MH 532
Revised 7/1/19

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 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

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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.

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

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)

Alcohol Screening Score: _____

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

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? *(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 marijuana? (smoked, edibles, wax, or other)	☐	☐	☐	☐
7. Have you used hallucinogens? (MDMA or Ecstasy, LSD, PCP, mushrooms, or psilocin)	☐	☐	☐	☐
8. Have you used drugs intravenously?	☐	☐	☐	☐
9. Have you used other substances of abuse?	☐	☐	☐	☐

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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	
☐	☐	☐	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):

☐ ☐ 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

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
- Code

Disposition/Recommendations/Plan:

SIGNATURE

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

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