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| **Initial Assessment**Patient Name: | Date of Assessment: |
| Clinician Completing Assessment: |
| **Initial Information** |
| Chief Complaint: |
| History of Present Illness: |
| Current Symptoms: |
| Previous Treatment History: (dates of treatment or hospitalization, clinician names, interventions & response to treatment, etc.)  |
| History of Risk:Any previous suicide attempts? □ Yes □ No If yes, enter dates and measures used for attempt: |
| Past Psychiatric Medications: (include names of clinicians past/present, medications/dosages, when taken, who prescribed, and response) |
| History of Substance Use |
| (include age of onset, history and current use or denial of use, consequences of use)Alcohol:Drugs: (street, prescription, and over the counter)Nicotine: |
| Family Substance Use History: |
| Medical History |
| Self:[ ]  Stroke [ ]  Seizures  [ ]  Migraines [ ]  Liver Damage [ ]  Thyroid Problems [ ]  Anemia  [ ]  Diabetes  [ ]  Chronic Pain  [ ]  Chronic Fatigue [ ]  Urinary Tract Infection[ ]  Asthma  [ ]  Hepatitis [ ]  Tuberculosis [ ]  Eating Disorder [ ]  Persistent flu-like symptoms[ ]  Cancer [ ]  Hypertension [ ]  Cardiac Problems [ ]  Communicable Diseases[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Children/Adolescents: Prenatal events, Childhood Diseases, Vaccination History, Developmental Milestones: |
| Family: [ ]  Stroke [ ]  Seizures [ ]  Migraines [ ]  Liver Damage [ ]  Thyroid Problems [ ]  Anemia [ ]  Diabetes [ ]  Chronic Pain [ ]  Chronic Fatigue [ ]  Urinary Tract Infection[ ]  Asthma [ ]  Hepatitis [ ]  Tuberculosis [ ]  Eating Disorder [ ]  Persistent flu-like symptoms[ ]  Cancer [ ]  Hypertension [ ]  Cardiac Problems [ ]  Communicable Diseases[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Children/Adolescents: Prenatal events, Childhood Diseases, Vaccination History, Developmental Milestones: |
| Current Medications: |
| Physical Exam in the past year? [ ]  Yes [ ]  NoPrimary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  No PCPConsent for coordination of care? [ ]  Yes [ ]  No [ ]  N/AIf no, state reason for refusal: |
| Food or drug allergies? [ ]  Yes [ ]  NoIf yes, what specific allergies? |
| Based on information, a physical examination is recommended: [ ]  Yes [ ]  No |
| Psychosocial History |
| Spiritual/Religious Affiliation: |
| Education: |
| Legal History: |
| Sexual Orientation: |
| Employment History: |
| Cultural Influences: |
| Community Resources: |
| Significant Life Events: |
| Marriage/Family: (marital history, including current/prior marriages/significant relationships; names/relationships with children) |
| Interests and Activities: |
| Strengths and Weaknesses: |
| Mental Status Exam:Please skip this part. I will do this part after we meet.Appearance: □ Well Groomed □ Unkempt □ Disheveled Eye Contact: □ WNL □ Avoidant □ IntenseThought Content: □ WNL □ Delusions □ Grandiose □ Somatic □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Thought Process: □ Logical □ Incoherent □ Circumstantial □ Concrete □ Racing □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Perception: □ WNL □ Impaired □ Hallucinations\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mood: □ WNL □ Depressed □ Anxious □ Angry/Irritable □ Euthymic □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Affect: □ Full □ Labile □ Flat □ Blunted □ InappropriateBehavior: □ Cooperative □ Resistant □ Hyperactive □ Withdrawn □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insight/Judgment: |
| Risk Assessment:Homicidal/Suicidal Ideation Nature of Plan & IntentAvailability of Means (address access to guns specifically) Lethality of Method Marked Change in Recent Behavior Previous Attempts Significant Other Attempts Perception of Loss Support System History of Human-Induced Trauma Legal Complications Financial Problems Active Substance Use/Abuse Presence of Psychosis Other Risk IssuesSafety Plan Reviewed (include client strengths that support current care plan)Please leave this blank, but do bring it in with you.Assessment Summary: |
| Primary Diagnosis:Secondary Diagnosis:Co-morbid Medical Concerns:Psychosocial stressors:Functional Impairments: |
| Initial Treatment Plan: |

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Clinician Signature Date