Person's Name (First MI Last):	**Record #:**	**DOB:**
Organization Name:		**Date of Admission:**

List Name(s) of Person(s) Present:	☐ Person Present ☐ No Show ☐ Person Cancelled ☐ Provider Cancelled Explanation: ☐ Others Present (please identify name(s) and relationship(s) to person):
Place of Evaluation:	☐ ER ☐ Court ☐ Police Dept. ☐ Outpatient Office ☐ Residential Treatment Setting ☐ ESP ☐ Home ☐ School ☐ Other:

Presenting Concerns in person's own words; what occurred to cause the person to seek services now:

History of Present Illness: ☐ None Reported

Comprehensive Assessment has been completed? Yes ☐ No ☐ **If yes: Date of most recent assessment:** _____

Medication Information

NOTE: I have reviewed the Medication Information in the Comprehensive Assessment of _____ (date) with the person and:
☐ There have been no medication changes, **OR** ☐ Additional medication changes below (include OTC/Herbal Supplements)

Medication	Current or Past	Rationale/ Condition	Dosage / Route / Frequency	Person Taking/Took Meds as Prescribed? WA=*With Assistance*
	☐ C ☐P			☐ No ☐ Yes ☐ WA
	☐ C ☐P			☐ No ☐ Yes ☐ WA
	☐ C ☐P			☐ No ☐ Yes ☐ WA
	☐ C ☐P			☐ No ☐ Yes ☐ WA
	☐ C ☐P			☐ No ☐ Yes ☐ WA
	☐ C ☐P			☐ No ☐ Yes ☐ WA
	☐ C ☐P			☐ No ☐ Yes ☐ WA
	☐ C ☐P			☐ No ☐ Yes ☐ WA

Reported side effects / adverse drug reactions / other comments on current or past medications:

Primary Care Provider Name and Credentials	Address	Tel Number	Fax	Date of Last Exam

Physical Health History

NOTE: I have reviewed the Physical Health Summary in the Comprehensive Assessment of _____ (date) with the person and: ☐ No additional history to be added, **OR** ☐ Additional History/Comments:

Person's Name (First MI Last):	**Record #:**

Family Mental Health / Substance Use History (check all that apply): ☐ None Reported
☐ Schizophrenia ☐ Bipolar ☐ Depression ☐ Anxiety Disorder ☐ ADD ☐ Substance Use ☐ Suicide Attempts
☐ Other**:** **Comments:**

Substance Use / Addictive Behavior History:
NOTE: I have reviewed the Substance Use / Addictive Behavior History in the Comprehensive Assessment of _____ (date) with the person and: ☐ No additional history to be added, **OR** ☐ Additional history indicated below:

Substance/Alcohol/Tobacco/Gambling/Other	Age of First Use	Date of Last Use	Frequency	Amount	Method

Toxicology Screen Completed:
☐ **No** ☐ **Yes – If Yes, Results:**

Treatment History
NOTE:I have reviewed the Treatment History in the Comprehensive Assessment of _____ (date) with the person and:
☐ **No additional history to be added** OR ☐ **Additional history indicated below:**

Type of Service:	MH / SU	Name of Provider/Agency:	Dates of Service:	Completed?
	☐ **MH** ☐ **SU**			☐Yes ☐No
	☐ **MH** ☐ **SU**			☐Yes ☐No
	☐ **MH** ☐ **SU**			☐Yes ☐No
	☐ **MH** ☐ **SU**			☐Yes ☐No
	☐ **MH** ☐ **SU**			☐Yes ☐No

Other Assessment Domains:

☐ **I have reviewed the Comprehensive Assessment of _____ (date) with the person and have added other pertinent information or changes where applicable.**

☐ **I have not reviewed the comprehensive assessment, but have indicated pertinent information for each of the areas below.**

Living Situation ☐No Changes	Comments:
Family and Social Supports ☐No Changes	Comments:
Legal Status ☐No Changes	Comments:
Legal Involvement ☐No Changes ☐None Reported	Comments:
Education ☐No Changes	Comments:
Employment ☐No Changes	Comments:
Military Service ☐No Changes ☐None Reported	Comments:
Trauma ☐No Changes ☐None Reported	Comments:
**Developmental Issues *****Child Only* ☐N/A ☐None Reported	Comments:

Person's Name (First MI Last):	**Medicaid #** (if applicable):	**Record #:**

Mental Status Exam – (WNL = Within Normal Limits) (**) ***– If Checked, Risk Assessment is Required***

Appearance: ☐ WNL ☐ Neat and appropriate ☐ Physically unkempt
Eye Contact: ☐ WNL ☐ Avoidant ☐ Intense ☐ Intermittent
Clothing: ☐ WNL ☐ Disheveled ☐ Out of the ordinary

Build: ☐ WNL ☐ Thin ☐ Overweight ☐ Short ☐ Tall

Posture: ☐ WNL ☐ Slumped ☐ Rigid, tense ☐ Atypical

Body Movement: ☐ WNL ☐ Accelerated ☐ Slowed ☐ Peculiar ☐ Restless ☐ Agitated

Behavior: ☐ Relaxed ☐ Cooperative ☐ Uncooperative ☐ Overly compliant ☐ Withdrawn ☐ Sleepy
☐ Nervous / Anxious ☐ Restless ☐ Silly ☐ Avoidant / Guarded / Suspicious ☐ Preoccupied ☐ Demanding
☐ Controlling ☐ Unable to perceive pleasure ☐ Provocative ☐ Hyperactive ☐ Impulsive ☐ Agitated ☐ Angry
☐ Assaultive ☐ Aggressive ☐ Compulsive

Speech: ☐ WNL ☐ Mute ☐ Over-talkative ☐ Slowed ☐ Slurred ☐ Stammer ☐ Rapid ☐ Pressured
☐ Loud ☐ Soft ☐ Clear ☐ Repetitive

Emotional State-Mood: ☐ WNL ☐ Lack of feelings ☐ Blunted, unvarying ☐ Euphoric, elated ☐ Tranquil
☐ Anger ☐ Hostility ☐ Irritable ☐ Fear, apprehension ☐ Depressed, sadness ☐ Anxious

Emotional State-Affect: ☐ WNL ☐ Constricted ☐ Flat ☐ Inappropriate ☐ Changeable ☐ Full
☐ Panic attacks or symptoms ☐ Sleep disturbance ☐ Appetite disturbance

Facial Expression: ☐ WNL ☐ Anxiety, fear, apprehension ☐ Sadness, depression ☐ Anger, hostility, irritability
☐ Expressionless ☐ Unvarying ☐ Inappropriate ☐ Elated

Perception: ☐ WNL ☐ Illusions ☐ Depersonalization ☐ De-realization ☐ Re-experiencing
Hallucinations - ☐ Auditory ☐ Visual ☐ Olfactory ☐ Gustatory ☐ Tactile ☐ Command**

Thought Content: ☐ WNL
Delusions - ☐ None reported ☐ Grandiose ☐ Persecutory ☐ Somatic ☐ Illogical ☐ Chaotic ☐ Religious
Other Content - ☐ Preoccupied ☐ Obsessional ☐ Guarded ☐ Phobic ☐ Suspicious ☐ Guilty
☐ Thought broadcasting ☐ Thought insertion ☐ Ideas of reference
Self Abuse Thoughts- ☐ None reported ☐ Cutting** ☐ Burning** ☐ Other self mutilation**
Suicidal Thoughts - ☐ None reported ☐ Passive SI** ☐ Intent** ☐ Plan** ☐ Means**
Aggressive Thoughts - ☐ None reported ☐ Intent** ☐ Plan** ☐ Means**

Thought Process ☐ WNL ☐ Incoherent ☐ Circumstantial ☐ Decreased thought flow
☐ Blocked ☐ Flight of ideas ☐ Loose ☐ Racing ☐ Increased thought flow ☐ Concrete ☐ Tangential

Intellectual Functioning ☐ WNL ☐ Lessened fund of common knowledge ☐ Short attention span
☐ Impaired concentration ☐ Impaired calculation ability
Intelligence Estimate - ☐ MR ☐ Borderline ☐ Average ☐ Above average ☐ No formal testing

Orientation: ☐ WNL **Disoriented to**: ☐ Person ☐ Time ☐ Place

Memory: ☐ WNL **Impaired:** ☐ Immediate recall ☐ Recent memory ☐ Remote memory

Insight: ☐ WNL ☐ Difficulty acknowledging presence of psychological problems
☐ Mostly blames other for problems ☐ Thinks he/she has no problems

Judgment: ☐ WNL **Impaired Ability to Make Reasonable Decisions**: ☐ Some ☐ Severe**

Past Attempts to Harm Self or Others: ☐ None Reported ☐ Self** ☐ Others**
Comment:

Comments:

Provider - Print Name/Credential:	**Date:**	**Supervisor - Print Name/Credential** (if needed):	**Date:**
Provider Signature:	**Date:**	**Supervisor Signature** (if needed):	**Date:**

Person's Name (First MI Last):	**Record #:**
Summary of Current Mental Health Functioning/Symptoms/Strengths and Limitations related to Medication Management/Self Administration :	
Other symptoms of note or information from other sources (family, referring agency, etc.) ☐ **None Reported**	

Diagnoses : ☐ DSM-IV Codes (or successor) ☐ ICD-9 CM Codes (or successor)

Check Primary	Axis	Code	Narrative Description
☐ ☐ ☐	Axis I		
☐ ☐ ☐	Axis II		
Rationale for ALL above Diagnoses (as evidenced by):			
☐ ☐ ☐	Axis III		
☐ ☐ ☐	Axis IV		
☐	Axis V	Current GAF: _____	Highest GAF in Past Year: _____

Does person served have any medical conditions that require consideration in prescribing (i.e. pregnancy, diabetes, etc.)?
☐ Yes ☐ None reported or known If yes, specify:

Medication Status / Orders

☐ None ☐ As indicated below:

Medication	Status	Rationale/ Condition	Dosage / Route / Frequency	Amount/ Refills
	☐ New/Adjusted ☐ Refill ☐ Discontinued			
	☐ New/Adjusted ☐ Refill ☐ Discontinue			

Person's Name (First MI Last):			**Record #:**	
	☐ New/Adjusted ☐ Refill ☐ Discontinue			
	☐ New/Adjusted ☐ Refill ☐ Discontinue			
	☐ New/Adjusted ☐ Refill ☐ Discontinue			
	☐ New/Adjusted ☐ Refill ☐ Discontinue			

Explained rationale for medication choices, reviewed mixture of medications, discussed possible risks, benefits, effectiveness (if applicable) and alternative treatment with the person (parent/guardian): ☐ No ☐ Yes

Person's /Guardian Response: ☐ N/A

Person	☐ Understands information	☐ Does not understand	☐ Agrees with Medication	☐ Refuses Medication
Guardian	☐ Understands information	☐ Does not understand	☐ Agrees with Medication	☐ Refuses Medication

Laboratory Tests Ordered: ☐ None Ordered

Follow Up Plan/Referrals (Include all referrals, including commitment orders, those to higher levels of care, labs to be ordered, medical strategies/recommendations, other types of treatment, frequency/interval of next visit and duration):

1.

2.

3.

4.

Other Psychopharmalogical Considerations to be added to Individualized Action Plan: ☐ None indicated at this time

Physician/APRN/RNCS - Print Name/Credential:	**Date:**	**Supervisor - Print Name/Credential** (if needed):	**Date:**
Physician/APRN/RNCS Signature:	**Date:**	**Supervisor Signature** (if needed):	**Date:**
Person's Signature (optional, if appropriate)**:**	**Date:**		

Date of Service	Provider Number	Loc. Code	Prcdr. Code	Mod 1	Mod 2	Mod 3	Mod 4	Start Time	Stop Time	Total Time	Diagnostic Code