

BH Assessment Form

Client Name: _____
MRN#: _____

Language in which client received
services, if other than English:

Spanish
Interpreter Utilized?

Vietnamese
No

Other (Specify):
Yes (Describe in Progress Note)

DOMAIN 1

Presenting Problems & Current Episode

Presenting Problem (should include current sxs/bx's, intensity of sxs/bx's and duration of sxs/bx's):

Use CI's words, referral's description, and/or clinician's understanding of the problem. Include duration, severity, frequency, what makes it worse or better impact on CI's life, CI's perception, and CI's understanding of problem

History of Presenting Problem:

Use CI's words, referral's description, and/or clinician's understanding of the problem. Include duration, severity, frequency, what makes it worse or better impact on CI's life, CI's perception, and CI's understanding of problem

Mental Status Exam

Appearance/Speech/Interaction/Eye Contact/Motor Activity

Appears

- ☐ Stated Age
- ☐ Older than stated age
- ☐ Younger than stated age

Manner of Dress

- ☐ Appropriate
- ☐ Inappropriate
- ☐ Seductive
- ☐ Odd
- ☐ Other: _____

Hygiene Level

- ☐ Normal
- ☐ Neat
- ☐ Poor
- ☐ Disheveled
- ☐ Malodorous
- ☐ Other: _____

Eye Contact

- ☐ Good
- ☐ Avoidant
- ☐ Stares into space
- ☐ Intense/ Fixed
- ☐ Poor
- ☐ Eyes shut
- ☐ Other: _____

Attitude & Rapport

- ☐ Cooperative
- ☐ Evasive
- ☐ Dependent
- ☐ Manipulative
- ☐ Responsive
- ☐ Apathetic
- ☐ Oppositional
- ☐ Eager to Please
- ☐ Pleasant
- ☐ Aggressive
- ☐ Demanding
- ☐ Passive
- ☐ Engaging
- ☐ Uncooperative
- ☐ Threatening
- ☐ Silly
- ☐ Impulsive
- ☐ Distant
- ☐ Dramatic
- ☐ Guarded
- ☐ Hostile
- ☐ Seductive
- ☐ Other: _____

Motor Activity

- ☐ Agitated
- ☐ Hyperactive
- ☐ Normal
- ☐ Slow
- ☐ Tics
- ☐ No Extrapyrarnidal Symptoms/ Tardive Dyskinesia
- ☐ Tremor
- ☐ Posturing
- ☐ Pacing
- ☐ Hand Wringing
- ☐ Buccolingual masticatory
- ☐ Other: _____

Emotional State

Mood

- | | | | |
|------------------------------------|------------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Euthymic | <input type="checkbox"/> Euphoric | <input type="checkbox"/> Irritable | <input type="checkbox"/> Hostile |
| <input type="checkbox"/> Bland | <input type="checkbox"/> Expansive | <input type="checkbox"/> Fearful | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Manic | <input type="checkbox"/> Anxious | |
| <input type="checkbox"/> Anhedonic | <input type="checkbox"/> Agitated | <input type="checkbox"/> Elevated | |

Affect

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Appropriate | <input type="checkbox"/> Constricted |
| <input type="checkbox"/> Expansive | <input type="checkbox"/> Flat |
| <input type="checkbox"/> Inappropriate | <input type="checkbox"/> Blunted |
| <input type="checkbox"/> Labile | <input type="checkbox"/> Other: _____ |

Thought Process/Content/Perceptions

Process

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Normal | <input type="checkbox"/> Loose associations |
| <input type="checkbox"/> Blocking | <input type="checkbox"/> Poverty of thought |
| <input type="checkbox"/> Concrete | <input type="checkbox"/> Circumstantial |
| <input type="checkbox"/> Slow | <input type="checkbox"/> Perseverating |
| <input type="checkbox"/> Rambling | <input type="checkbox"/> Disorganized |
| <input type="checkbox"/> Tangential | <input type="checkbox"/> Illogical |
| <input type="checkbox"/> Other: _____ | |

Content

- | |
|---|
| <input type="checkbox"/> Mood congruent |
| <input type="checkbox"/> Mood incongruent |
| <input type="checkbox"/> Bizarre |
| <input type="checkbox"/> Systemized |
| <input type="checkbox"/> Poorly Organized |
| <input type="checkbox"/> Other: _____ |

Delusions

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Thought broadcasting | <input type="checkbox"/> Guilt |
| <input type="checkbox"/> Paranoid | <input type="checkbox"/> Persecutory | <input type="checkbox"/> Grandiosity |
| <input type="checkbox"/> Jealousy | <input type="checkbox"/> Ideas of reference | <input type="checkbox"/> Erotomanic |
| <input type="checkbox"/> Being controlled | <input type="checkbox"/> Thought Insertion | |
| <input type="checkbox"/> Hyper religiosity | <input type="checkbox"/> Hypochondriacal | |
| <input type="checkbox"/> Somatic | <input type="checkbox"/> Other: _____ | |

Hallucinations

- | | |
|---------------------------------------|------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Gustatory |
| <input type="checkbox"/> Auditory | <input type="checkbox"/> Somatic |
| <input type="checkbox"/> Visual | <input type="checkbox"/> Tactile |
| <input type="checkbox"/> Olfactory | <input type="checkbox"/> Command |
| <input type="checkbox"/> Other: _____ | |

Themes of Preoccupation

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Sexual |
| <input type="checkbox"/> Obsessions | <input type="checkbox"/> Somatic |
| <input type="checkbox"/> Compulsions | <input type="checkbox"/> Magical thinking |
| <input type="checkbox"/> Phobias | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Other: _____ | |

Somatic

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Dizzy/unsteady | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Muscle tension | <input type="checkbox"/> Lightheaded | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Heart palpitation | <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Heart pounding | <input type="checkbox"/> Chest pain/discomfort | |
| <input type="checkbox"/> Trembling | <input type="checkbox"/> Shortness of breath | |
| <input type="checkbox"/> Choking Sensation | <input type="checkbox"/> Nausea/stomach distress | |

Sensorium/ Intellectual Functioning

Orientation

- | |
|--|
| <input type="checkbox"/> Oriented x4 |
| <input type="checkbox"/> Person |
| <input type="checkbox"/> Place |
| <input type="checkbox"/> Date |
| <input type="checkbox"/> Purpose/Environment/Situation |
| <input type="checkbox"/> None |

Concentration & Memory

- | |
|---|
| <input type="checkbox"/> Intact |
| <input type="checkbox"/> Impaired |
| <input type="checkbox"/> Poor |
| <input type="checkbox"/> Unable to assess |

As Measured by

- | | |
|--|---|
| <input type="checkbox"/> Serial 7's/3's | <input type="checkbox"/> Immediate Recall |
| <input type="checkbox"/> Number of digits forward | <input type="checkbox"/> Recent recall |
| <input type="checkbox"/> Number of digits backward | <input type="checkbox"/> Remote recall |
| <input type="checkbox"/> Naming 3 items | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Recall 3 items at 5 minutes | |

General Fund of Knowledge

- | |
|--|
| <input type="checkbox"/> Average |
| <input type="checkbox"/> Above average |
| <input type="checkbox"/> Below average |

Estimated Intellectual Functioning

- | |
|--|
| <input type="checkbox"/> Average |
| <input type="checkbox"/> Above average |
| <input type="checkbox"/> Below average |

Insight

- | |
|-------------------------------|
| <input type="checkbox"/> Good |
| <input type="checkbox"/> Fair |
| <input type="checkbox"/> Poor |

Judgement

- | |
|-------------------------------|
| <input type="checkbox"/> Good |
| <input type="checkbox"/> Fair |
| <input type="checkbox"/> Poor |

Areas of Immediate Concern

Current Thoughts of Self-Harm

- | |
|---|
| <input type="checkbox"/> Denies |
| <input type="checkbox"/> Yes |
| <input type="checkbox"/> Refused to State |
| <input type="checkbox"/> Unable to assess |

Self-Harm

- | |
|-----------------------------------|
| <input type="checkbox"/> Thoughts |
| <input type="checkbox"/> Intent |
| <input type="checkbox"/> Plan |
| <input type="checkbox"/> Means |

Method, Frequency & Triggers

--

Current Suicidal Ideation

- ☐ Denies
- ☐ Yes
- ☐ Refused to State
- ☐ Unable to assess

Suicidal Ideation

- ☐ Thoughts
- ☐ Intent
- ☐ Plan
- ☐ Means

Specificity, Availability & Lethality**Suicide Risk Indicators**

- | | | |
|---|--|--|
| <input type="checkbox"/> Current/previous S/I, S/A | <input type="checkbox"/> Recent loss (death, divorce, job) | <input type="checkbox"/> Hopelessness |
| <input type="checkbox"/> History of psychiatric hospitalization | <input type="checkbox"/> Significant life events/stressors | <input type="checkbox"/> Suicide Plans |
| <input type="checkbox"/> Means or access to means | <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Intent to commit suicide |
| <input type="checkbox"/> Chronic physical illness | <input type="checkbox"/> Perceives self as burden to other | <input type="checkbox"/> Possession of a firearm |
| <input type="checkbox"/> Access to a firearm | <input type="checkbox"/> Sees no other option | <input type="checkbox"/> Prior use of violent meth |
| <input type="checkbox"/> History of impulsivity | <input type="checkbox"/> Major psychiatric diagnosis | <input type="checkbox"/> Command hallucination |
| <input type="checkbox"/> History of drug/alc use/abuse | <input type="checkbox"/> Preparations (will, give aways, goodbyes) | |

Suicide Protective Factors/Consumer Strengths

- | | | |
|---|---|--|
| <input type="checkbox"/> Hope and optimism about future | <input type="checkbox"/> Religiously/spiritually involved | <input type="checkbox"/> Resilient towards life stressors |
| <input type="checkbox"/> Future plans/goals | <input type="checkbox"/> Agrees to elimination of means | <input type="checkbox"/> Immediate, reliable support |
| <input type="checkbox"/> Purpose/meaning in life | <input type="checkbox"/> Agrees to 24-hour monitoring | <input type="checkbox"/> Able to follow thru w/safety planning |
| <input type="checkbox"/> Seeing a therapist | <input type="checkbox"/> Agrees to take psychiatric meds | <input type="checkbox"/> Agrees not to consume drugs/alcohol |
| <input type="checkbox"/> Will see psychiatrist in 24-48 hours | <input type="checkbox"/> Positive connection with family | |
| <input type="checkbox"/> Suicide not supported by current belief/values | <input type="checkbox"/> Other_____ | |

Current Homicidal Ideation

- ☐ Denies
- ☐ Yes
- ☐ Refused to State
- ☐ Unable to assess

Homicidal Ideation

- ☐ Thoughts
- ☐ Intent
- ☐ Plan
- ☐ Means

Specificity, Availability & Lethality**Danger to Others Risk Indicators**

- | | | |
|---|---|---|
| <input type="checkbox"/> History of violence | <input type="checkbox"/> History of impulsivity | <input type="checkbox"/> Preoccupation with violent fantasy |
| <input type="checkbox"/> Plans to harm or kill another | <input type="checkbox"/> Paranoid delusions about others | <input type="checkbox"/> Command halluc. involving violence |
| <input type="checkbox"/> Possession of a firearm | <input type="checkbox"/> Agitated easily | <input type="checkbox"/> Persecutory delusions |
| <input type="checkbox"/> Access to a firearm | <input type="checkbox"/> Prescription drug abuse | <input type="checkbox"/> Major psychiatric diagnosis |
| <input type="checkbox"/> Other means | <input type="checkbox"/> Obsessing about violence | <input type="checkbox"/> Sees no other option |
| <input type="checkbox"/> Intent to harm or kill another | <input type="checkbox"/> History of psychiatric hospitalization | <input type="checkbox"/> Identifiable/intended victim(s) |
| <input type="checkbox"/> Anger/rage/frustration | <input type="checkbox"/> History of drug/alcohol use/abuse | |

Danger to Others Protective Factors/Consumer Strengths

- | | |
|---|--|
| <input type="checkbox"/> Hope and optimism about future | <input type="checkbox"/> Violence not supported by current belief/values |
| <input type="checkbox"/> Future plans/goals | <input type="checkbox"/> Religiously/spiritually involved |
| <input type="checkbox"/> Immediate, reliable support | <input type="checkbox"/> Resilient towards life stressors |
| <input type="checkbox"/> Purpose/meaning in life | <input type="checkbox"/> Agrees to elimination of means |
| <input type="checkbox"/> Positive connection with family | <input type="checkbox"/> Able to follow thru w/safety planning |
| <input type="checkbox"/> Seeing a therapist | <input type="checkbox"/> Agrees to 24 hr monitoring |
| <input type="checkbox"/> Agrees to take psychiatrist meds | <input type="checkbox"/> Agrees not to consume drugs/alcohol |
| <input type="checkbox"/> Will see psychiatrist in 24-48 hrs | <input type="checkbox"/> Other: |

Current Grave Disability

- ☐ Yes
☐ No
☐ Unable to assess

Grave Disability/Self Neglect Risk Indicators

- | | | |
|---|--|--|
| <input type="checkbox"/> Previous history of grave disability | <input type="checkbox"/> Poor hygiene | <input type="checkbox"/> Lack of positive social support |
| <input type="checkbox"/> Refusing or failing to eat | <input type="checkbox"/> Disoriented/confused | <input type="checkbox"/> Paranoia related to food or shelter |
| <input type="checkbox"/> Major psychiatric diagnosis | <input type="checkbox"/> Insufficient clothing | <input type="checkbox"/> No plans for filling basic needs (food) |
| <input type="checkbox"/> Refusing to take medications | <input type="checkbox"/> Wandering aimlessly | <input type="checkbox"/> Eviction/recent homelessness |

Comments**Impulse Control**

- ☐ Good
☐ Fair
☐ Poor

Impulse Control Narrative**Activities of Daily Living (ADL's)****ADL's**

	Descriptor	Independence	Requires Assistance
Personal Hygiene	Bathing/showering, grooming, nail care and oral care.		
Dressing	Being able to make appropriate clothing decisions and physically dress and undress oneself.		
Eating	The ability to obtain food, feed oneself.		
Maintaining Contenance	Being able to mentally and physically use a restroom. This includes the ability to get on and off the toilet and cleaning oneself.		
Transferring/Mobility	Being able to stand from a sitting position, as well as get in and out of bed. The ability to walk independently from one location to another.		

Travel's Via

- ☐ Public Transportation
☐ Own Conveyance

Effectively communicates needs to others

- ☐ Yes ☐ Sometimes
☐ No ☐ Other _____

Instrumental Activities of Daily Living (IADL's)

	Independent	Requires Assistance
Ability to keep appointments		
Housework		
Meal Preparation		
Managing Medication		
Transportation		

Is there an impairment in this area of Functioning in Daily Activities due to Mental Health? ☐ Yes ☐ No

If yes, Identify the DSM symptoms and behaviors resulting in the impairment/s:

Symptoms LPHA or licensed waived only**Behaviors****Impairments**

--	--	--

DOMAIN 2

Abuse & Trauma

Any History of Abuse or Trauma?

- ☐ Yes
☐ No

(i.e., having experienced traumatic events including experiences such as having witnessed violence, having been a victim of crime or violence, having lived through a natural disaster, having been a combatant or civilian in a war zone, having witnessed or having been a victim of a severe accident or having been a victim of physical, emotional, or sexual abuse)

If yes, please provide additional information regarding the history and exposure to trauma:

As a child was the client:

PAST			CURRENT			Describe:
	Yes	No		Yes	No	
Physically Abused?			Physically Abused?			
Neglected?			Neglected?			
Sexually abused or molested?			Sexually abused or molested?			
Witness to violent acts?			Witness to violent acts?			
Were there any other childhood events to note?			Were there any other events to note?			

If yes to any items above, please describe any negative life circumstances (e.g., homelessness) or placements (e.g., foster care) which resulted from the past or current abuse or trauma: **MANDATORY** if Marked **Yes** to any items above

DOMAIN 3

Psychiatric & Substance Abuse History

Psychiatric History

History of Mental Health Treatment?

☐ Yes ☐ No ☐ Unknown

If yes is selected then the Outpatient and Psychiatric Hospitalization Section, below is **MANDATORY**.

Age of Onset

Outpatient

☐ Yes ☐ No

If yes is selected, then the Outpatient Mental Health Treatment History Narrative is **MANDATORY**.

Outpatient Mental Health Treatment Narrative

Previous treatment, including providers, therapeutic modality (i.e. medications, psychosocial treatment, and response).

Is there an impairment in the client's ability to manage their Mental Illness? ☐Yes ☐No

(i.e. Hospitalizations, dropping out of services, gap in services, stopping medications, missed appointments, etc.)

If yes, identify the DSM symptoms and behaviors resulting in the impairment/s:

Symptoms LPHA or licensed waived only

Behaviors

Impairments

History of Psychiatric Hospitalization

☐Yes

☐No

If yes, how many times in past 12 months? _____ How many times in past 36 months? _____

Psychiatric Hospitalization History Narrative: (Previous hospitalizations and hospitalization patterns, including name of hospital, admit legal status, date of admit and length of stay)

Substance Abuse & Recovery

Substance Abuse & Recovery Narrative: (Please include current/past use, age first use, type of substance/s and previous SUD services in narrative)

Questions to consider:

Can you tell me a bit about your past and/or current substance use?

About how often did/do you use substances?

Do you think that substance use has led to any negative effects on your life? If so, can you explain those negative effects and which areas of your life have been affected?

Do you think that you use substances to cope with negative feelings or experiences?

Do you ever feel like you want to reduce or quit using substances?

Is there an impairment in this area of Substance Abuse due to Mental Health? (comorbidity) ☐Yes ☐No

(i.e., getting arrested due to substance use, relapse, frequent ER visits due to drug-induced psychosis, etc.)

If yes, identify the DSM symptoms and behaviors resulting in the impairment/s:

Symptoms LPHA or licensed waived only

Behaviors

Impairments

Medical, Developmental, Care Coordination

Medical Problems & Medications

Current & Past Medical Problems & Allergies as Reported by Client:

Current & Past Medications as Reported by Client

Is there an impairment in this area of Physical Health Care due to Mental Health? ☐ Yes ☐ No

(i.e. Not taking prescribed medications, refusing to see PCP, inability to manage chronic conditions, generally poor health care hx, etc.)

If yes, identify the DSM symptoms and behaviors resulting in the impairment/s:

Symptoms LPHA or licensed waived only

Behaviors

Impairments

Developmental History

Is the client 20 years or younger? ☐ Yes ☐ No *(If no, then the remainder of Developmental History section does not need to be filled out)*

Were the client's developmental milestones achieved within normal limits? ☐ Yes ☐ No ☐ Unable to assess

If "No", please give a Developmental History Narrative:

During the mother's pregnancy did any of the following occur?

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Inadequate prenatal care | <input type="checkbox"/> Father used drugs or alcohol | <input type="checkbox"/> Mother smoked | <input type="checkbox"/> Mother was victim of violence |
| <input type="checkbox"/> Mother used caffeine | <input type="checkbox"/> Mother had medical problems | <input type="checkbox"/> Mother used drugs or alcohol | <input type="checkbox"/> Mother was hospitalized |
| <input type="checkbox"/> Mother used medications | <input type="checkbox"/> Mother had accident/injury | <input type="checkbox"/> Mother had emotional problems | |
| <input type="checkbox"/> Unknown | <input type="checkbox"/> Other | | |

During the client's birth, did any of the following perinatal problems or conditions occur?

- | | | |
|---|---|---|
| <input type="checkbox"/> Child was premature | <input type="checkbox"/> Baby placed in incubator | <input type="checkbox"/> Fetal distress |
| <input type="checkbox"/> Complicated labor | <input type="checkbox"/> Baby remained in hospital after mother went home | |
| <input type="checkbox"/> Breech, caesarian, or forceps delivery | <input type="checkbox"/> None reported | <input type="checkbox"/> Delayed crying |
| <input type="checkbox"/> Baby given oxygen or transfusion | <input type="checkbox"/> Unknown | <input type="checkbox"/> Other |

Were there any special problems, delays, or events regarding the client's childhood?

- | | | | | |
|--|--|---|---|----------------------------------|
| <input type="checkbox"/> Holding head up | <input type="checkbox"/> Dressing independently | <input type="checkbox"/> Sleeping through the night | <input type="checkbox"/> Language delay | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Learning to bond | <input type="checkbox"/> Writing his or her name | <input type="checkbox"/> Cognitive delay | <input type="checkbox"/> Learning to sit up alone | <input type="checkbox"/> Other |
| <input type="checkbox"/> Learning to crawl | <input type="checkbox"/> Learning to walk | <input type="checkbox"/> Learning to talk | <input type="checkbox"/> Tying shoes | |
| <input type="checkbox"/> Bowel or bladder training | <input type="checkbox"/> Feeding self with a spoon | <input type="checkbox"/> Unspecified motor delay | <input type="checkbox"/> None reported | |

Care Coordination

Health Plans

Does client have Medi-Cal/Health Insurance? ☐ Yes ☐ No

Have BHS staff offered client assistance in obtaining Medi-Cal/Health Insurance? ☐ Yes ☐ No

If yes, what was the Intervention/Outcome?

☐ Linked to Medi-Cal/Health Insurance ☐ Referred to Medi-Cal Enrollment Counselor ☐ Client Not Eligible

☐ Other: ☐ Client Declined Assistance – Explain: _____

PCP/ Other Health Care Providers

Does client have a Primary Care Physician (PCP) or other Health Care Providers? ☐ Yes ☐ No

If yes, Name of PCP _____ Phone _____ Email _____

Address: _____

If "No", what was the Intervention/Outcome

☐ Linked to PCP under Medi-Cal/Health Insurance

☐ Linked to OC Community health Center (for clients without Health Insurance)

☐ Other:

Please list all other Ancillary Service Providers ☐ None

Ancillary Service Provider	Ancillary Service	Contact Info	Location	Comment

DOMAIN 5

Family History, Education, Employment-Financial, Gender-Sexual Orientation, Legal, Cultural/Religious/Spirituality and Supplemental

Family History

Family History – For how many people age -17 is the Client the Primary Care Giver (50% or more of their time): _____

For how many people age 18 or older is the Client the Primary Care Giver (50% or more of their time): _____

Pertinent Family History to presenting problem: ☐ Yes ☐ No ☐ Unknown

Mental Health History: ☐ Yes ☐ No ☐ Unknown

Substance Use History: ☐ Yes ☐ No ☐ Unknown

Other Pertinent Medical Condition: ☐ Yes ☐ No ☐ Unknown

If yes, please explain:

If yes, please explain:

If yes, please explain:

If yes, please explain:

Family History (narrative for additional details)

Education

Has the client ever had:	Yes	No	Unknown
Problems learning certain subjects			
Problems with paying attention			
Problems getting along with teachers			
Problems with studying			
Problems with grades			
Problems with truancy			
Disruptive class behavior			
Suspensions or transfers			
Special education			
Special day classes			
Tutoring			

Other Education Problems:

Highest Level of Education Completed: _____

Date Type	Event Date	Education Status	Attendance Level	Grades	Spec. Education Eligibility (Per IEP)	Special Ed Setting	Educational Goal (Adult)

Employment/Financial

Current Employment Status: _____

Is Employment a goal? ☐ Yes ☐ No

Employment Year	LOS	Employment Description	Avg Hrs per week	Reason for Leaving	Comment

Is there an impairment in this area of Education/Employment due to Mental Health? ☐ Yes ☐ No
If "Yes", please fill out the symptom/behavior(s) and impairment(s) below:

Symptoms LPHA or licensed waived only

Behaviors

Impairments

Financial

Income Source: _____ Amount per month: _____

Assisted by and/or payee: _____ Phone Number: _____

SSI/SSDI Status: _____

Is there an impairment in this area of Financial/Money Management due to Mental Health? ☐ Yes ☐ No

If "Yes", please fill out the symptom/behavior(s) and impairment(s) below:

Symptoms LPHA or licensed waived only

Behaviors

Impairments

Gender/Sexual Orientation

Sex assigned at birth

- ☐ Male
☐ Female
☐ Intersex
☐ Declined to State
☐ Unknown

Gender Identity

- ☐ Male
☐ Female
☐ Transgender: Male to Female
☐ Transgender: Female to Male
☐ Questioning or unsure of gender identity
☐ Other:
☐ Declined to State
☐ Unknown

Sexual Orientation

- ☐ Bisexual
☐ Gay
☐ Heterosexual
☐ Lesbian
☐ Questioning
☐ Declined to State
☐ Other:

Gender Identity/Sexual Orientation Narrative (if applicable):

Preferred Gender Pronouns

- ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ Declined to State ☐ Other:

Coming out experience, if applicable:

Client's Relationship with their Family ☐ Positive ☐ Negative ☐ Other: _____

Describe how the client's relationship with their family, or lack thereof, contributes to the client's current mental health

If the client identifies as transgender, are they pursuing a medical transition process? ☐ Yes ☐ No

Does the client believe they would benefit from Trans Health Care resources (knowledge of the transition process, trans-friendly providers, support resources, etc.)? ☐ Yes ☐ No

Living Arrangement

Current Housing Assistance

	Yes	No	Unknown
Section 8			
Other Financial			
Continuum of Care			
IPF			
IHF			
Family Support			

Additional information (if applicable): _____

Current Living Arrangement (MANDATORY): _____

For additional Living Arrangement information, please describe here:

Please include the length of time client has maintained current living arrangement and/or reason for leaving recent living arrangement and include facility name if applicable.

Is there an impairment in this area of functioning in Living Arrangement/Housing due to Mental Health? ☐ Yes ☐ No

If "Yes", please fill out the symptom/behavior(s) and impairment(s) below:

Symptoms LPHA or licensed waived only

Behaviors

Impairments

Legal

Is there an impairment in this area of Legal Status due to Mental Health?

☐ Yes ☐ No

If "Yes", please fill out the symptom/behavior(s) and impairment(s) below:

Symptoms LPHA or licensed waived only

Behaviors

Impairments

Court Involvement -

☐ Yes

☐ No

If yes, please explain:

Incarceration History -

☐ Yes

☐ No

If yes, please explain:

Culture, Religion, Spirituality

Please gather information for this section based on an interview with the client or, when clinically or developmentally appropriate, from the client's conservator/caregiver/parent.

Client's culture and how it may impact treatment recovery

Client's religion and how it may impact treatment/recovery

Client's spirituality and how it may impact treatment/recovery

Caregivers

Conservator/Care Giver	Address	Phone	Fax	Email	Relationship

DOMAIN 6

Harm Assessment, Suicide Attempts, Strengths

Self-Harm

Thoughts ☐ No ☐ Yes

If yes, please explain when and how and resulting treatment:

Suicidal Ideation ☐ No ☐ Yes

If yes, please explain when and how and resulting treatment:

Suicide Attempts ☐ No ☐ Yes

If yes, please explain when and how and resulting treatment in grid below:

Date Type	Date	How	Comments	Outpatient Tx	Hospitalization?

Homicidal Ideation/Thoughts of Hurting Others ☐ No ☐ Yes

If yes, please explain when and how and resulting treatment

History of Violence (Toward People, Animals, Objects) ☐ No ☐ Yes

If yes, please explain when and how and resulting treatment:

Safety Planning (specific Safety Plans to be used should risk behaviors arise and emergency contacts:

Please describe safety plan:

Emergency Contact	Phone Number

Was a support person informed about the Safety Plan: ☐No ☐Yes
If yes, who was informed and what is their role in the client’s life? _____

Strengths, Social Relationships & Communication Skills *(strengths should help achieve objective and/or overcome barriers)*

Describe the client’s overall strengths

MANDATORY

Please list client's strengths that may benefit client in treatment (i.e., social/family support, displays good verbal skills, etc.).

Describe the client’s social relationships & communication skills

Is there an impairment in this area of functioning in Social Relationship/ Communication Skills due to Mental Health? ☐Yes ☐No
If “Yes”, please fill out the symptom/behavior(s) and impairment(s) below:

Symptoms LPHA or licensed waived only	Behaviors	Impairments

Clinical Narrative Summary & Differential Diagnosis

A clinical hypothesis / understanding / core theme regarding what drives the client's experience of illness and recovery, makes connections between themes and describes the provider's understanding of the "why."

Diagnostic/Clinical Impression:

Determination of medical necessity, level of care, access criteria

Treatment recommendations:

I have completed the assessment and am ready to add a diagnosis: ☐ Yes

Problem List

Code	Descriptor (Use ICD10 codes only or Snomed codes verbatim - see https://snomed.terminology.tools/terminology-ui/index.html#/terminology#content)	Date Established	Date Ended	Responsible Provider

Print Name: _____

Date: _____

Provider Signature: _____

Credentials: _____

Additional Signature if needed:

Print Name: _____

Date: _____

Provider Signature: _____

Credentials: _____