

# ADULT INITIAL ASSESSMENT

Admit Date: \_\_\_\_\_

## I. Demographic Data & Special Service Needs:

Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Referral Source: \_\_\_\_\_

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: \_\_\_\_\_

## II. Reason for Referral/Chief Complaint

Describe precipitating event(s), current symptoms and impairments in life functioning, including intensity and duration, from the perspective of the client as well as significant others:

## III. Psychiatric History:

**A. Hospitalizations** [date(s) & location(s)]. **Outpatient treatment** [date(s) & location(s)]. History and onset of current symptoms/manifestations/precipitating events (i.e., aggressive behaviors, suicidal, homicidal, access to lethal means). Treated & non-treated history.

**B.** Describe the **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.

**C. Family history of mental illness**

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**IV. 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"/>	Seizure/neuro disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular disease/symp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
	<input type="checkbox"/>	<input type="checkbox"/>	Head trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease/symp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Renal disease/symp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/lung disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual dysfunction
	<input type="checkbox"/>	<input type="checkbox"/>	Weight/appetite chg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually trans disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (If Yes, specify):												
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensory/Motor Impairment (If Yes, specify):												
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pap smear If yes, date: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mammogram If yes, date: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV Test If yes, date: _____	<input type="checkbox"/>	<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.

**V. Medications**

List "all" past and present medications used, prescribed/non-prescribed, psychotropic, 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>

**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 MH633**
- 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 MH633**

*Be sure to document re: Trauma or Domestic Violence in Part A of "Psychosocial History" on page 3 of the Initial Assessment.*

**How is Mental Health impacted by substance use (Clinician's Perspective)?** Must be completed if any services will be directed towards Substance Use/Abuse.

\* MH 633 "Supplemental Co-Occurring Disorders Assessment" completed on: \_\_\_\_\_

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**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.**

- A. Family & Relationships:** Family constellation, family of origin and current family, family dynamics, cultural factors, nature of relationships, domestic violence, physical or sexual abuse, home safety issues (i.e., the presence of firearms.)
  
- B. Dependent Care Issues:** # \_\_\_\_ of Adults, # \_\_\_\_ dependent children, age(s) of child(ren), school attendance/behavior problems learning problems, special need(s), including physical impairments, discipline issues, juvenile court history, dependent care needs; any unattended needs of children, child support, child custody, and guardianship issues, foster care/group home placement.
  
- C. Current Living Arrangement & Social Support Systems:** Type of setting and associated problems, support from community, religious, government agencies, and other sources (i.e., Section 8 Housing, SRO, Board and Care, Semi-independent, family and transitional living, etc.)
  
- D. Education:** Highest grade level completed, educational goals. Skill level: literacy level, vocabulary, general knowledge, math skills, school problems, motivation.
  
- E. Employment History/Employment Readiness/Mean of Financial Support:** Longest period of employment, employment history, military service, work related problems, money management, source of income. Areas of strength.
  
- F. Legal History and Current Legal Status:** Parole, probation, arrests, convictions, divorce, child custody, conservatorship

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**VIII. Mental Status Evaluation**

**Length of current treatment:** \_\_\_\_\_ **Is this part of a 5150?**  Yes  No **Medication:**  Yes  No **Client is:**  Stable  Unstable

Instructions: Check all descriptions that apply

General Description	Mood and Affect	Thought Content Disturbance
<p><b>Grooming &amp; Hygiene:</b> <input type="checkbox"/> Well Groomed  <input type="checkbox"/> Average <input type="checkbox"/> Dirty <input type="checkbox"/> Odorous <input type="checkbox"/> Disheveled  <input type="checkbox"/> Bizarre  Comments:</p>	<p><b>Mood:</b> <input type="checkbox"/> Euthymic <input type="checkbox"/> Dysphoric <input type="checkbox"/> Tearful  <input type="checkbox"/> Irritable <input type="checkbox"/> Lack of Pleasure  <input type="checkbox"/> Hopeless/Worthless <input type="checkbox"/> Anxious  <input type="checkbox"/> Known Stressor <input type="checkbox"/> Unknown Stressor  Comments:</p>	<p><input type="checkbox"/> None Apparent    <b>Delusions:</b> <input type="checkbox"/> Persecutory <input type="checkbox"/> Paranoid <input type="checkbox"/> Grandiose  <input type="checkbox"/> Somatic <input type="checkbox"/> Religious <input type="checkbox"/> Nihilistic  <input type="checkbox"/> Being Controlled  Comments:</p>
<p><b>Eye Contact:</b> <input type="checkbox"/> Normal for culture  <input type="checkbox"/> Little <input type="checkbox"/> Avoids <input type="checkbox"/> Erratic  Comments:</p>	<p><b>Affect:</b> <input type="checkbox"/> Appropriate <input type="checkbox"/> Labile <input type="checkbox"/> Expansive  <input type="checkbox"/> Constricted <input type="checkbox"/> Blunted <input type="checkbox"/> Flat <input type="checkbox"/> Sad  <input type="checkbox"/> Worried  Comments:</p>	<p><b>Ideations:</b> <input type="checkbox"/> Bizarre <input type="checkbox"/> Phobic <input type="checkbox"/> Suspicious  <input type="checkbox"/> Obsessive <input type="checkbox"/> Blames Others <input type="checkbox"/> Persecutory  <input type="checkbox"/> Assaultive Ideas <input type="checkbox"/> Magical Thinking  <input type="checkbox"/> Irrational/Excessive Worry  <input type="checkbox"/> Sexual Preoccupation  <input type="checkbox"/> Excessive/Inappropriate Religiosity  <input type="checkbox"/> Excessive/Inappropriate Guilt  Comments:</p>
<p><b>Motor Activity:</b> <input type="checkbox"/> Calm <input type="checkbox"/> Restless  <input type="checkbox"/> Agitated <input type="checkbox"/> Tremors/Tics <input type="checkbox"/> Posturing <input type="checkbox"/> Rigid  <input type="checkbox"/> Retarded <input type="checkbox"/> Akathesis <input type="checkbox"/> E.P.S.  Comments:</p>	<p style="text-align: center;"><b>Perceptual Disturbance</b></p> <p><input type="checkbox"/> None Apparent</p> <p><b>Hallucinations:</b> <input type="checkbox"/> Visual <input type="checkbox"/> Olfactory  <input type="checkbox"/> Tactile <input type="checkbox"/> Auditory: <input type="checkbox"/> Command  <input type="checkbox"/> Persecutory <input type="checkbox"/> Other  Comments:</p>	<p><b>Behavioral Disturbances:</b> <input type="checkbox"/> None <input type="checkbox"/> Aggressive  <input type="checkbox"/> Uncooperative <input type="checkbox"/> Demanding <input type="checkbox"/> Demeaning  <input type="checkbox"/> Belligerent <input type="checkbox"/> Violent <input type="checkbox"/> Destructive  <input type="checkbox"/> Self-Destructive <input type="checkbox"/> Poor Impulse Control  <input type="checkbox"/> Excessive/Inappropriate Display of Anger  <input type="checkbox"/> Manipulative <input type="checkbox"/> Antisocial  Comments:</p>
<p><b>Speech:</b> <input type="checkbox"/> Unimpaired <input type="checkbox"/> Soft  <input type="checkbox"/> Slowed <input type="checkbox"/> Mute <input type="checkbox"/> Pressured <input type="checkbox"/> Loud  <input type="checkbox"/> Excessive <input type="checkbox"/> Slurred <input type="checkbox"/> Incoherent  <input type="checkbox"/> Poverty of Content  Comments:</p>	<p><b>Self-Perceptions:</b> <input type="checkbox"/> Depersonalizations  <input type="checkbox"/> Ideas of Reference  Comments:</p>	<p><b>Suicidal/Homicidal:</b> <input type="checkbox"/> Denies Ideation Only  <input type="checkbox"/> Threatening <input type="checkbox"/> Plan <input type="checkbox"/> Past Attempts  <input type="checkbox"/> Access to Lethal Means  Comments:</p>
<p><b>Interactional Style:</b> <input type="checkbox"/> Culturally congruent  <input type="checkbox"/> Cooperative <input type="checkbox"/> Sensitive  <input type="checkbox"/> Guarded/Suspicious <input type="checkbox"/> Overly Dramatic  <input type="checkbox"/> Negative <input type="checkbox"/> Silly  Comments:</p>	<p style="text-align: center;"><b>Thought Process Disturbances</b></p> <p><input type="checkbox"/> None Apparent</p> <p><b>Associations:</b> <input type="checkbox"/> Unimpaired <input type="checkbox"/> Loose  <input type="checkbox"/> Tangential <input type="checkbox"/> Circumstantial <input type="checkbox"/> Confabulous  <input type="checkbox"/> Flight of Ideas <input type="checkbox"/> Word Salad  Comments:</p>	<p><b>Passive:</b> <input type="checkbox"/> Amotivational <input type="checkbox"/> Apathetic  <input type="checkbox"/> Isolated <input type="checkbox"/> Withdrawn <input type="checkbox"/> Evasive <input type="checkbox"/> Dependent  Comments:</p>
<p><b>Orientation:</b> <input type="checkbox"/> Oriented  <input type="checkbox"/> Disoriented to:  <input type="checkbox"/> Time <input type="checkbox"/> Place <input type="checkbox"/> Person <input type="checkbox"/> Situation  Comments:</p>	<p><b>Concentration:</b> <input type="checkbox"/> Intact <input type="checkbox"/> Impaired by:  <input type="checkbox"/> Rumination <input type="checkbox"/> Thought Blocking  <input type="checkbox"/> Clouding of Consciousness <input type="checkbox"/> Fragmented  Comments:</p>	<p><b>Other:</b> <input type="checkbox"/> Disorganized <input type="checkbox"/> Bizarre  <input type="checkbox"/> Obsessive/compulsive <input type="checkbox"/> Ritualistic  <input type="checkbox"/> Excessive/Inappropriate Crying  Comments:</p>
<p><b>Intellectual Functioning:</b> <input type="checkbox"/> Unimpaired  <input type="checkbox"/> Impaired  Comments:</p>	<p><b>Abstractions:</b> <input type="checkbox"/> Intact <input type="checkbox"/> Concrete  Comments:</p>	
<p><b>Memory:</b> <input type="checkbox"/> Unimpaired  <input type="checkbox"/> Impaired re: <input type="checkbox"/> Immediate <input type="checkbox"/> Remote <input type="checkbox"/> Recent  <input type="checkbox"/> Amnesia  Comments:</p>	<p><b>Judgments:</b> <input type="checkbox"/> Intact  <input type="checkbox"/> Impaired re: <input type="checkbox"/> Minimum <input type="checkbox"/> Moderate <input type="checkbox"/> Severe  Comments:</p>	
<p><b>Fund of Knowledge:</b> <input type="checkbox"/> Average  <input type="checkbox"/> Below Average <input type="checkbox"/> Above Average  Comments:</p>	<p><b>Insight:</b> <input type="checkbox"/> Adequate  <input type="checkbox"/> Impaired re: <input type="checkbox"/> Minimum <input type="checkbox"/> Moderate <input type="checkbox"/> Severe  Comments:</p>	
	<p><b>Serial 7's:</b> <input type="checkbox"/> Intact <input type="checkbox"/> Poor  Comments:</p>	

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**IX. Summary and Diagnosis**

**I. Diagnostic Summary:** (Be sure to include assessment for 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. Admission Diagnosis** (check one Principle and one Secondary)

**Axis I**  Prin  Sec Code \_\_\_\_\_ Nomenclature \_\_\_\_\_  
(Medications cannot be prescribed with a deferred diagnosis)

Sec Code \_\_\_\_\_ Nomenclature \_\_\_\_\_

Code \_\_\_\_\_ Nomenclature \_\_\_\_\_

Code \_\_\_\_\_ Nomenclature \_\_\_\_\_

Code \_\_\_\_\_ Nomenclature \_\_\_\_\_

**Axis II**  Prin  Sec Code \_\_\_\_\_ Nomenclature \_\_\_\_\_

Sec Code \_\_\_\_\_ Nomenclature \_\_\_\_\_

Code \_\_\_\_\_ Nomenclature \_\_\_\_\_

**Axis III** \_\_\_\_\_ Code \_\_\_\_\_

\_\_\_\_\_ Code \_\_\_\_\_

\_\_\_\_\_ Code \_\_\_\_\_

**Axis IV** Psychological and Environmental Problems which may affect diagnosis, treatment, or prognosis

**Primary Problem #:** \_\_\_\_

**Check as many that apply:**

- 1.  Primary support group    2.  Social environment    3.  Educational    4.  Occupational
- 5.  Housing    6.  Economics    7.  Access to health care    8.  Interaction with legal system
- 9.  Other psychosocial/environmental    10.  Inadequate information

**Axis V** Current GAF: \_\_\_\_\_ DMH Dual Diagnosis Code: \_\_\_\_\_

Above diagnosis from: \_\_\_\_\_ Dated: \_\_\_\_\_

**III. Disposition/Recommendations/Plan**

**IV. Signatures**

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

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