



INITIAL ASSESSMENT FORM

Client Name: _____ Age: _____ Medicaid ID #: _____

Date of Assessment: _____ Persons Present: _____

Source of Referral: _____

1. **PRESENTING PROBLEM:** (describe what client sees as the problem in emotional/behavioral terms)

2. **PRECIPITATING FACTORS OR EVENTS:** (what prompted request for treatment?)

3. **CURRENT SYMPTOMS AND IMPACT ON FUNCTIONING:** (include onset, frequency, intensity and impact of emotional/behavioral symptoms)

4. **RISK FACTORS:** Suicide Homicide Gravely Disabled Elopement Other None
 - a. SAFETY PLAN IF NEEDED:

5. **MENTAL STATUS:** (Check all that apply)
 - a. *Appearance:* Age Appropriate Younger than Age Older than Age
 - b. *Eye Contact:* Good Fair Poor
 - c. *Grooming:* Good Fair Poor
 - d. *Attentiveness:* Attentive Distracted Resistant Preoccupied Disinterested
 - e. *Alertness:* Alert Drowsy Stupor
 - f. *Motor:* Normal Slowed Agitated Abnormal (tics, tremors, grimaces, other)
 - g. *Speech:* Normal Slowed Pressured Loud Quiet Inarticulate
 - h. *Affect:* Stable/Appropriate Labile Constricted Flat Blunted Inappropriate to Content & Circumstance Other
 - i. *Mood:* Neutral Pleasant Happy Sad Euphoric Irritable Anxious Fearful Angry Apathetic Other
 - j. *Thought Content:* Normal Worthless/Hopeless Self-Deprecating Threatening Obsessions Ruminating Phobias Ideas of Reference Paranoia Magical Ideation Delusions Grandiose Other
 - k. *Thought Process:* Normal Associations Illogical Incoherent Tangential Flight of Ideas Word Salad Other
 - l. *Perceptions:* Normal Auditory Hallucinations Visual Hallucinations Tactile Hallucinations Depersonalization Derealization Other
 - m. *Intelligence:* Average Below Average Above Average



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n. *Insight (for age)*: __Good __Fair __Poor

o. *Judgment (for age)*: __Good __Fair __Poor

DESCRIBE ANY MSE CONCERNS:

6. **CULTURAL FACTORS THAT MAY IMPACT TREATMENT** (may include age, values/beliefs, preferred language, communication needs, gender, sexual orientation, relational roles, among others)
 - a. __ Select if cultural factors will not impact treatment

7. **PSYCHOSOCIAL HISTORY:** (include living arrangements, family problems, abuse hx, legal problems, school adjustment, significant events, etc.)

8. **CLIENT STRENGTHS:** (include personal characteristics, attitudes/beliefs, resources, and abilities that will help client achieve goals of treatment)

9. **PSYCHIATRIC TREATMENT HISTORY:** (include dates, provider, effectiveness)
 - a. __ Select if Not Applicable

10. **SUBSTANCE ABUSE** Past and Present for Clients 12 of Older: (include tobacco, alcohol, prescription drugs, illicit substances, caffeine)
 - a. __ Select if Not Applicable
 - b. __ Referral for Substance Abuse Services made to:

11. **FAMILY HISTORY OF MH OR SUBSTANCE PROBLEMS:**
 - a. __ Select if Not Applicable



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12. **DEVELOPMENTAL HISTORY** for Clients < 18: (include perinatal events, physical/intellectual/social development levels, behavioral issues, school adjustment, etc.)
 - a. Select if Not Applicable

13. **MENTAL RETARDATION/DEVELOPMENTAL DISABILITIES/ORGANIC CONDITIONS** that may impact presentation or functioning
 - a. Select if Not Applicable

14. **CONCERNS OF AGING** for Clients 60 or older: (include loss of hearing, vision, mobility, physical functioning, other factors of aging)
 - a. Select if Not Applicable

15. **MEDICAL CONDITIONS** that may impact presentation or functioning: (include allergies)
 - a. Select if Not Applicable
 - b. Medical exam referral made to:

16. **CURRENT MEDICATIONS:** (include name, dose, frequency, provider, effectiveness)
 - a. Select if Not Applicable
 - b. Medication referral made to:



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17. CLINICAL FORMULATION AND THERAPEUTIC RECOMMENDATIONS:

- a. Summary of symptoms/ behaviors that explain diagnosis
- b. Diagnosis rule outs, if any, & plan to gather additional information
- c. Assess client's/family's willing and ability to participate in treatment
- d. Prioritized problem list--which symptoms, behaviors, skill or functional deficits, or services/supports needed will be addressed or deferred at this level of care?
- e. What level of care is recommended and why? (including how what has or has not worked in the past affected the decision)
- f. Summary of client/family strengths & supports that will help move treatment forward

18. INITIAL DIAGNOSIS:

- a. Axis I:
- b. Axis II:
- c. Axis III:
- d. Axis IV:
- e. Axis V (GAF):

19. ADDITIONAL NOTES/COMMENTS:

PROVIDER SIGNATURE with credentials:

(REV. 10-1-11)