ADULT
FULL ASSESSMENT

Date of first assessment contact: ______________

ASSESSING PRACTITIONER (NAME AND DISCIPLINE): ____________________________________

Client/Others Interviewed: ____

I. DEMOGRAPHIC DATA & SPECIAL SERVICE NEEDS:

DOB: ______ **GENDER:** ______ **ETHNICITY:**____________ **Marital Status:** __________________________

Referral Source:

☐ Non-English Speaking, specify language used for this interview: ____

Were Interpretive Services provided for this interview? ☐ Yes ☐ No

☐ Cultural Considerations, specify: ____

☐ Physically challenged (wheelchair, hearing, visual, etc.) specify: ____

☐ Access issues (transportation, hours), specify: ____

II. Reason for Referral/Chief Complaint

Describe **PRECIPITATING EVENTS(S)/REASON FOR REFERRAL**

CURRENT SYMPTOMS AND BEHAVIORS (INTENSITY, DURATION, ONSET, FREQUENCY) and **IMPAIRMENTS IN LIFE FUNCTIONING** caused by the symptoms/behaviors (from perspective of client and others):

CLIENT STRENGTHS (to assist in achieving treatment goals)

SUICIDAL THOUGHTS/ATTEMPTS: *"Columbia Suicide Severity Rating Scale Screener (LACDMH Version)"*

Wish to be Dead: *Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.*

1. Within the past 30 days, have you wished you were dead or wished you could go to sleep and not wake up? ☐ Yes ☐ No

Suicidal Thoughts: *General non-specific thoughts of wanting to end one's life/commit suicide, "I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan.*

2. Within the past 30 days, have you actually had any thoughts of killing yourself? ☐ Yes ☐ No

If YES to 2, ask questions 3, 4, 5, and 6
If NO to 2, go directly to question 6

Suicidal Thoughts with Method (without Specific Plan or Intent to Act): *Person endorses thoughts of suicide and has thoughts of at least one method during the assessment period.*

3. Have you been thinking about how you might kill yourself? ☐ Yes ☐ No

Suicidal Intent (without Specific Plan): *Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts.*

4. Have you had these thoughts and had some intention of acting on them? ☐ Yes ☐ No

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Suicide Intent with Specific Plan: *Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.*

5. Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan? ☐Yes ☐No

Suicidal Behavior:

6. Have you done anything, started to do anything, or prepared to do anything to end your life? ☐Yes ☐No

If yes, How long ago did you do any of these?
Additional comments regarding suicidal thoughts/attempts:

Self-Harm (without statement of suicidal intent) ☐ Yes ☐ No ☐ Unable to Assess
If yes, describe

III. MENTAL HEALTH HISTORY/RISKS

History of Problem Prior to Precipitating Event: Include treated & non-treated history.

Impact of treatment and non-treatment history: on the client's level of functioning, e.g., ability to maintain residence, daily living and social activities, health care, and/or employment.

PSYCHIATRIC HOSPITALIZATIONS: ☐ Yes ☐ No ☐ Unable to Assess
If yes, describe **DATES, LOCATIONS, AND REASONS**

OUTPATIENT TREATMENT: ☐ Yes ☐ No ☐ Unable to Assess
If yes, describe **DATES, LOCATIONS, AND REASONS**.

TRAUMA or Exposure to Trauma: ☐ Yes ☐ No ☐ Unable to Assess
Has client ever (1) been physically hurt or threatened by another, (2) been raped or had sex against their will, (3) lived through a disaster, (4) been a combat veteran or experienced an act of terrorism, (5) been in a severe accident, or been close to death from any cause, (6) witnessed death or violence or the threat of violence to someone else, or (7) been the victim of a crime?

ADULT FULL ASSESSMENT

IV. MEDICATIONS

Has the client ever taken psychotropic medications? ☐ Yes ☐ No ☐ Unable to Assess

List "all" past and present psychotropic medications used, prescribed/non-prescribed, by name, dosage, frequency. Indicate from client's perspective what seems to be working and not working.

MEDICATION	DOSAGE/FREQUENCY	PERIOD TAKEN	EFFECTIVENESS/RESPONSE/SIDE EFFECTS/REACTIONS

General Medication Comments (include significant non-psychotic medication issues/history):

V. SUBSTANCE USE/ABUSE Screening and Assessment

A. Alcohol Screening Questions 1 Drink = 12 Ounces of beer, 5 Ounces of wine, or 1.5 Ounces of liquor

1. In the past year, how often did you have a drink containing alcohol? If "Never", proceed to Drug Screening Questions.	☐ Never (0)	☐ Monthly or less (1)	☐ 2-4 times a month (2)	☐ 3 times a week (3)	☐ 4+ times a week (4)
1a. In the past year, how many drinks containing alcohol did you have on a typical day when you are drinking?	☐ 1 or 2 (0)	☐ 3 or 4 (1)	☐ 5 or 6 (2)	☐ 7 to 9 (3)	☐ 10+ (4)
1b. In the past year, how often did you have six or more drinks on one occasion?	☐ Never (0)	☐ Less than monthly (1)	☐ Monthly (2)	☐ Weekly (3)	☐ Daily or almost daily (4)

Alcohol Screening Score: __________ *(For a score of 4 or more, proceed to Assessment. A brief intervention is also indicated)*

Was a brief intervention provided? ☐ Yes ☐ No

B. Drug Screening Questions *("Yes" to any of the questions below indicates a positive screening)*

	Ever Used?		Recently Used? (Past 6 Months)	
	Yes	No	Yes	No
1. Have you used nicotine products? *(Cigarettes, cigars, electronic cigarettes, smokeless tobacco)*	☐	☐	☐	☐
2. Do you use products containing caffeine, such as tea, coffee or high-caffeine energy drinks? *(Such as AMP, Monster, Red Bull or 5 Hour Energy*	☐	☐	☐	☐
3. Have you used opioids? *(Heroin, opium, non-prescribed pain medications)*	☐	☐	☐	☐
4. Have you used prescription medications, over the counter medications, and/or non-prescription supplements in a manner other than prescribed? *(For example, to get high)*	☐	☐	☐	☐
5. Have you used stimulants, such as cocaine or methamphetamine?	☐	☐	☐	☐
6. Have you used drugs intravenously?	☐	☐	☐	☐
7. Have you used other substances of abuse?	☐	☐	☐	☐

C. Are you interested in changing your substance use patterns? ☐ Yes ☐ No ☐ NA

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name: **DMH ID#:**

Agency: **Provider #:**

Assessment/Additional Information (answer only if screening is positive)

PAST AND PRESENT USE OF TOBACCO, ALCOHOL, CAFFEINE, CAM (COMPLEMENTARY AND ALTERNATIVE MEDICATIONS) AND OVER-THE-COUNTER, AND ILLICIT DRUGS, if not determined by screener. Be sure to include route of administration, frequency (amount), withdrawals, etc.

VI. MEDICAL HISTORY

MD NAME: ______________________________ **MD PHONE:** ____________________ **Date of Last Physical Exam:** ______________

Major medical problem (treated or untreated) (Indicate problems with check: Y or N for client, Fam for family history.)

Fam	Y	N		Fam	Y	N		Fam	Y	N		Fam	Y	N	
☐	☐	☐	Seizure/neuro disorder	☐	☐	☐	Cardiovascular disease/symp	☐	☐	☐	Liver disease		☐	☐	Diarrhea
	☐	☐	Head trauma	☐	☐	☐	Thyroid disease/symp	☐	☐	☐	Renal disease/symp	☐	☐	☐	Cancer
	☐	☐	Sleep disorder	☐	☐	☐	Asthma/lung disease	☐	☐	☐	Hypertension		☐	☐	Sexual dysfunction
	☐	☐	Weight/appetite chg	☐	☐	☐	Blood disorder	☐	☐	☐	Diabetes		☐	☐	Sexually trans disease

☐ ☐ ☐ **ALLERGIES** (If Yes, specify):

☐ ☐ Sensory/Motor Impairment (If Yes, specify):

Y	N		Y	N		Y	N		Y	N	
☐	☐	Pap smear If yes, date: __________	☐	☐	Mammogram If yes, date: __________	☐	☐	HIV Test If yes, date: __________	☐	☐	Pregnant If yes, due date: __________

Comments on above medical problems, other medical problems, and any hospitalizations, including dates and reasons.

VII. PSYCHOSOCIAL HISTORY

Please state specifically how Mental Health status directly impacts each area below; Be sure to include the client's strengths in each area.

EDUCATION/SCHOOL HISTORY

Special Education: ☐ Yes ☐ No ☐ Unable to Assess Learning Disability: ☐ Yes ☐ No ☐ Unable to Assess

Motivation, education goals, literacy skill level, general knowledge skill level, math skill level, school problems, etc:

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name: **DMH ID#:**

Agency: **Provider #:**

EMPLOYMENT HISTORY, Readiness for Employment and MEANS OF FINANCIAL SUPPORT

Current Paid Employment: ☐ Yes ☐ No ☐ Unable to Assess Military Service: ☐ Yes ☐ No ☐ Unable to Assess

Work related problems, volunteer work, money management, source of income, longest period of employment, etc:

LEGAL HISTORYAND CURRENT LEGAL STATUS

Arrests/DUI, probation, convictions, divorce, conservatorship, parole, child custody, etc:

CURRENT LIVING ARRANGEMENT and Social Support Systems

Type of living setting, problems at setting, community, religious, government agency, or other types of support, etc:

DEPENDENT CARE ISSUES

Number of Dependent Adults: ______ Number of Dependent Children: _______

Ages of children, school attendance/behavior problems of children, special needs of dependents, foster care/group home placement issues, child support, etc:

FAMILY HISTORY/RELATIONSHIPS

History of Mental Illness in Immediate Family: ☐ Yes ☐ No ☐ Unable to Assess

Alcohol/Drug Abuse in Immediate Family: ☐ Yes ☐ No ☐ Unable to Assess

History of Incarceration in Immediate Family: ☐ Yes ☐ No ☐ Unable to Assess

Family constellation, family of origin, family dynamics, cultural factors, nature of relationships, domestic violence, physical or sexual abuse, home safety issues, family medical history, family legal/criminal issues

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name: **DMH ID#:**

Agency: **Provider #:**

ADULT FULL ASSESSMENT

VIII. MENTAL STATUS EVALUATION

Instructions: Check all descriptions that apply

General Description

Grooming & Hygiene: ☐ Well Groomed ☐ Average ☐ Dirty ☐ Odorous ☐ Disheveled ☐ Bizarre
Comments:

Eye Contact: ☐ Normal for culture ☐ Little ☐ Avoids ☐ Erratic
Comments:

Motor Activity: ☐ Calm ☐ Restless ☐ Agitated ☐ Tremors/Tics ☐ Posturing ☐ Rigid ☐ Retarded ☐ Akathesis ☐ E.P.S.
Comments:

Speech: ☐ Unimpaired ☐ Soft ☐ Slowed ☐ Mute ☐ Pressured ☐ Loud ☐ Excessive ☐ Slurred ☐ Incoherent ☐ Poverty of Content
Comments:

Interactional Style: ☐ Culturally congruent ☐ Cooperative ☐ Sensitive ☐ Guarded/Suspicious ☐ Overly Dramatic ☐ Negative ☐ Silly
Comments:

Orientation: ☐ Oriented ☐ Disoriented to: ☐ Time ☐ Place ☐ Person ☐ Situation
Comments:

Intellectual Functioning: ☐ Unimpaired ☐ Impaired
Comments:

Memory: ☐ Unimpaired ☐ Impaired re: ☐ Immediate ☐ Remote ☐ Recent ☐ Amnesia
Comments:

Fund of Knowledge: ☐ Average ☐ Below Average ☐ Above Average
Comments:

Mood and Affect

Mood: ☐ Euthymic ☐ Dysphoric ☐ Tearful ☐ Irritable ☐ Lack of Pleasure ☐ Hopeless/Worthless ☐ Anxious ☐ Known Stressor ☐ Unknown Stressor
Comments:

Affect: ☐ Appropriate ☐ Labile ☐ Expansive ☐ Constricted ☐ Blunted ☐ Flat ☐ Sad ☐ Worried
Comments:

Perceptual Disturbance

☐ None Apparent

Hallucinations: ☐ Visual ☐ Olfactory ☐ Tactile ☐ Auditory: ☐ Command ☐ Persecutory ☐ Other
Comments:

Self-Perceptions: ☐ Depersonalizations ☐ Ideas of Reference
Comments:

Thought Process Disturbances

☐ None Apparent

Associations: ☐ Unimpaired ☐ Loose ☐ Tangential ☐ Circumstantial ☐ Confabulous ☐ Flight of Ideas ☐ Word Salad
Comments:

Concentration: ☐ Intact ☐ Impaired by: ☐ Rumination ☐ Thought Blocking ☐ Clouding of Consciousness ☐ Fragmented
Comments:

Abstractions: ☐ Intact ☐ Concrete
Comments:

Judgments: ☐ Intact ☐ Impaired re: ☐ Minimum ☐ Moderate ☐ Severe
Comments:

Insight: ☐ Adequate ☐ Impaired re: ☐ Minimum ☐ Moderate ☐ Severe
Comments:

Serial 7's: ☐ Intact ☐ Poor
Comments:

Thought Content Disturbance

☐ None Apparent

Delusions: ☐ Persecutory ☐ Paranoid ☐ Grandiose ☐ Somatic ☐ Religious ☐ Nihilistic ☐ Being Controlled
Comments:

Ideations: ☐ Bizarre ☐ Phobic ☐ Suspicious ☐ Obsessive ☐ Blames Others ☐ Persecutory ☐ Assaultive Ideas ☐ Magical Thinking ☐ Irrational/Excessive Worry ☐ Sexual Preoccupation ☐ Excessive/Inappropriate Religiosity ☐ Excessive/Inappropriate Guilt
Comments:

Behavioral Disturbance

Behavioral Disturbances: ☐ None ☐ Aggressive ☐ Uncooperative ☐ Demanding ☐ Demeaning ☐ Belligerent ☐ Violent ☐ Destructive ☐ Self-Destructive ☐ Poor Impulse Control ☐ Excessive/Inappropriate Display of Anger ☐ Manipulative ☐ Antisocial
Comments:

Suicidality/Homicidality

Suicidal: ☐ Denies ☐ Ideation Only ☐ Threatening ☐ Plan
Comments:

Homicidal: ☐ Denies ☐ Ideation Only ☐ Threatening ☐ Target ☐ Plan
Comments:

Other

Passive: ☐ Amotivational ☐ Apathetic ☐ Isolated ☐ Withdrawn ☐ Evasive ☐ Dependent
Comments:

Other: ☐ Disorganized ☐ Bizarre ☐ Obsessive/compulsive ☐ Ritualistic ☐ Excessive/Inappropriate Crying
Comments:

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name: **DMH ID#:**

Agency: **Provider #:**

ADULT FULL ASSESSMENT

IX. Summary and Diagnosis

I. CLINICAL FORMULATION:
(Be sure to include assessment of risk of suicidal/homicidal behaviors, significant strengths/weaknesses, observations/descriptions, symptoms/impairments in life functioning, i.e. Work, School, Home Community, Living Arrangements, etc, and justification for diagnosis)

II. DIAGNOSTIC DESCRIPTOR

____
____
____
____
____
____
____
____
____

ICD DIAGNOSIS CODE (check at least one Primary)

☐ Primary Code ________
☐ Sec Code ________
Code ________
Code ________
Code ________
Code ________
Code ________
Code ________
Code ________

III. SPECIALTY MENTAL HEALTH SERVICES MEDICAL NECESSITY CRITERIA:

1. Medi-Cal Specialty Mental Health Included Diagnosis ☐ Yes ☐ No
2. Significant impairment in life functioning due to the Included Diagnosis ☐ Yes ☐ No
3. Expectation that proposed interventions can impact the client's condition ☐ Yes ☐ No
4. Mental Health Condition will not be responsive to physical health care based treatment ☐ Yes ☐ No

For EPSDT clients, if criteria (2)-Impairment and (3)-Intervention above are not met, medical necessity is met when the following exists:

1. Specialty mental health services are needed to correct or ameliorate a defect, mental illness, or condition ☐ Yes ☐ No

IV. Disposition/Recommendations/Plan

V. SIGNATURE

Assessor's Signature & Discipline	Date	Co-Signature & Discipline	Date

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name: **DMH ID#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health