|  |  |  |
| --- | --- | --- |
| Person’s Name (First MI Last): | Record #: | Date of Admission: |

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| --- | --- | --- |
| Organization/Program Name: | DOB: | Gender:  Male  Female Transgender |

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| --- |
| Presenting Concerns (In Person’s /Family’s Own Words) |
| Referral Source: Reason for Referral: |

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| --- |
| **What Occurred to Cause the Person to Seek Services Now** (Note Precipitating Event, Symptoms, Behavioral and Functioning Needs)**:** |

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| Living Situation |
| What is the person’s current living situation? (check one) Rent  Own  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:  Residential Care/Treatment Facility*:*  *Hospital*  *Temporary Housing*  *Residential Program*  *Nursing/Rest Home*  *Supportive Housing*At Risk of Losing Current Housing  Yes  No Satisfied with Current Living Situation  Yes  NoComments (Include environmental surroundings and neighborhood description): |

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| --- |
| **Family History** |

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| --- |
| **Family History and Relationship, Parental/ Familial Caretaker Obligations:** |

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| --- |
| **Pertinent Family Medical, MH and SU History:** |

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| --- |
| **Developmental History and Status:** |

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| --- |
| **Social Support** |

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| --- |
| **Friendship/Social/Peer Support Relationships, Pets, Community Supports/Self Help Groups** (AA, NA, SMART, NAMI, Peer Support, etc.)**:** |

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| --- |
| **Religion/Spirituality and Cultural/Ethnic Information:** |

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| --- | --- |
| Person’s Name (First MI Last): | Record #: |

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| **Legal Status and Legal Involvement 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** |

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| **Education** |
| **Highest Level of Education Achieved**:  GED  HS Grad  College  Vocational Training  Graduate Degree Highest Grade Completed:  Person’s Preferred Learning Style(s): Visual  Auditory  Verbal Written  Learn by doing  Currently Enrolled in Educational Program?: No  Yes;  **If yes, complete and attach Education Addendum**  Is person interested in further education or assistance in education?:  No  Yes:  **If yes, complete and attach Education Addendum** |

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| --- |
| **Employment and Meaningful Activities** |
| **Employment Status/Interests:**  Never Worked Currently Employed? No  Yes; If yes, length of employment:        (If not currently employed) – Person served wants to work?  No  Yes  Uncertain / Comments:  Does the person want help to find employment or vocational training?  No  Yes / Comments:       **If yes, complete Employment Addendum**  **Meaningful Activities** (Community Involvement, Volunteer Activities, Leisure/Recreation, Other Interests): |

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| Income/Financial Support |
| How does the person describe her/his current financial situation?  Comfortable/ living within means  Occasional struggle with finances  Often struggles with finances  Financial struggles are a major source of stress Comments:  Do you receive any sources of financial assistance?  SSI  SSDI  Food Stamps  Contributions from family or friends  Disability  Child Support  Veterans Benefits  TAFDC  EAEDC Other:  If yes, Type and Amount: |

|  |  |
| --- | --- |
| **Military Service**  **None Reported** - If None Reported, skip to the Substance Use / Addictive Behavior History Section | |
| **Military Status:**  Active  Veteran | **Date of Discharge:**  **Type of Discharge:**  1. Honorable  2. General (under Honorable Conditions  3. Other than Honorable  4. Bad Conduct  5. Dishonorable  Reason: |
| Is a complete Military Service assessment needed?  No  Yes; **If yes, complete and attach Military Service Addendum** | |

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| **Addictive Behavior and Substance Abuse History** |
| Does person report a history of, or current, substance use or other addictive behavior concerns (i.e., alcohol, tobacco, gambling, food)?NoYes;**. If yes, complete and attach Addictive Behavior History/SA Addendum.** |

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| Person’s Name (First MI Last): | Record #: |

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| Mental Health and Addiction Treatment History |

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| --- | --- | --- | --- | --- | --- |
| **Type of Service** | **Dates of Service** | **Reason** | **Name of Provider/ Agency:** | **Inpatient/ Outpatient** | **Completed** |
|  | / |  |  | In  Out | No  Yes |
|  | / |  |  | In  Out | No  Yes |
|  | / |  |  | In  Out | No  Yes |
|  | / |  |  | In  Out | No  Yes |
|  | / |  |  | In  Out | No  Yes |
|  | / |  |  | In  Out | No  Yes |
|  | / |  |  | In  Out | No  Yes |

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| --- |
| **Efficacy of past and current treatment:** |

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| --- |
| **Psychiatric History (including past diagnoses):** |

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| --- |
| **Source(s) of Information:**   Person Served  Significant other/Family member(s)  Service Provider(s)  Case Manager  Written records  Other: |

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| **Physical Health** |

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| **PCP, Medical Specialist and Dentist**  **Name, Credentials, Specialty** | **Telephone Number** | **Fax Number** | **Address** | **Date of Last Exam** |
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| Person’s Name (First MI Last): | Record #: |

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| **Physical Health Summary**  **OR**  **Refer to Attached Physical Health Assessment**  **Bureau of Substance Abuse Services (BSAS) Programs must complete the MSDP Infectious Disease Risk Addendum and the BSAS TB Assessment**  **Allergies:** No Known Allergies  **Yes, list below:**  Food:       Medication Allergies and Medication Sensitivities (including OTC, herbal):       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.)  Does the person use complimentary health approaches (e.g. natural products, mind-body practices, yoga)?  Yes  No  If yes, please describe:  Does the person wish to consider using complimentary health approaches and want help finding a provider?  Yes  No  NA  If yes, please describe:  **Sexual History/Concerns:**  **Pain Screening:**  Does the person experience pain currently?  Yes  No Has the person experienced pain in past few months?  Yes  No  Describe the type, frequency, duration, intensity, identified cause, any limitations to functioning and what helps relieve the pain:    **Nutritional Screening:** (check all that are reported)  Special diet? (e.g. diabetic, celiac) Follows special diet?  Yes  No  Medications affecting nutritional status  Weight gain/loss of 10 pounds or more without specific diet  Change in appetite  Binging  Purging  Use of laxatives  Intense focus on weight, body size, calorie intake, exercise  Beliefs, perceptions, attitude, behaviors regarding food:  **Physical Health Summary and Recommendations:**  If person has not had physical exam in past year, or if person has reported pain without a determined cause, or if person has reported eating disordered behaviors that are not being medically followed:  Referral for physical exam  Referral for Nutritional Assessment  Person declined exam (reason):        PCP contacted |

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| **Medication Summary**  **Medication information and history of adverse reactions:** (Include what medications work well and 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):        **Is the person served currently taking any medication**  **No**  **Yes; If yes, complete and attach the Medication Addendum** |

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| **Advanced Directive** |
| Does the person have advanced directive established No Yes  If yes, what type?  Living Will  Power of Attorney  Health Care Proxy  Other:  If no, does the person wish to develop them at this time? No Yes / If yes, follow agency’s procedure for completion |

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| Trauma History |
| Does person report a history of trauma?  No  YesDoes person report history/current family/significant other, household, and/or environmental violence, abuse or neglect or exploitation?  No  Yes **If the answer to either of the above questions is yes, complete and attach the Trauma History Addendum.** |

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| Person’s Name (First MI Last): | Record #: |

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Appearance/ Clothing:** | WNL | Neat and appropriate | Physically unkempt | Disheveled | Out of the Ordinary |  | |
| **Eye Contact:** | WNL | Avoidant | Intense | Intermittent |  |  | |
| **Build:** | WNL | Thin | Overweight | Short | Tall |  | |
| **Posture:** | WNL | Slumped | Rigid, Tense | Atypical |  |  | |
| **Body Movement:** | WNL | Accelerated | Slowed | Peculiar | Restless | Agitated | |
| **Behavior:** | WNL | Cooperative | Uncooperative | Overly Compliant | Withdrawn | Sleepy | |
|  | Silly | Avoidant/Guarded/ Suspicious | Nervous/ Anxious | Preoccupied | Restless | Demanding | |
|  | Controlling | Unable to perceive pleasure | Provocative | Hyperactive | Impulsive | Agitated | |
|  | Angry | Assaultive | Aggressive | Compulsive  Relaxed | | | |
| **Speech:** | WNL | Mute | Over-talkative | Slowed | Slurred | Stammering | |
|  | Rapid | Pressured | Loud | Soft | Clear | Repetitive | |
| **Emotional State-Mood (in person’s words):** | WNL | Not feeling anything | Irritated | Happy | Angry | Hostile | |
|  | Depressed, sad | Anxious | Afraid, Apprehensive |  |  |  | |
| **Emotional State- Affect** | WNL | Constricted | Changeable | Inappropriate | Flat |  | |
|  | Full | Blunted, unvarying |  |  |  |  | |
| **Facial Expression** | WNL | Anxiety, fear, apprehension | Sadness, depression | Anger, hostility, irritability |  |  | |
|  | Elated | Expressionless | Inappropriate | Unvarying |  |  | |
| **Perception:** | WNL |  |  |  |  | |  |
| *Hallucinations-* | Tactile | Auditory | Visual | Olfactory | 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 |  |  |  | |
| **Thought Process:** | WNL | Incoherent | Decreased thought flow | Blocked | Flight of ideas |  | |
|  | Loose | Racing | Chaotic | Concrete | Tangential |  | |
| **Intellectual Functioning:** | WNL | Lessened fund of common knowledge | Impaired concentration | Impaired calculation ability |  |  | |
| *Intelligence Estimate -* | Develop. Disabled | Borderline | Average | Above average | No formal testing |  | |
| **Orientation**: | WNL | **Disoriented to**: | Time | Place | Person |  | |
| **Memory**: | WNL | **Impaired:** | Immediate recall | Recent memory | Remote memory | Short Attention Span | |
| **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**: | | Mild | Moderate | Severe\*\* | |
| **Past Attempts to Harm Self or Others:** | None Reported | Self\*\* | Others\*\* |  |  |  | |
| **Self Abuse Thoughts:** | None reported | Cutting\*\* | Burning\*\* | Other: | | | |
| **Suicidal Thoughts:** | None reported | Passive SI\*\* | Intent\*\* | Plan\*\* | Means\*\* |  | |
| **Aggressive Thoughts:** | None reported | Intent\*\* | Plan\*\* | Means\*\* |  |  | |

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| **Comments:** |  |

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| Person’s Name (First MI Last): | | Record #: |
| **Person’s Served Strengths/Abilities/Resiliency**  (Skills, talents, interests, aspirations, protective factors) | |

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| **Personal Qualities:** (Examples: open, friendly, engaging, motivated, loyal, resourceful, caring, thoughtful) |  |

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| --- | --- |
| **Living Situation:** (Examples: has maintained long-term stable housing, gets along with living companions) |  |

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| **Financial/Employment/Education:** (Examples: graduated HS, attended college, currently working, hx of working, multiple work skills) |  |

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| **Health:** (Examples: consistent good health, exercises regularly, self cares for health issues as directed by physician, eats nutritional foods) |  |

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| **Leisure/Recreational/Community Involvement:** (Examples: plays a sport, belongs to social group, attends gym, volunteers for Red Cross) |  |

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| **Natural Supports:** (Examples: Family members, clergy, close friends, neighbors, advisors) |  |

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| --- | --- |
| **Spirituality/Culture/Religion:** (Examples: enjoys religious services, participates in cultural events, meet regularly with rabbi) |  |

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| Assessed Needs Checklist Including Functional Domains |

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|  |  | |  |  | **Activities of Daily Living**  **CN = Current Need Area**  **PD = Person Desires Change Now** |  |  |  |
| **CN** | **PD** |  | **CN** | **PD** |  | **CN** | **PD** |  |
|  |  | **Housekeeping/Laundry** |  |  | **Money Management** |  |  | **Transportation** |
|  |  | **Housing Stability** |  |  | **Personal Care Skills (includes Grooming/ Dress)** |  |  | **Problem Solving Skills** |
|  |  | **Grocery Shopping/ Food Preparation** |  |  | **Exercise** |  |  | **Time Management** |
|  |  | **Medication Management** |  |  | **Safety/Self Preservation** | | | |
|  |  | **Other:** | | | | | | |
| **Current Needs Selected Above as Evidenced By:** | | | | | | | | |

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| --- | --- |
| Person’s Name (First MI Last): | Record #: |

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|  |  | |  |  | **Family and Social Supports**  **CN = Current Need Area**  **PD = Person Desires Change Now** |  |  |  |
| **CN** | **PD** |  | **CN** | **PD** |  | **CN** | **PD** |  |
|  |  | **Communication Skill** |  |  | **Family Education (Directed at the exclusive well being of the person served)** |  |  | **Peer/ Personal Support Network** |
|  |  | **Community Integration** |  |  | **Family Relationships** |  |  | **Social/ Interpersonal Skills** |
|  |  | **Caretaker Obligation Issues** |  |  | **Other:** | | | |
| **Current Needs Selected Above as Evidenced By:** | | | | | | | | |

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|  |  | |  |  | **Legal**  **CN = Current Need Area**  **PD = Person Desires Change Now** |  |  |  |
| **CN** | **PD** |  | **CN** | **PD** |  |  |  |  |
|  |  | **Legal Issues** |  |  | **Other:** | | | |
| **Current Needs Selected Above as Evidenced By:** | | | | | | | | |

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|  |  | |  |  | **Employment/ Education/ Finances**  **CN = Current Need Area**  **PD = Person Desires Change Now** |  |  |  |
| **CN** | **PD** |  | **CN** | **PD** |  | **CN** | **PD** |  |
|  |  | **Education** |  |  | **Employment/ Volunteer Activities** |  |  | **Meaningful Activities** |
|  |  | **Financial/Benefits** (include VA benefits) |  |  | **Other:** | | | |
| **Current Needs Selected Above as Evidenced By:** | | | | | | | | |

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|  |  | |  |  | **Addictive Behavior and Substance Use**  **CN = Current Need Area**  **PD = Person Desires Change Now** |  |  |  |
| **CN** | **PD** |  | **CN** | **PD** |  |  |  |  |
|  |  | **Substance Use/ Addiction** (Tobacco, illicit & licit drugs) |  |  | **Other Addictive Behaviors** (food, gambling, exercise, sex etc.) | | | |
| **Current Needs Selected Above as Evidenced By:** | | | | | | | | |

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| Person’s Name (First MI Last): | Record #: |

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|  |  | |  |  | **Mental Health/ Illness Management-Behavior Management**  **CN = Current Need Area**  **PD = Person Desires Change Now** |  |  |  |
| **CN** | **PD** |  | **CN** | **PD** |  | **CN** | **PD** |  |
|  |  | **Anxiety** |  |  | **Dissociation** |  |  | **Lack of Assertiveness** |
|  |  | **Anger/ Aggression** |  |  | **Disturbed Reality** (Hallucinations) |  |  | **Mood Swings** |
|  |  | **Antisocial Behaviors** |  |  | **Disturbed Reality** (Delusions) |  |  | **Obsessions** |
|  |  | **Coping/ Symptom Management** |  |  | **Gender Identity** |  |  | **Oppositional Behaviors** |
|  |  | **Cognitive Problems** |  |  | **Grief/Bereavement** |  |  | **Somatic Problems** |
|  |  | **Compulsive Behavior** |  |  | **Hyperactivity/Hypomania** |  |  | **Stress Management** |
|  |  | **Depression/Sadness** |  |  | **Impulsivity** |  |  | **Trauma** |
|  |  | **Other:** | | | | | | |
| **Current Needs Selected Above as Evidenced By:** | | | | | | | | |

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|  |  | |  |  | **Physical Health**  **CN = Current Need Area**  **PD = Person Desires Change Now** |  |  |  |
| **CN** | **PD** |  | **CN** | **PD** |  | **CN** | **PD** |  |
|  |  | **Health Practices** |  |  | **Pain Management** |  |  | **Sleep Problems** |
|  |  | **Diet/Nutrition** |  |  | **Sexual Health Issues** | | | |
|  |  | **Other:** | | | | | | |
| **Current Needs Selected Above as Evidenced By:** | | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | |  |  | **Risk**  **CN = Current Need Area**  **PD = Person Desires Change Now** |  |  |  |
| **CN** | **PD** |  | **CN** | **PD** |  | **CN** | **PD** |  |
|  |  | **High Risk Behaviors** |  |  | **Suicidal Ideation** |  |  | **Homicidal Ideation** |
|  |  | **Other:** | | | | | | |
| **Current Needs Selected Above as Evidenced By:** | | | | | | | | |

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| Person’s Name (First MI Last): | Record #: |

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|  |  | |  |  | **Other Need Areas**  **CN = Current Need Area**  **PD = Person Desires Change Now** |  |  |  |
| **CN** | **PD** |  | | |  |  |  |  |
|  |  | **Other:** | | | | | | |
|  |  | **Other:** | | | | | | |
| **Current Needs Selected Above as Evidenced By:** | | | | | | | | |

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| 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? | | | |

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| **Further Evaluations Needed:**  None Indicated  Psychiatric  Psychological  Neurological  Medical  Educational  Vocational  Visual  Auditory  Nutritional  SU Assessment  Other: |

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

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| --- | --- | --- |
| **Diagnosis:**  DSM-IV Codes  DSM 5 Codes  ICD-9 Codes  ICD-10 Codes | | |
| **Check Primary/Billing Diagnosis** | **Code** | **Narrative Description** |
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| Person’s Name (First MI Last): | Record #: |

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| **Prioritized Assessed Needs:**  AC-Active, PD-Person Declined, DF-Deferred, RE-Referred Out  (If declined/deferred/referred out, please provide rationale) | **AC** | **PD\*** | **DF\*** | **RE\*** |
| **1.** |  |  |  |  |

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| **2.** |  |  |  |  |

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| **3.** |  |  |  |  |

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| **4.** |  |  |  |  |

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| **5.** |  |  |  |  |

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| **6.** |  |  |  |  |

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| --- |
| **Person Does Not Want A Need Area Included In The IAP Or The Area Is Deferred/Referred Out Rationale(s)**  (Explain why Person Declined to work on Need Area; List rationale(s) for why Need Area(s) is/are Deferred/Referred Out below)**.**  **None** |
| **1.** |
| **2.** |
| **3.** |
| **4.** |
| **5.** |

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| --- |
| Person’s Service Preferences, Level of Care/Indicated Services Recommendation: |

|  |
| --- |
| Person Served/Guardian/Family Response To Recommendations: |

|  |  |  |  |
| --- | --- | --- | --- |
| **Person’s Signature** (Optional, if clinically appropriate) | **Date:** | **Parent/Guardian Signature** (If appropriate): | **Date:** |
| **Clinician/Provider - Print Name/Credential:** | **Date:** | **Supervisor - Print Name/Credential** (if needed): | **Date:** |
| **Clinician/Provider Signature:** | **Date:** | **Supervisor Signature** (if needed): | **Date:** |
| **Psychiatrist/MD/DO** (If required): | **Date:** | **Next Appointment:**  **Date:** **Time****:**  **am**  **pm** | |