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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  No  Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No PCP  Consent for coordination of care?  Yes  No  N/A  If no, state reason for refusal: | |
| Food or drug allergies?  Yes  No  If 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 □ Intense  Thought 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 □ Inappropriate  Behavior: □ Cooperative □ Resistant □ Hyperactive □ Withdrawn □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insight/Judgment: | |
| Risk Assessment:  Homicidal/Suicidal Ideation    Nature of Plan & Intent  Availability 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 Issues  Safety 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