

Interviewed: Client and/or Other (name and relationship): _____

Special Service Needs:

Non-English Speaking, specify language needs: _____

Were Interpretive Services provided for this interview? Yes No

Cultural Considerations, specify: _____

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

Access issues (transportation, hours), specify: _____

I. Reason for Referral/Chief Complaint See Information on _____ dated: _____

Reason for Referral

Current Symptoms/Behaviors

Impairments in Life Functioning (daily living activities, social, employment/education, housing, financial, etc)

II. Psychiatric History See Information on _____ dated: _____

Outpatient and Inpatient, include dates, providers, interventions, and responses See information on IS Screen Prints

III. Current Risk and Safety Concern See Information on _____ dated: _____

| | | | |
|--|--|--|--|
| Current Thoughts of Self-Harm/Suicide | <input type="checkbox"/> Yes <input type="checkbox"/> No | Current Thoughts of Harming Another Person | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Past Thoughts of Self-Harm/Suicide | <input type="checkbox"/> Yes <input type="checkbox"/> No | Past Thoughts of Harming Another Person | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Prior Suicide Attempts/If yes, # _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | History of Homicide/Manslaughter | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Probation/Parole Involvement | <input type="checkbox"/> Yes <input type="checkbox"/> No | History of Injuring Another Person | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Current/History of Injuring Animals | <input type="checkbox"/> Yes <input type="checkbox"/> No | School Issues or IEP in place | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Recent Trauma Exposure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Current Substance Use/Abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Recent Job Loss | <input type="checkbox"/> Yes <input type="checkbox"/> No | Past Substance Use/Abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Victim of Violence/Abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Perpetrator of Violence/Abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| DCFS Involvement | <input type="checkbox"/> Yes <input type="checkbox"/> No | Homeless | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Access to Guns/Weapons | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other (specify): | |

For any risk/safety concerns marked yes, please explain. Identify if any safety measures are needed, required or taken.

IV. Relevant Medical Conditions See Information on _____ dated: _____

Hearing Impairment Yes No Visual Impairment Yes No Motor Impairment Yes No

Other Sensory Impairment Yes No If yes, specify:

Allergies Yes No If yes, specify:

Other Medical Conditions Yes No If yes, specify:

Last Physical Exam Date: _____

Other Comments Regarding Medical Conditions:

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Name:

IS#:

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V. Medications

Client is currently on medications: Yes No If yes, How many days of medication does the client have left? _____
If yes, specify medications (include name and if there are any side-effects/adverse reactions).

VI. Substance Use/Abuse

"MH659 -Co-Occurring Joint Action Council Screening Instrument"

1. Were any of the questions checked "Yes" in Section 2 "Alcohol & Drug Use"? Yes* No **If yes, complete A and B below**

2. Were any of the questions checked "Yes" in Section 3 "Trauma/Domestic Violence"? Yes No **If yes, answer 2a**

2a. Was the Trauma or Domestic Violence related to substance use? Yes* No **If yes, complete A and B below**

A. Alcohol Screening Questions

1 Drink = 12 Ounces of Beer

1. How often do you have a drink containing alcohol?
If "Never", proceed to Drug Screening Questions. Never Monthly or less 2-4 times a month 3 times a week 4+ times a week

1a. How many drinks containing alcohol do you have on a typical day when you are drinking? 1 or 2 3 or 4 5 or 6 7 to 9 10+

1b. How often do you have six or more drinks on one occasion? Never Less than monthly Monthly Weekly Daily or almost daily

B. Drug Screening Questions

1. Have you used any drug in the past 30 days that was NOT prescribed by a doctor? Yes No

| 2. Drug Type(s) Used (Indicate with an "*" which substances are most preferred.) | Ever Used? | | Recently Used? (Past 6 Months) | | Route of Administration or other comments (IV use, smoking, snorting, etc.) |
|---|--------------------------|--------------------------|-----------------------------------|--------------------------|--|
| | Yes | No | Yes | No | |
| Amphetamines (Meth, crank, ice, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Cocaine or crack | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Hallucinogens | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Inhalants | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Marijuana | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Nicotine (Cigarettes, cigars, smokeless tobacco) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Opiates (Heroin, codeine, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Over the Counter Meds (Cough syrup, diet aids, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Sedatives (Pain meds, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Other (specify): | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

C. Additional Comments (i.e. frequency, duration of use, etc.):

VII. Psychosocial See Information on _____ dated: _____

Family & Relationships, Dependent Care Issues (Number of Dependents, Ages, Needs & Special Needs), Current Living Arrangement, Social Support Systems, Education, Employment History/Readiness/Means of Financial Support, Legal History and Current Legal Status which may impact linkage/referral.

VIII. Additional Client Contacts/Relationships: Refer to the "MH 525: Contact Information" form.

DCFS Probation DPSS Health Outside Meds Regional Center Substance Abuse/12 Step Consumer Run/NAMI Education/AB 3632
 Other _____

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IX. Mental Status

General Description

- Grooming & Hygiene:** Well Groomed
 Average Dirty Odorous Disheveled
 Bizarre
Eye Contact: Normal for culture
 Little Avoids Erratic
Motor Activity: Calm Restless
 Agitated Tremors/Tics Posturing Rigid
 Retarded Akathesis E.P.S.
Speech: Unimpaired Soft Slowed
 Mute Pressured Loud Excessive
 Slurred Incoherent Poverty of Content
Interactional Style: Culturally congruent
 Cooperative Sensitive
 Guarded/Suspicious Overly Dramatic
 Negative Silly
Orientation: Oriented
 Disoriented to:
 Time Place Person Situation
Intellectual Functioning: Unimpaired
 Impaired
Memory: Unimpaired
 Impaired re: Immediate Remote Recent
 Amnesia
Fund of Knowledge: Average
 Below Average Above Average

Mood and Affect

- Mood:** Euthymic Dysphoric Tearful
 Irritable Lack of Pleasure
 Hopeless/Worthless Anxious
 Known Stressor Unknown Stressor
Affect: Appropriate Labile Expansive
 Constricted Blunted Flat Sad Worries

Perceptual Disturbance

- None Apparent
Hallucinations: Visual Olfactory
 Tactile Auditory: Command
 Persecutory Other
Self-Perceptions: Depersonalizations
 Ideas of Reference

Thought Process Disturbances

- None Apparent
Associations: Unimpaired Loose
 Tangential Circumstantial
 Confabulous
 Flight of Ideas Word Salad
Concentration: Intact Impaired by:
 Rumination Thought Blocking
 Clouding of Consciousness
 Fragmented
Abstractions: Intact Concrete
Judgments: Intact
 Impaired re: Minimum Moderate
 Severe
Insight: Adequate
 Impaired re: Minimum Moderate
 Severe
Serial 7's: Intact Poor

Thought Content Disturbance

- None Apparent
Delusions: Persecutory Paranoid
 Grandiose Somatic Religious
 Nihilistic Being Controlled
Ideations: Bizarre Phobic Suspicious
 Obsessive Blames Others Persecutory
 Assaultive Ideas Magical Thinking
 Irrational/Excessive Worry
 Sexual Preoccupation
 Excessive/Inappropriate Religiosity
 Excessive/Inappropriate Guilt
Behavioral Disturbances: None
 Aggressive
 Uncooperative Demanding Demeaning
 Belligerent Violent Destructive
 Self-Destructive Poor Impulse Control
 Excessive/Inappropriate Display of Anger
 Manipulative Antisocial
Suicidal/Homicidal: Denies Ideation Only
 Threatening Plan Past Attempts
Passive: Amotivational Apathetic
 Isolated Withdrawn Evasive
 Dependent
Other: Disorganized Bizarre
 Obsessive/compulsive Ritualistic
 Excessive/Inappropriate Crying

Comments on Mental Status:

X. Summary

Summary/ Clinical Impression (including strengths and attitude towards treatment):

Diagnosis: **Axis I** Prim Sec Code _____ Nomenclature _____
 Sec Code _____ Nomenclature _____
 Sec Code _____ Nomenclature _____
Axis II Prim Sec Code _____ Nomenclature _____
 Sec Code _____ Nomenclature _____
Axis III Code _____ Nomenclature _____
Code _____ Nomenclature _____
Code _____ Nomenclature _____
Axis IV 1. Primary support group 2. Social environment 3. Educational 4. Occupational
5. Housing 6. Economics 7. Access to health care 8. Interaction w/legal system
9. Other psychosocial/environmental 10. Inadequate information
Axis V GAF _____ **Dual Diagnosis Code:** _____

Disposition/Recommendations/Plan:

Signature & Discipline

Date

Co-Signature & Discipline (if required)

Date

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