



Person's Name (First MI Last):	Record #:	Date of Admission:
Organization Name:	DOB:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender

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

Referral Source and Reason for Referral:

What Occurred to Cause the Person to Seek Services Now (Note Symptoms, Behavioral and Functioning Needs):

Living Situation

What is the person's current living situation? (check one)
Person's Home: Rent Own
Residential Care/Treatment Facility: Hospital Temporary Housing Residential Program Nursing/Rest Home Supportive Housing
Other:
 Friend's Home Relative's/Guardian's Home Foster Care Home Respite Care Jail/Prison
 Homeless living with friend Homeless in shelter/No residence Other:
Contact name and phone number:
At Risk of Losing Current Housing Yes No Satisfied with Current Living Situation Yes No
Comments:

Family and Social Support History

Family History and Relationships:

Pertinent Family Medical, MH and SU History:

Parental/ Familial Obligations:

Developmental History and Status:



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Family and Social Support History (continued)

Friendship/Social/Peer Support Relationships:

Meaningful Activities (Community Involvement, Volunteer Activities, Leisure/Recreation, Other Interests):

Community Supports/Self Help Groups (AA, NA, SMART, NAMI, Peer Support, etc.):

Religion/Spirituality:

Cultural/Ethnic Information:

Sexual History/Concerns:

Limitations of Activities of Daily Living:

Legal Status and Legal Involvement and History

Does Person Served have a Legal Guardian, Rep Payee or Conservatorship? No Yes; **If yes, complete and attach the Legal Status Addendum**

Is there a need for a Legal Guardian, Rep Payee or Conservatorship? No Yes / Explain:

Does the person have a history of, or current involvement with the legal system (i.e., legal charges)? No Yes; **If yes, complete and attach the Legal Involvement and History Addendum**

Education

Education History (Check all that apply):

GED HS Grad College Vocational Training Graduate Degree Currently Enrolled

Highest Grade Completed:

Person's Preferred Learning Style(s): Visual spatial Auditory/Musical Verbal/writing Physical
 Logical/mathematical Social Solitary/self-study Other

Further Education assessment needed? No Yes; **If yes, complete and attach Education Addendum**



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Mental Health Service History (continued)

Was treatment helpful? Explain:

Past/Current Diagnoses: Not known by person served /

Source(s) of Information: Person served Significant Other/Family Member Hospital Records Case Manager
 Other:

Medication Information (Include All 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	
				<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 Medications: (Include what medications have worked well previously, any adverse side effects, why person doesn't take meds as prescribed and/or which one(s) the person would like to avoid taking in the future.):

Health Summary OR Refer to Attached Physical Health Assessment

Allergies: No Known Allergies

Food:

Medication:

Environmental:

Physical Health Summary: (Include health history, chronic conditions, significant dental history, and current physical complaints that may interfere with the person's served functioning.)

Advanced Directive:

Does the person have advanced directives established No Yes

If yes, what type? Living Will Power of Attorney Other:

If no, does the person wish to develop them at this time? No Yes / If yes, follow agency's procedure for completion

Primary Care Provider and Dentist Name and Credentials	Address	Tel Number	Fax	Date of Last Exam
Specialist(s) Name and Credentials <input type="checkbox"/> NA	Address	Tel Number	Fax	Date of Last Exam



Person's Name (First MI Last):	Record #:
Trauma History	
Does person report a history of trauma? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Does person report history/current family/significant other, household, and/or environmental violence, abuse or neglect or exploitation? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If the answer to either of the above questions is yes, complete and attach the Trauma History Addendum.	
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**	



Person's Name (First MI Last):	Record #:
Past Attempts to Harm Self or Others: <input type="checkbox"/> None Reported <input type="checkbox"/> Self** <input type="checkbox"/> Others** Comment:	
Comments:	

Assessed Needs Checklist Including Functional Domains			
✓	Check All Current Need Areas	As Evidenced By:	Person Served Desires Change Now?:
Activities of Daily Living			
<input type="checkbox"/> <i>If checked, agency's functional assessment should be completed</i>			
<input type="checkbox"/>	Employment:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Education:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Housekeeping/Laundry:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Housing Stability:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Grocery Shopping/Food Preparation:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Medication Management:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Money Management:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Personal Care Skills (includes Grooming/Dress):		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Exercise:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Transportation:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Problem Solving Skills:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Time Management:		<input type="checkbox"/> Yes <input type="checkbox"/> No
Addictive Behaviors			
<input type="checkbox"/>	Substance Use/Addiction:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Other Addictive Behaviors (food, gambling, exercise, sex, etc.):		<input type="checkbox"/> Yes <input type="checkbox"/> No
Behavior Management			
<input type="checkbox"/>	Anger/Aggression:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Antisocial Behaviors:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Impulsivity:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Lack of Assertiveness:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Legal Problems:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Oppositional Behaviors:		<input type="checkbox"/> Yes <input type="checkbox"/> No



Person's Name (First MI Last):		Record #:
<i>Family and Social Support</i>		
<input type="checkbox"/>	Communication Skills:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Community Integration:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Dependency Issues:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<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
<input type="checkbox"/>	Family Relationships:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Peer/Personal Support Network:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Recreation/Leisure Skills:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Social/Interpersonal Skills:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Mental Health/Illness Management</i>		
<input type="checkbox"/>	Anxiety:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Coping/ Symptom Management Skills:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Cognitive Problems:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Compulsive Behavior:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Depression/Sadness:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Dissociation:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Disturbed Reality (Hallucinations):	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Disturbed Reality (Delusions):	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Gender Identity:	<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



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Physical Health			
<input type="checkbox"/>	Health Practices:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Diet/Nutrition:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Pain Management:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Sexual Problems:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Sleep Problems:		<input type="checkbox"/> Yes <input type="checkbox"/> No
Risk/Safety			
<input checked="" type="checkbox"/>	Check All Current Need Areas	As Evidenced By:	Person Served Desires Change Now?:
<input type="checkbox"/>	High Risk Behaviors:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Suicidal Ideation:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Homicidal Ideation:		<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:			
Health:			
Leisure/Recreational:			
Spirituality/Culture/Religion:			



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Service Preferences:

Clinical Formulation – Interpretive Summary

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

- Person Served
 Parent(s)
 Guardian(s)
 Family/Friend(s)
 Physician
 Records
 Law Enforcement
 Service Provider
 School Personnel
 Other:

Interpretive Summary: What in your clinical judgment are the need areas, the factors that led to the needs, and your plan to address them?

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:

