIS V: Current GAF __________ **HIGHEST IN THE PAST YEAR** __________

ISSUES TO BE CARRIED OVER FOR TREATMENT PLANNING: ____________________

Practitioner Signature: ____________________ **License:** ________ **Date:** __________