Immediate / Same Day Services Assessment

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

Was assessment conducted in language other than English? ☐ Yes ☐ No Language: _____

SPECIAL SERVICE NEEDS:
☐ Cultural Considerations, specify: _____
☐ Physically challenged (wheelchair, hearing, visual, etc.), specify: _____
☐ Access issues (transportation, hours, etc.), specify: _____

I. REASON FOR REFERRAL / CHIEF COMPLAINT

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):

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

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:

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II. MENTAL HEALTH HISTORY

Outpatient and inpatient history (include dates, providers, interventions, and responses)

III. CURRENT RISK AND SAFETY CONCERNS ☐ See Information on _____ dated: _____

Current Thoughts of Self-injurious behavior	☐Yes	☐No	Past Thoughts of Self-injurious behavior	☐Yes	☐No
Probation/Parole Involvement	☐Yes	☐No	Current/History of Injuring Animals	☐Yes	☐No
Recent Trauma Exposure	☐Yes	☐No	Recent Job Loss	☐Yes	☐No
Victim of Violence/Abuse	☐Yes	☐No	DCFS Involvement	☐Yes	☐No
Access to Guns/Weapons	☐Yes	☐No	Current Thoughts of Harming Another Person	☐Yes	☐No
Past Thoughts of Harming Another Person	☐Yes	☐No	History of Homicide/Manslaughter	☐Yes	☐No
History of Injuring Another Person	☐Yes	☐No	School Issues or IEP in place	☐Yes	☐No
Current Substance Use/Abuse	☐Yes	☐No	Past Substance Use/Abuse	☐Yes	☐No
Perpetrator of Violence/Abuse	☐Yes	☐No			

Other (specify):

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

IV. RELEVANT MEDICAL CONDITIONS

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: _____
For any marked yes, please specify. Other Comments Regarding Medical Conditions:

V. DEVELOPMENTAL HISTORY (required for children)

Describe developmental history, making note of developmental milestones and environmental stressors

VI. MEDICATIONS

Client is currently on medications: ☐ Yes ☐ No If yes, How many days of medication does the client have left? _____
Specify current or past medications (include name, dosage/frequency, period taken, and if there are any side-effects/adverse reactions).

VII. SUBSTANCE USE / ABUSE

Does the client currently appear to be under the influence of alcohol or drugs? ☐ Yes ☐ No
Additional Comments (i.e. drugs using, frequency, duration of use, etc.):

When was the last time the client used alcohol or drugs? _____
Has the client ever received professional help for his/her use of alcohol or drugs? ☐ Yes ☐ No If yes, please explain below:

Any other comments regarding substance use:

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VIII. RELEVANT PSYCHOSOCIAL INFORMATION

Describe any of the following issues that may impact linkage/referral: *education/school history, employment history, vocational information, legal/Juvenile Court history, child abuse/protective service information, dependent care issues, current and past living situations, family history/relationships, family strengths*

Is the client homeless: ☐ Yes ☐ No ☐ Unable to Assess
If yes, when did the client become homeless (estimated date)? _____
Military Service: ☐ **Yes** ☐ **No** ☐ **Unable to Assess**

IX. Other Agency Involvement:

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

X. MENTAL STATUS EXAM

Instructions: Check all descriptions that apply

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: ☐ Denies ☐ Ideation Only
☐ Threatening ☐ Plan
Homicidal: Denies Ideation Only Threatening Plan Target(s)
Passive: ☐ Amotivational ☐ Apathetic
☐ Isolated ☐ Withdrawn ☐ Evasive
☐ Dependent
Other: ☐ Disorganized ☐ Bizarre
☐ Obsessive/compulsive ☐ Ritualistic
☐ Excessive/Inappropriate Crying

Comments on Mental Status:

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XI. CLINICAL FORMULATION AND PLAN

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 _____
Code _____
Code _____

Disposition/Recommendations/Plan:

SIGNATURE:

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

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