



Name (First MI Last):	Record #:	DOB:
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Organization Name:	Date of Admission:
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Referral Source: (include name/role/organization):
Referral Telephone:

Presenting Concerns (In Person's Served/Family's Own Words)

What Occurred to Cause the Person to Seek Services Now:

Precipitating Factors (Note Symptoms, Behavioral and Functioning Needs, include what has the person has done in this instance and/or previously to cope and stabilize, coping skills resources and supports the person wants to use right now):

Risk Management/Safety Plan: Does the person have a Risk Management/Safety Plan? No Yes
 If yes, indicate how it was used during this encounter to impact the assessment, intervention and disposition (check all that apply):
 reviewed contacted collaterals on plan contacted natural supports on plan utilized stabilization strategies identified on plan revised plan plan saved in ESP system plan forwarded to collaterals other:
 If no, complete a Risk Management/Safety Plan. Completed? Yes No

Collaterals involved and/or Contacted					
Contact	Contact (Name)		Telephone		Date & Time
PCP					
Results:					
Clinician					
Results:					
Psychiatrist					
Results:					
DMH/DDS					
Results:					
DCF					
Results:					
School/ Residence					
Results:					
Guardian					
Indicate Type of Guardianship:					
Results:					
Family/ Sig Other					
Results:					
Other					
Results:					



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Substance Use / Addictive Behavior History

Does person report a history of, or current, substance use or other addictive behavior concerns? No Yes; If no, skip to MH Service History section. If yes, please complete and attach SU/Addictive Behavior History Addendum.

Mental Health Service History
 None Reported - If None Reported, skip to the Health Summary section

Mental Health Treatment: (Check all that apply) CBFS Assertive Community Treatment Outpatient
 Inpatient Day Treatment/Rehab/Clubhouse Other:

Type of Service	Dates of Service	Reason	Name of Provider/Agency:	Completed
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

Previous or Current Diagnoses: Not known by person served /

Summary of Current Mental Health Functioning/Symptoms:

Current Medication Information (Include Non-Psych Meds/Prescription/ OTC/ Herbal) None Reported

Medication	Rationale/ Condition	Dosage / Route / Frequency	Reported Side-effects	Adherence WA = With Assistance	Prescriber
				<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> WA	
				<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> WA	
				<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> WA	
				<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> WA	
				<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> WA	
				<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> WA	
				<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> WA	
				<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> WA	

Comments on Past Medications: (Include what medications have worked well previously, any adverse side effects, and/or which one(s) the person would like to avoid taking in the future.):



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MEDICAL/PHYSICAL

Physical Health Summary OR Refer to Attached Physical Health Assessment

Allergies Reported: No Known Allergies

Food: _____ Medication: _____ Environmental: _____

Significant History Regarding Physical Health Reported (Include asthma, obesity, diabetes):

Current Status of Medical/Physical Functioning Reported (include current physical complaints):

Does the person or guardian request immediate medical evaluation? No Yes If yes, state reason:

Trauma History (Describe in comments section each element checked)

No Self Reported History of Abuse/Violence

Comments: (Include single event versus sustained):

Physical Abuse Victim Perpetrator

Domestic Violence/Abuse Victim Perpetrator

Elder Abuse Victim Perpetrator

Community Violence Victim Perpetrator

Physical Neglect Victim Perpetrator

Verbal/Emotional Abuse Victim Perpetrator

Sexual Abuse/Molestation Victim Perpetrator

Military Trauma Victim Perpetrator

Other Trauma Victim Perpetrator

Witness to Violence

Witness to MH/SU issues of household members

Current Involvement by: None Reported DCF DPPC Elder Affairs / Comments:

Additional Mandated Report Required?: DCF DPPC Elder Affairs / Comments:



Name (First MI Last):		Record #:	DOB:
Mental Status Exam – (WNL = Within Normal Limits) (** – If Checked, Risk Assessment is Required)			
Appearance:	<input type="checkbox"/> WNL <input type="checkbox"/> Neat and appropriate	<input type="checkbox"/> Physically unkempt	Clothing: <input type="checkbox"/> WNL <input type="checkbox"/> Disheveled <input type="checkbox"/> Out of the ordinary
Eye Contact:	<input type="checkbox"/> WNL <input type="checkbox"/> Avoidant <input type="checkbox"/> Intense	<input type="checkbox"/> Intermittent	
Build:	<input type="checkbox"/> WNL <input type="checkbox"/> Thin <input type="checkbox"/> Overweight	<input type="checkbox"/> Short	<input type="checkbox"/> Tall
Posture:	<input type="checkbox"/> WNL <input type="checkbox"/> Slumped <input type="checkbox"/> Rigid, tense	<input type="checkbox"/> Atypical	
Body Movement:	<input type="checkbox"/> WNL <input type="checkbox"/> Accelerated <input type="checkbox"/> Slowed <input type="checkbox"/> Peculiar <input type="checkbox"/> Restless <input type="checkbox"/> Agitated		
Behavior:	<input type="checkbox"/> Relaxed <input type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Overly compliant	<input type="checkbox"/> Withdrawn	<input type="checkbox"/> Sleepy
	<input type="checkbox"/> Nervous / Anxious <input type="checkbox"/> Restless <input type="checkbox"/> Silly <input type="checkbox"/> Avoidant / Guarded / Suspicious	<input type="checkbox"/> Preoccupied	<input type="checkbox"/> Demanding
	<input type="checkbox"/> Controlling <input type="checkbox"/> Unable to perceive pleasure <input type="checkbox"/> Provocative <input type="checkbox"/> Hyperactive <input type="checkbox"/> Impulsive <input type="checkbox"/> Agitated	<input type="checkbox"/> Angry	
	<input type="checkbox"/> Assaultive <input type="checkbox"/> Aggressive <input type="checkbox"/> Compulsive		
Speech:	<input type="checkbox"/> WNL <input type="checkbox"/> Mute <input type="checkbox"/> Over-talkative <input type="checkbox"/> Slowed <input type="checkbox"/> Slurred <input type="checkbox"/> Stammer <input type="checkbox"/> Rapid <input type="checkbox"/> Pressured		
	<input type="checkbox"/> Loud <input type="checkbox"/> Soft <input type="checkbox"/> Clear <input type="checkbox"/> Repetitive		
Emotional State-Mood:	<input type="checkbox"/> WNL <input type="checkbox"/> Lack of feelings <input type="checkbox"/> Blunted, unvarying <input type="checkbox"/> Euphoric, elated	<input type="checkbox"/> Tranquil	
	<input type="checkbox"/> Anger <input type="checkbox"/> Hostility <input type="checkbox"/> Irritable <input type="checkbox"/> Fear, apprehension <input type="checkbox"/> Depressed, sadness	<input type="checkbox"/> Anxious	
Emotional State-Affect:	<input type="checkbox"/> WNL <input type="checkbox"/> Constricted <input type="checkbox"/> Flat <input type="checkbox"/> Inappropriate <input type="checkbox"/> Changeable <input type="checkbox"/> Full		
	<input type="checkbox"/> Panic attacks or symptoms <input type="checkbox"/> Sleep disturbance <input type="checkbox"/> Appetite disturbance		
Facial Expression:	<input type="checkbox"/> WNL <input type="checkbox"/> Anxiety, fear, apprehension <input type="checkbox"/> Sadness, depression <input type="checkbox"/> Anger, hostility, irritability		
	<input type="checkbox"/> Expressionless <input type="checkbox"/> Unvarying <input type="checkbox"/> Inappropriate <input type="checkbox"/> Elated		
Perception:	<input type="checkbox"/> WNL <input type="checkbox"/> Illusions <input type="checkbox"/> Depersonalization	<input type="checkbox"/> De-realization	<input type="checkbox"/> Re-experiencing
Hallucinations -	<input type="checkbox"/> Auditory <input type="checkbox"/> Visual <input type="checkbox"/> Olfactory <input type="checkbox"/> Gustatory	<input type="checkbox"/> Tactile	<input type="checkbox"/> Command**
Thought Content:	<input type="checkbox"/> WNL		
Delusions -	<input type="checkbox"/> None reported <input type="checkbox"/> Grandiose <input type="checkbox"/> Persecutory <input type="checkbox"/> Somatic <input type="checkbox"/> Illogical <input type="checkbox"/> Chaotic <input type="checkbox"/> Religious		
Other Content -	<input type="checkbox"/> Preoccupied <input type="checkbox"/> Obsessional <input type="checkbox"/> Guarded <input type="checkbox"/> Phobic <input type="checkbox"/> Suspicious <input type="checkbox"/> Guilty		
	<input type="checkbox"/> Thought broadcasting <input type="checkbox"/> Thought insertion <input type="checkbox"/> Ideas of reference		
Self Abuse Thoughts-	<input type="checkbox"/> None reported <input type="checkbox"/> Cutting** <input type="checkbox"/> Burning** <input type="checkbox"/> Other self mutilation**		
Suicidal Thoughts -	<input type="checkbox"/> None reported <input type="checkbox"/> Passive SI** <input type="checkbox"/> Intent** <input type="checkbox"/> Plan** <input type="checkbox"/> Means**		
Aggressive Thoughts -	<input type="checkbox"/> None reported <input type="checkbox"/> Intent** <input type="checkbox"/> Plan** <input type="checkbox"/> Means**		
Thought Process	<input type="checkbox"/> WNL <input type="checkbox"/> Incoherent <input type="checkbox"/> Circumstantial <input type="checkbox"/> Decreased thought flow		
	<input type="checkbox"/> Blocked <input type="checkbox"/> Flight of ideas <input type="checkbox"/> Loose <input type="checkbox"/> Racing <input type="checkbox"/> Increased thought flow <input type="checkbox"/> Concrete <input type="checkbox"/> Tangential		
Intellectual Functioning	<input type="checkbox"/> WNL <input type="checkbox"/> Lessened fund of common knowledge <input type="checkbox"/> Short attention span		
	<input type="checkbox"/> Impaired concentration <input type="checkbox"/> Impaired calculation ability		
Intelligence Estimate -	<input type="checkbox"/> MR, <input type="checkbox"/> Borderline <input type="checkbox"/> Average <input type="checkbox"/> Above average <input type="checkbox"/> No formal testing		
Orientation:	<input type="checkbox"/> WNL Disoriented to: <input type="checkbox"/> Person <input type="checkbox"/> Time <input type="checkbox"/> Place		
Memory:	<input type="checkbox"/> WNL Impaired: <input type="checkbox"/> Immediate recall <input type="checkbox"/> Recent memory <input type="checkbox"/> Remote memory		
Insight:	<input type="checkbox"/> WNL <input type="checkbox"/> Difficulty acknowledging presence of psychological problems		
	<input type="checkbox"/> Mostly blames other for problems <input type="checkbox"/> Thinks he/she has no problems		
Judgment:	<input type="checkbox"/> WNL Impaired Ability to Make Reasonable Decisions: <input type="checkbox"/> Some <input type="checkbox"/> Severe**		
Past Attempts to Harm Self or Others:	<input type="checkbox"/> None Reported <input type="checkbox"/> Self** <input type="checkbox"/> Others**		
Comment:			
Comments:			



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Risk Assessment								
Assess each risk factor and rate from 'No Risk' to 'High' Risk and check each row accordingly								
Risk Factors	<input checked="" type="checkbox"/>	No Risk	<input checked="" type="checkbox"/>	Low	<input checked="" type="checkbox"/>	Moderate	<input checked="" type="checkbox"/>	High
Plan to Harm Self	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	No Plan	<input type="checkbox"/>	Vague Plan	<input type="checkbox"/>	Specific Plan
Means Accessibility	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Poor Access	<input type="checkbox"/>	Accessible	<input type="checkbox"/>	Possesses
Lethality Of Means	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Low Lethality	<input type="checkbox"/>	Potentially Lethal	<input type="checkbox"/>	Lethal
Suicidal History	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Ideation/Threat(s)	<input type="checkbox"/>	Gesture(s)	<input type="checkbox"/>	Attempt(s)
Lethality Of Attempts	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Non-Lethal	<input type="checkbox"/>	Injurious	<input type="checkbox"/>	Potentially Lethal
Last Attempt	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	>2 Years	<input type="checkbox"/>	6 Months To 2 Years	<input type="checkbox"/>	Less Than 6 Months
Family History	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Ideation/Threat(s)	<input type="checkbox"/>	Suicide Attempts	<input type="checkbox"/>	Death(s) By Suicide
Plan To Harm Others	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	No Plan	<input type="checkbox"/>	Vague Plan	<input type="checkbox"/>	Specific Plan
Means Accessibility	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Poor Access	<input type="checkbox"/>	Accessible	<input type="checkbox"/>	Possesses
Lethality Of Means	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Low Lethality	<input type="checkbox"/>	Potentially Lethal	<input type="checkbox"/>	Lethal
Assault History	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Ideation/Threat(s)	<input type="checkbox"/>	Single Assault	<input type="checkbox"/>	Multiple Assaults
Lethality Of Assaults	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Minor Injuries	<input type="checkbox"/>	Moderate Injuries	<input type="checkbox"/>	Severe Injuries
Last Assault	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	>2 Years	<input type="checkbox"/>	6 Months To 2 Years	<input type="checkbox"/>	Less Than 6 Months
Family History	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	None	<input type="checkbox"/>	Periodic Violence	<input type="checkbox"/>	Persistent Violence
Arrest Record	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	None	<input type="checkbox"/>	Single Arrest	<input type="checkbox"/>	Multiple Arrests
Physical Abuse Hx	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Minimal Abuse	<input type="checkbox"/>	Moderate Abuse	<input type="checkbox"/>	Severe Abuse
Sexual Abuse Hx	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	No Abuse Reported	<input type="checkbox"/>	Abuse Reported	<input type="checkbox"/>	Severe Abuse
Substance Abuse	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Social Use	<input type="checkbox"/>	AoD Abuse Hx Not Under Influence	<input type="checkbox"/>	AoD Dependent &/Or Under The Influence
Mental Status								
Hallucinations	<input type="checkbox"/>	None reported	<input type="checkbox"/>	Periodic or non-intrusive	<input type="checkbox"/>	Troubling Hallucinations	<input type="checkbox"/>	Command Hallucinations
Judgment and Reality Testing	<input type="checkbox"/>	Intact and functional	<input type="checkbox"/>	Predominantly intact and functional	<input type="checkbox"/>	Periodically impaired	<input type="checkbox"/>	Grossly impaired
Orientation	<input type="checkbox"/>	Hopeful/Immediate and distant future oriented	<input type="checkbox"/>	Predominantly hopeful and future oriented	<input type="checkbox"/>	Minimal hope and sense of efficacy	<input type="checkbox"/>	Hopeless/helpless
Interpersonal interactions	<input type="checkbox"/>	Fully interactive	<input type="checkbox"/>	Intermittent contact with others	<input type="checkbox"/>	Minimal contact with others	<input type="checkbox"/>	Isolated
Impulsivity	<input type="checkbox"/>	Normal	<input type="checkbox"/>	Occasional	<input type="checkbox"/>	Frequent	<input type="checkbox"/>	Persistent
Stress	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Minimal	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe
Loss	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	>2 Years	<input type="checkbox"/>	6 Months To 2 Years	<input type="checkbox"/>	Less Than 6 Months
Physical Condition	<input type="checkbox"/>	Excellent	<input type="checkbox"/>	Good	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor
Financial Stress	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe
Living Arrangements	<input type="checkbox"/>	Safe	<input type="checkbox"/>	With Others	<input type="checkbox"/>	Access To Others	<input type="checkbox"/>	Alone/Isolated
Support From Significant Others	<input type="checkbox"/>	Positive/Helpful	<input type="checkbox"/>	Present/Helpful	<input type="checkbox"/>	Accessible/Somewhat Helpful	<input type="checkbox"/>	Unable/Unwilling To Help
Male Age Suicide	<input type="checkbox"/>	0-12	<input type="checkbox"/>	35-49	<input type="checkbox"/>	13-34	<input type="checkbox"/>	50+
Homicide	<input type="checkbox"/>	1-8	<input type="checkbox"/>	9-12/60+	<input type="checkbox"/>	13-16/30-60	<input type="checkbox"/>	17-30
Female Age Suicide	<input type="checkbox"/>	0-12	<input type="checkbox"/>	39-59	<input type="checkbox"/>	13-38	<input type="checkbox"/>	60+
Homicide	<input type="checkbox"/>	0-12	<input type="checkbox"/>	45+	<input type="checkbox"/>	13- 16/26-44	<input type="checkbox"/>	17-25

Overall Risk Level: **None:** **Low:** **Moderate:** **High:**
 Self Other Self Other Self Other Self Other

Comments:



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Assessed Needs Checklist Including Functional Domains

<input checked="" type="checkbox"/>	Check All Current Areas of Need	As Evidenced By:	Person Served Desires Change Now?:
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Activities of Daily Living

<input type="checkbox"/>	Activities of Daily Living		<input type="checkbox"/> Yes <input type="checkbox"/> No
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Addictive Behaviors

<input type="checkbox"/>	Substance Use/Addiction:		<input type="checkbox"/> Yes <input type="checkbox"/> No
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<input type="checkbox"/>	Other Addictive Behaviors:		<input type="checkbox"/> Yes <input type="checkbox"/> No
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Behavior Management

<input type="checkbox"/>	Anger/Aggression:		<input type="checkbox"/> Yes <input type="checkbox"/> No
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<input type="checkbox"/>	Antisocial Behaviors:		<input type="checkbox"/> Yes <input type="checkbox"/> No
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<input type="checkbox"/>	Impulsivity:		<input type="checkbox"/> Yes <input type="checkbox"/> No
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<input type="checkbox"/>	Lack of Assertiveness:		<input type="checkbox"/> Yes <input type="checkbox"/> No
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<input type="checkbox"/>	Oppositional Behaviors:		<input type="checkbox"/> Yes <input type="checkbox"/> No
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Family and Social Support

<input type="checkbox"/>	Communication Skills:		<input type="checkbox"/> Yes <input type="checkbox"/> No
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<input type="checkbox"/>	Community Integration:		<input type="checkbox"/> Yes <input type="checkbox"/> No
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<input type="checkbox"/>	Dependency Issues:		<input type="checkbox"/> Yes <input type="checkbox"/> No
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<input type="checkbox"/>	Family Education: (Family education must be directed to the exclusive well being of the person served)		<input type="checkbox"/> Yes <input type="checkbox"/> No
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<input type="checkbox"/>	Family Relationships:		<input type="checkbox"/> Yes <input type="checkbox"/> No
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<input type="checkbox"/>	Peer Support:		<input type="checkbox"/> Yes <input type="checkbox"/> No
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<input type="checkbox"/>	Personal Support Network:		<input type="checkbox"/> Yes <input type="checkbox"/> No
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<input type="checkbox"/>	Recreation/Leisure Skills:		<input type="checkbox"/> Yes <input type="checkbox"/> No
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<input type="checkbox"/>	Social/Interpersonal Skills:		<input type="checkbox"/> Yes <input type="checkbox"/> No
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Mental Health/Illness Management

<input type="checkbox"/>	Anxiety:		<input type="checkbox"/> Yes <input type="checkbox"/> No
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<input type="checkbox"/>	Coping/ Symptom Management Skills:		<input type="checkbox"/> Yes <input type="checkbox"/> No
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<input type="checkbox"/>	Cognitive Problems:		<input type="checkbox"/> Yes <input type="checkbox"/> No
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<input type="checkbox"/>	Compulsive Behavior:		<input type="checkbox"/> Yes <input type="checkbox"/> No
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<input type="checkbox"/>	Depression/Sadness:		<input type="checkbox"/> Yes <input type="checkbox"/> No
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<input type="checkbox"/>	Dissociation:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Disturbed Reality (Psychosis):		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Gender Identity Problems:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Grief/Bereavement:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Hyperactivity/Hypomania:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Mood Swings:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Obsessions:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Somatic Problems:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Stress Management:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Trauma:		<input type="checkbox"/> Yes <input type="checkbox"/> No
Risk/Safety			
<input type="checkbox"/>	High Risk Behaviors:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Safety/Self-Preservation Skills:		<input type="checkbox"/> Yes <input type="checkbox"/> No
Other			
<input type="checkbox"/>	Other:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Other:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Other:		<input type="checkbox"/> Yes <input type="checkbox"/> No
Person's Served Strengths/Abilities/Resiliency (Skills, talents, interests, aspirations, protective factors)			
Personal Qualities:			
Daily Living Situation:			
Financial:			
Employment/Education:			
Social Supports:			
Health:			
Leisure/Recreational:			
Spirituality/Culture/Religion:			



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Person Served/Family/Guardian Expression of Service Preferences:

Behavioral Health Clinical and Rehabilitative Service Preferences:

Environmental Support Preferences:

Intervention and Stabilization:

Therapeutic Interventions Delivered, including solution-focused crisis counseling:

Person's Response to Interventions:

Stabilization Activities: N/A (If N/A Explain):

Clinical Formulation – Interpretive Summary

This Clinical Formulation is Based Upon Information Provided By (Check all that apply):

<input type="checkbox"/> Person Served	<input type="checkbox"/> Parent(s)	<input type="checkbox"/> Guardian(s)	<input type="checkbox"/> Family/Friend(s)	<input type="checkbox"/> Physician	<input type="checkbox"/> Records
<input type="checkbox"/> Law Enforcement	<input type="checkbox"/> Service Provider	<input type="checkbox"/> School Personnel	<input type="checkbox"/> Other:		

Interpretive Summary: What in your clinical judgment are the issue(s), the factors that led to the issues, and your plan to address the issues? This section should reflect the person's status, and your plan, after the ESP has provided crisis intervention and stabilization activities as reflected in the previous section.



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Diagnosis: DSM Codes (or successor) ICD Codes (or successor)

Check Primary	Axis	Code	Narrative Description
<input type="checkbox"/>	Axis I		
<input type="checkbox"/>			
<input type="checkbox"/>			
<input type="checkbox"/>	Axis II		
<input type="checkbox"/>			
<input type="checkbox"/>	Axis III		
<input type="checkbox"/>	Axis IV		
<input type="checkbox"/>	Axis V	Current GAF:	Highest GAF in Past Year (if known):

Further Evaluations Needed:

None Indicated
 Psychiatric
 Psychological
 Neurological
 Medical
 Educational
 Vocational
 Visual
 Auditory
 Nutritional
 SU Assessment
 Other:

Was Outcomes tool administered? Yes No **If Yes, specify:**

BPRS Completed and attached (MBHP hospital admissions only)? Yes No N/A

Prioritized Assessed Needs to be addressed at the next Level of Care as Evidenced by: <small>A-Active, PR-Person Decline, D-Deferred, R-Referred Out (If deferred, please provide rationale)</small>	A	PD*	D*	R
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Deferred Rationale(s):

