Initial Health Assessment

Today's Date: _____ Program Entrance Date: _____ Birth Date: _____ Age: _____ Race/Ethnicity: _____

Name: _____ Gender: M ☐ F ☐ TG ☐ Cell Phone Number: _____

Address: _____

Marital Status: Married ☐ Separated ☐ Divorced ☐ Single ☐ Widowed ☐

Number of Children: _____ Ages: _____

Health Insurance Information Yes ☐ No ☐

Name of Insurance Co.: _____ Member Number _____

Effective Date: _____ Clinic Name: _____

Clinic Address: _____ Hospital: _____

Your next medical appointment is on (date): _____

Health History

Please list diagnosis (es) made by any Medical Doctor and/or Psychiatrist _____

_____

Current medications: _____

_____

Special Needs

Mental Health ☐Yes ☐No Developmentally Disabled ☐Yes ☐No Drug Abuse ☐Yes ☐No

HIV/AIDS ☐Yes ☐No Physical Disability ☐Yes ☐No Alcohol Abuse ☐Yes ☐No

Gay/Lesbian/Bisexual ☐Yes ☐No Immigrant ☐Yes ☐No Older Person 65+ ☐Yes ☐No

Allergies

Medication(s): _____

Food: _____ Insect Stings: _____

Asthma: _____ Other: _____

In the past 6 months, have you been in contact with anyone with? Hepatitis: ☐Yes ☐No Tuberculosis: ☐Yes ☐No
Chicken Pox: ☐Yes ☐No

Do you currently have any physical pain? ☐Yes ☐No If yes, where? _____ For how long? _____

Are you pregnant? ☐Yes ☐No Date of last menses/menstrual cycle: _____

Method of Contraception: _____

Date of last OB/GYN exam _____ Date of last pap-smear _____ Date of last mammogram _____

Have you ever been diagnosed w/ TB? ☐Yes ☐No If yes, when? _____ Treated? ☐Yes ☐No

Date of last TB test date: _____ Results: _____

1a. General Questions

Date of last physical exam: _____

Date of last dental exam: _____

Have dental prosthesis? ☐Yes ☐No

Ever been knocked unconscious? ☐Yes ☐No

Ever had seizures? ..... ☐Yes ☐No
If yes, when? _____

Ever had surgery? ..... ☐Yes ☐No
If yes, when? _____

What type? _____

Ever had a head injury? ☐Yes ☐No

If yes, when? _____

Frequent headaches? ..... ☐Yes ☐No

Do you have a heart murmur? ☐Yes ☐No

Wears contact lenses/glasses? ☐Yes ☐No

1b. General Questions

Diabetes? ..... ☐Yes ☐No

Cancer? ..... ☐Yes ☐No

Ever had been hospitalized? ... ☐Yes ☐No

If yes, why? _____

If yes, when? _____

Ever had high cholesterol? ..... ☐Yes ☐No

Ever had skin problems? ..... ☐Yes ☐No
If yes what kind? _____

Abnormal menstrual history? ☐Yes ☐No

Ever had an eating disorder? ☐Yes ☐No

Any other medical conditions not covered?

_____

_____

_____

_____

Do you smoke? ☐Yes ☐No
If yes, how long? _____ ☐ Years ☐Months ☐Days

Previous Illness

Tested for STDs ☐No ☐Yes Date: _____ Results: _____

Treated ☐No ☐Yes Date: _____

Tested for HIV ☐No ☐Yes Date: _____ Results: _____

Treated ☐No ☐Yes Date: _____

Substance Abuse History

In the past six months, have you abused?

Alcohol ☐Yes ☐No Drugs (recreational/street) ☐Yes ☐No

If yes, have you been treated? ☐Yes ☐No

Sexual Abuse

Have you ever been sexually abused? ☐Yes ☐No
If yes, age when abuse occurred? _____
Length of time abuse occurred? _____
Have you had more than one attacker? ☐Yes ☐No
Was abuse reported? ☐Yes ☐No
If yes, was anything done to the abuser? ☐Yes ☐No ☐ Don't know

Psychosocial
Client was:

Alert ☐ Confused ☐ Forgetful ☐ Disoriented ☐ Lethargic ☐ Angry ☐ Hostile ☐

Client Behavior during Intake

Cooperative ☐ Anxious ☐ Depressed ☐ Demanding ☐ Talkative ☐ Aggressive ☐

Comments: _____

_____

The following health care issues have been identified:

- _____
- _____
- _____
- _____

The following plan will be implemented:

ACTIVITY	RESPONSIBLE PARTY	TIMEFRAME	OUTCOME

Referral

√	REFERRAL TYPE	ORGANIZATION/ COMPANY NAME	CONTACT NAME
	Health		
	Dental		
	Vision		
	Other		

_____ _____

Completed by **Date**

Adult Mental Health Assessment

I. Demographic Data:

Age: _____ Gender: _____ Ethnicity: _____ Marital Status: _____

Preferred Language: _____ Referral Source: _____

II. Presenting Problem/Chief Complaint:

Describe event(s), including intensity and duration, from the perspective of the client as well as any significant others.

III. Psychiatric History:

A. Outpatient treatment (number, first, last, when and where). History and onset of current symptoms/ manifestations/ precipitating events (aggressive, suicidal, homicidal). Treated & non-treated history. What client feels has and has not worked. Hospitalizations (number, first, last, when and where).

B. Describe the impact of the 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.

IV. Medical History

Date of last physical. Current medical problem (treated or untreated). Other medical problems. Medical hospitalizations (number of times, first and last, when and where). Surgeries. Allergies. Head traumas. Seizures. Accidents. Menstruation history. Attending physician.

V. Medications

List past and present medications used, prescribed/ non-prescribed, psychotropic, etc. by name, dosage, frequency. Indicate from client's perspective what seems to be working and not working.

VI. Substance Abuse:

Discuss the following: What is currently being used? How much? How often? When used? What is the history of use for each substance discussed? Does client see use as a problem? How does client pay for substance? Is client currently in substance abuse treatment program? History of treatment (detox, outpatient, treatment for what, when, where, how long).

VII. Psychosocial History

A. **Family & Relationships:** Family constellation, family of origin and current family, family dynamics, dependant care issues, nature of relationships, cultural factors, domestic violence, physical or sexual abuse, family members with psychiatric history.

B. **Current Living & Support Situation:** Type of setting and association, problems, support from community, religious, government agencies, and other sources.

C. **Education:** Grade completed, skill level: literate, vocabulary, general knowledge, math skills, school problems, motivation.

D. **Employment History or Means of Financial Support:** Military history, money management, source of income, longest period of employment, employment history, work related problems.

E. **Legal History:** Parole, probation, arrests, convictions, divorce, child custody, conservatorship.

F. **Religious History:** Are you part of a religious or spiritual community? (If no: Were you ever?

If no, ask: What do you feel guides you when you are making important decisions about your life?

If yes: Do your religious or spiritual beliefs influence the way you look at your problems and the way you think about your health?

Would you like me to address your religious or spiritual beliefs and practices with you, or is there some way in which you would like your faith included in treatment?

VII. Mental Status Evaluations

Length of current treatment: _____ Medication: Yes, No, Stable, Not Stable _____

Instructions: Circle 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
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: Time Place Person Situation
Comments:_____

Intellectual Functioning:
Unimpaired Impaired
Comments:_____

Memory: Unimpaired
Impaired: Immediate Remote Recent Amnesia
Comments:_____

Fund of Knowledge: Average Below Average Above Average

Mood and Affect

Mood: Euthymic Dysphoric Tearful Irritable Lack of pleasure Irritable Hopeless/Worthless Anxious: Known stressor Unknown stressor Euphoric

Comment:_____
Affect: Appropriate Labile Expansive Constricted Blunted Flat Sad Worried

Comment:_____

Perceptual Disturbance

None Apparent
Hallucinations: Visual Olfactory Tactile Auditory (command/persecutory/other)

Comments:_____
Self-Perceptions:
Depersonalizations Ideas of reference

Comments:_____

Clouding of consciousness
Fragmented
Abstractions: Intact Concrete
Judgments: Intact Impaired: minimum, moderate, severe
Insight: Adequate
Impaired: minimum, moderate, severe

Comments:_____

Serial 7's: Intact Poor (100 –7) (-7) (-7)

Thought Content Disturbance

None Apparent
Delusions: Persecutory/Paranoid Grandiose Somatic Religious Nihilistic Being controlled

Comments:_____

Ideations: Bizarre Phobic Suspicious Obsessive Blame Others Persecutory Assaultive ideas Magical thinking Irrational/Excessive worry Sexual preoccupation Excessive/Inappropriate religiosity Excessive/Inappropriate guilt

Comments:_____

Behavioral Disturbances: None Aggressive Uncooperative Demanding Demeaning Belligerent Violent/Destructive Self-destructive Poor impulsive control Excessive/Inappropriate display of anger Manipulative Antisocial

Comments:_____

Suicidal/Homicidal: Denies Ideation only Threatening Plan Past attempts

Comments:_____

Passive: Amotivational/Apathetic Isolated/withdrawn Evasive Dependent
Comments:_____

Other: Disorganized/Bizarre Obsessive/Compulsive/Ritualistic Excessive/Inappropriate Crying

Comments:_____

VIII. Summary and Diagnosis

A. Diagnostic Summary: (Significant: strengths/weaknesses, observations/descriptions, or list of symptoms.)

B. Admission Diagnosis:
(circle one)

Axis I Prim/Sec Code _____ Nomenclature _____
(Medications cannot be prescribed with a deferred diagnosis.)

P / S Code _____ Nomenclature _____

P / S Code _____ Nomenclature _____

Axis II P / S Code _____ Nomenclature _____

P / S Code _____ Nomenclature _____

Axis III _____ Code _____ DMH Dual Diagnoses Code _____

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

Primary Problem ____ Circle as many as apply: 1. Primary support group 2. Social environment

3. Educational 4. Occupational 5. Housing 6. Economic 7. Access to health care

8. interaction with legal system 9. Other psychosocial/environmental 10. Inadequate information

Axis V Current GAF _____

C. Disposition/Recommended/Plan:

IX. Signatures

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