|  |  |  |
| --- | --- | --- |
| Person’s Name (First MI Last):       | Record #:       | Date of Admission:       |
| Organization/Program Name:       | DOB:       | **Gender:** [ ]  Male [ ]  Female[ ]  Transgender |

|  |  |
| --- | --- |
| List Name(s) of Person(s) Present: | [ ]  Person Present [ ]  No Show [ ]  Person Cancelled [ ]  Provider Cancelled Explanation:       [ ]  Others Present (please identify name(s) and relationship(s) to person):        |
| Place of Evaluation:  | [ ]  ER [ ]  Court [ ]  Police Dept. [ ]  Outpatient Office [ ]  Residential Treatment Setting[ ]  ESP [ ]  Home [ ]  School [ ]  Other:       |

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| Presenting Concerns in person’s own words; what occurred to cause the person to seek services now:       |
| History of Present Illness: [ ]  None Reported       |
| Comprehensive Assessment has been completed? Yes [ ]  No [ ]  If yes: Date of most recent assessment:        |

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| **Primary Care Provider** **Name and Credentials** | **Tel Number**  | **Fax** | **Address** | **Date of Last Exam** |
|  |  |  |  |  |

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| Physical Health HistoryNOTE: I have reviewed the Physical Health Summary in the Comprehensive Assessment of  (date) with the person and: [ ]  No additional history to be added, **OR** [ ]  Additional History/Comments:  |

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| Family Mental Health / Substance Use History (check all that apply): [ ]  None Reported[ ]  Schizophrenia [ ]  Bipolar [ ]  Depression [ ]  Anxiety Disorder [ ]  ADD [ ]  Substance Use [ ]  Suicide and / or attempts[ ]  Other:       Comments-Specify family member, diagnosis, medication effectiveness:       |

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| **Substance Use / Addictive Behavior History**: **NOTE:** I have reviewed the Substance Use / Addictive Behavior History in the Comprehensive Assessment of  (date) with the person and:  [ ]  No additional history to be added, **OR** [ ]  Additional history indicated below: |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Substance/Alcohol/Tobacco/Gambling/Other | Age of First Use | Date of Last Use | Frequency | Amount | Method |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
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|  |  |  |  |  |  |
| Toxicology Screen Completed: [ ]  **No** [ ]  **Yes** **– If Yes,** **Results:**  |

|  |  |
| --- | --- |
| Person’s Name (First MI Last):       | Record #:       |

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| Treatment History**NOTE:**I have reviewed the Treatment History in the Comprehensive Assessment of  (date) with the person and: [ ]  No additional history to be added OR [ ]  Additional history indicated below: |
| Type of Service: | **MH / SU** | Name of Provider/Agency: | Dates of Service: | Completed? |
|       | [ ]  MH [ ]  SU |       |  | [ ] Yes [ ] No |
|       | [ ]  MH [ ]  SU |       |  | [ ] Yes [ ] No |
|       | [ ]  MH [ ]  SU |       |  | [ ] Yes [ ] No |
|       | [ ]  MH [ ]  SU |       |  | [ ] Yes [ ] No |
|       | [ ]  MH [ ]  SU |       |  | [ ] Yes [ ] No |

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| **Other Assessment Domains:**[ ]  **I have reviewed the Comprehensive Assessment of** **(date) with the person and have added other pertinent information or changes where applicable.**[ ]  **I have not reviewed the comprehensive assessment, but have indicated pertinent information for each of the areas below.**  |
| **Living Situation** [ ] No Changes | Comments:       |
| **Family and Social Supports** [ ] No Changes | Comments:       |
| **Legal Status** [ ] No Changes | Comments:       |
| **Legal Involvement** [ ] No Changes [ ] None Reported  | Comments:       |
| **Education** [ ] No Changes | Comments:       |
| **Employment** [ ] No Changes | Comments:       |
| **Military Service** [ ] No Changes[ ] None Reported | Comments:       |
| **Trauma** [ ] No Changes[ ] None Reported | Comments:       |
| **Developmental Issues** [ ] N/A [ ] None Reported  | Comments:       |

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| --- | --- |
| Person’s Name (First MI Last):       | Record #:       |

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| **Mental Status Exam –** (WNL = Within Normal Limits) (**\*\***) ***– If Checked, Risk Assessment is Required*** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Appearance/ Clothing:** | [ ]  WNL | [ ]  Neat and appropriate | [ ]  Physically unkempt | [ ]  Disheveled | [ ]  Out of the Ordinary |  |
| **Eye Contact:** | [ ]  WNL | [ ]  Avoidant | [ ]  Intense | [ ]  Intermittent |  |  |
| **Build:** | [ ]  WNL | [ ]  Thin  | [ ]  Overweight | [ ]  Short | [ ] Tall |  |
| **Posture:** | [ ]  WNL | [ ]  Slumped | [ ]  Rigid, Tense | [ ]  Atypical |  |  |
| **Body Movement:** | [ ]  WNL | [ ] Accelerated | [ ]  Slowed | [ ]  Peculiar | [ ]  Restless | [ ]  Agitated |
| **Behavior:** | [ ]  WNL | [ ]  Cooperative | [ ]  Uncooperative | [ ]  Overly Compliant | [ ]  Withdrawn | [ ]  Sleepy  |
|  | [ ]  Silly | [ ]  Avoidant/Guarded/ Suspicious | [ ]  Nervous/ Anxious | [ ]  Preoccupied | [ ]  Restless  | [ ]  Demanding |
|  | [ ]  Controlling | [ ]  Unable to perceive pleasure | [ ]  Provocative | [ ]  Hyperactive | [ ]  Impulsive | [ ]  Agitated |
|  | [ ]  Angry | [ ]  Assaultive | [ ]  Aggressive | [ ]  Compulsive [ ]  Relaxed |
| **Speech:** | [ ]  WNL | [ ]  Mute  | [ ]  Over-talkative | [ ]  Slowed | [ ]  Slurred | [ ]  Stammering |
|  | [ ]  Rapid | [ ]  Pressured | [ ]  Loud | [ ]  Soft | [ ]  Clear | [ ]  Repetitive |
| **Emotional State-Mood (in person’s words):** | [ ]  WNL | [ ]  Not feeling anything | [ ]  Irritated | [ ]  Happy | [ ]  Angry | [ ]  Hostile |
|  | [ ]  Depressed, sad | [ ]  Anxious | [ ]  Afraid, Apprehensive |  |  |  |
| **Emotional State- Affect** | [ ]  WNL | [ ]  Constricted | [ ]  Changeable | [ ]  Inappropriate | [ ]  Flat |  |
|  | [ ]  Full | [ ]  Blunted, unvarying |  |  |  |  |
| **Facial Expression** | [ ]  WNL | [ ]  Anxiety, fear, apprehension | [ ]  Sadness, depression | [ ]  Anger, hostility, irritability |  |  |
|  | [ ]  Elated | [ ]  Expressionless | [ ]  Inappropriate | [ ]  Unvarying |  |  |
| **Perception:** | [ ]  WNL |  |  |  |  |  |
| *Hallucinations-* | [ ]  Tactile | [ ]  Auditory | [ ]  Visual | [ ]  Olfactory | [ ]  Command **\*\*** |
| **Thought Content:** | [ ]  WNL |  |  |  |  |  |
| *Delusions-* | [ ]  None Reported | [ ]  Grandiose | [ ] Persecutory | [ ]  Somatic | [ ]  Illogical | [ ]  Chaotic |
|  | [ ]  Religious |  |  |  |  |  |
| *Other Content-* | [ ]  Preoccupied | [ ]  Obsessional | [ ]  Guarded | [ ]  Phobic | [ ]  Suspicious | [ ]  Guilty |
|  | [ ]  Thought broadcasting | [ ]  Thought insertion | [ ]  Ideas of reference |  |  |  |
| **Thought Process:** | [ ]  WNL | [ ]  Incoherent | [ ]  Decreased thought flow | [ ]  Blocked  | [ ]  Flight of ideas |  |
|  | [ ]  Loose | [ ]  Racing | [ ]  Chaotic | [ ]  Concrete  | [ ]  Tangential |  |
| **Intellectual Functioning:** | [ ]  WNL | [ ]  Lessened fund of common knowledge  | [ ]  Impaired concentration | [ ]  Impaired calculation ability |  |  |
| *Intelligence Estimate -* | [ ]  Develop. Disabled | [ ]  Borderline | [ ]  Average | [ ]  Above average  | [ ]  No formal testing |  |
| **Orientation**:  | [ ]  WNL | **Disoriented to**: | [ ]  Time | [ ]  Place | [ ]  Person |  |
| **Memory**:  | [ ]  WNL | **Impaired:**  | [ ]  Immediate recall  | [ ]  Recent memory  | [ ]  Remote memory | [ ]  Short Attention Span |
| **Insight**:  | [ ]  WNL  | [ ]  Difficulty acknowledging presence of psychological problems  | [ ]  Mostly blames other for problems  | [ ]  Thinks he/she has no problems |
| **Judgment**: | [ ]  WNL  | **Impaired Ability to Make** **Reasonable Decisions**:  | [ ]  Mild  | [ ]  Moderate  | [ ]  Severe\*\*  |
| **Past Attempts to Harm Self or Others:**  | [ ]  None Reported  |  [ ]  Self\*\*  | [ ]  Others\*\*  |  |  |  |
| **Self Abuse Thoughts:** | [ ]  None reported  | [ ]  Cutting\*\*  | [ ]  Burning\*\*  | [ ]  Other:       |
| **Suicidal Thoughts:** | [ ]  None reported  | [ ]  Passive SI\*\*  | [ ]  Intent\*\*  | [ ]  Plan\*\*  | [ ]  Means\*\*  |  |
| **Aggressive Thoughts:** | [ ]  None reported  | [ ]  Intent\*\*  | [ ]  Plan\*\*  | [ ]  Means\*\* |  |  |

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| --- | --- |
| **Comments:** |       |

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| --- | --- |
| Person’s Name (First MI Last):       |  Record #:       |
| **Other symptoms of note or information from other sources (family, referring agency, etc.)** [ ]  **None Reported**  |

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| --- |
| **Diagnosis: [ ]**  DSM-IV Codes **[ ]**  DSM 5 Codes [ ]  ICD-9 Codes [ ]  ICD-10 Codes |
| **Check Primary/Billing Diagnosis**  | **Code** | **Narrative Description**  |
| [ ]  |  |  |
| [ ]  |  |  |
| [ ]  |  |  |
| [ ]  |  |  |
| [ ]  |  |  |
| [ ]  |  |  |

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| Medication InformationNOTE: I have reviewed the Medication Information in the Comprehensive Assessment of  (date) with the person and: [ ]  There have been no medication changes, **OR** [ ]  Additional medication changes below (include OTC/Herbal Supplements)   |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication**  | **Current or Past** | **Rationale/ Condition** | **Dosage / Route / Frequency** | **Person Taking/Took Meds as Prescribed?**WA**=***With Assistance* |
|  | [ ]  C [ ] P |  |  | [ ]  No [ ]  Yes [ ]  WA |
|  | [ ]  C [ ] P |  |  | [ ]  No [ ]  Yes [ ]  WA |
|  | [ ]  C [ ] P |  |  | [ ]  No [ ]  Yes [ ]  WA |
|  | [ ]  C [ ] P |  |  | [ ]  No [ ]  Yes [ ]  WA |
|  | [ ]  C [ ] P |  |  | [ ]  No [ ]  Yes [ ]  WA |
|  | [ ]  C [ ] P |  |  | [ ]  No [ ]  Yes [ ]  WA |
|  | [ ]  C [ ] P |  |  | [ ]  No [ ]  Yes [ ]  WA |
|  | [ ]  C [ ] P |  |  | [ ]  No [ ]  Yes [ ]  WA |

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| Reported side effects / adverse drug reactions / other comments on current or past medications:        |

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| --- | --- |
| Person’s Name (First MI Last):       | Record #:       |
| Does person served have any medical conditions that require consideration in prescribing (i.e. pregnancy, diabetes, etc.)? [ ]  Yes [ ]  None reported or known If yes, specify:       |

|  |
| --- |
| Medication Status / Orders[ ]  None [ ]  As indicated below: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication**  | **Status** | **Rationale/ Condition** | **Dosage / Route / Frequency** | **Amount/ Refills** |
|  | [ ]  New/Adjusted [ ]  Refill [ ]  Discontinued |  |  |  |
|  | [ ]  New/Adjusted [ ]  Refill[ ]  Discontinue |  |  |  |
|  | [ ]  New/Adjusted [ ]  Refill[ ]  Discontinue |  |  |       |
|  | [ ]  New/Adjusted [ ]  Refill[ ]  Discontinue |  |  |       |
|  | [ ]  New/Adjusted [ ]  Refill[ ]  Discontinue |  |  |       |
|  | [ ]  New/Adjusted [ ]  Refill[ ]  Discontinue |  |  |       |

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| Explained rationale for medication choices, reviewed mixture of medications, discussed possible risks, benefits, effectiveness (if applicable) and alternative treatment with the person (parent/guardian): [ ]  No [ ]  Yes       |
| Person  | [ ]  Understands information | [ ]  Does not understand | [ ]  Agrees with Medication | [ ]  Refuses Medication |
| Guardian | [ ]  Understands information | [ ]  Does not understand | [ ]  Agrees with Medication | [ ]  Refuses Medication |

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| **Laboratory Tests Ordered:** [ ]  None Ordered       |

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| Follow Up Plan/Referrals (Include all referrals, including commitment orders, those to higher levels of care, labs to be ordered, medical strategies/recommendations, other types of treatment, frequency/interval of next visit and duration): **1.**      **2.**      **3.**      **4.**       |

|  |  |
| --- | --- |
| Person’s Name (First MI Last):       | Record #:       |
| **Other Psychopharmalogical Considerations to be added to Individualized Action Plan:** [ ]  None indicated at this time      |
| Person’s /Guardian Response to Plan: [ ]  N/A       |
| **Physician/APRN/RNCS - Print Name/Credential:**      | **Date:**      | **Supervisor - Print Name/Credential** (if needed):      | **Date:**      |
| **Physician/APRN/RNCS Signature:**      | **Date:**      | **Supervisor Signature** (if needed):      | **Date:**      |
| **Person’s Signature** (optional, if appropriate)**:** | **Date:**      |  |  |
| Date of Service | Provider Number | Loc. Code | Prcdr. Code | Mod 1 | Mod2 | Mod3 | Mod4 | Start Time | Stop Time | Total Time | Diagnostic Code |
|       |       |       |       |     |     |     |     |       |       |       |       |