

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

PRECIPITATING EVENT(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):

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

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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

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.**

Past Homicidal Thoughts/Attempts (including dates, threat, intent, plan, target(s), access to lethal means, methods used)

TRAUMA or Exposure to Trauma: Yes No Unable to Assess

Examples include: (1) physically hurt or threatened by another, (2) raped or had sex against their will, (3) lived through a disaster, (4) combat veteran or experienced an act of terrorism, (5) 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) victim of a crime

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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.

<u>MEDICATION</u>	<u>DOSAGE/FREQUENCY</u>	<u>PERIOD TAKEN</u>	<u>EFFECTIVENESS/RESPONSE/SIDE EFFECTS/REACTIONS</u>

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

V. SUBSTANCE USE / ABUSE Screening and Assessment

Does the client currently appear to be under the influence of alcohol or drugs? Yes No Unable to Assess

When was the last time the client used alcohol or drugs? _____

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? Never (0) Monthly or less (1) 2-4 times a month (2) 3 times a week (3) 4+ times a week (4)
- If "Never", proceed to Drug Screening Questions.
- 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)

Low risk/abstain = score of 0-3

Moderate/high risk = score of 3-7 (women) and score of 4-7 (men)

Severe risk (provide a brief intervention) = score of 8 or more

Alcohol Screening Score: _____

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? (within past 6 months)	
	Yes	No	Yes	No
1. Have you used nicotine products? (<i>Cigarettes, cigars, electronic cigarettes, smokeless tobacco</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you use products containing caffeine, such as tea, coffee or high-caffeine energy drinks? (<i>Such as AMP, Monster, Red Bull or 5 Hour Energy</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you used opioids? (<i>Heroin, opium, non-prescribed pain medications</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you used prescription medications, over the counter medications, and/or non-prescription supplements in a manner other than prescribed? (<i>For example, to get high</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you used stimulants, such as cocaine or methamphetamine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you used marijuana? (smoked, edibles, wax, or other)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you used hallucinogens? (<i>MDMA or Ecstasy, LSD, PCP, mushrooms, or psilocin</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you used drugs intravenously?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you used other substances of abuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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C. Are you interested in changing your substance use patterns? Yes No N/A

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
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Seizure/neuro disorder	Cardiovascular disease/symp	Liver disease	Diarrhea
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Head trauma	Thyroid disease/symp	Renal disease/symp	Cancer
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Sleep disorder	Asthma/lung disease	Hypertension	Sexual dysfunction
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Weight/appetite chg	Blood disorder	Diabetes	Sexually trans disease
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> ALLERGIES (If Yes, specify):			
<input type="checkbox"/> <input type="checkbox"/> Sensory/Motor Impairment (If Yes, specify):			
<input type="checkbox"/> <input type="checkbox"/> Pap smear If yes, date: _____	<input type="checkbox"/> <input type="checkbox"/> Mammogram If yes, date: _____	<input type="checkbox"/> <input type="checkbox"/> HIV Test If yes, date: _____	<input type="checkbox"/> <input type="checkbox"/> 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
 Describe motivation, education goals, literacy skill level, general knowledge skill level, math skill level, school problems, etc:

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

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LEGAL HISTORY AND CURRENT LEGAL STATUS

Describe any arrests/DUI, probation, convictions, divorce, conservatorship, parole, child custody, etc.:

CURRENT LIVING ARRANGEMENT and Social Support Systems

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

Is the client homeless? Yes No Unable to Assess

If yes, when did the client become homeless (estimated date)? _____

DEPENDENT CARE ISSUES

Number of Dependent Adults: _____ Number of Dependent Children: _____

Describe 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

Describe 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

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VIII. MENTAL STATUS EXAM 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:

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IX. Summary and Diagnosis

CLIENT'S STRENGTHS *(to assist with achieving treatment goals)*

CLINICAL FORMULATION AND DIAGNOSTIC JUSTIFICATION *Summarize/conceptualize all clinical information to determine the client's diagnosis and include initial proposal(s) for treatment. Be sure to identify any impairments in life functioning due to the client's diagnosis (Medical Necessity). Formulation should include risk factors as well as any significant strengths that can assist the client with treatment.*

DIAGNOSTIC DESCRIPTOR

ICD DIAGNOSIS CODE (check at least one Primary)

Primary Code _____
 Sec Code _____
Code _____
Code _____
Code _____

Disposition/Recommendations/Plan:

SIGNATURE

Assessor's Signature & Discipline

Date

Co-Signature & Discipline

Date

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