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| **Initial Assessment** | | | |
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| **Client Information:** | | | |
| Client Name |  | Date of Assessment |  |
| Date of Birth |  | Referral Source |  |
| CPT Code/ Time Spent: |  | Other Agencies Involved |  |
| Source of Information: |  | Preferred Language for treatment |  |
| **Beneficiary Rights:**  *(if not provided, please note why):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*   * Explanation of the State Guide to Medi-Cal Mental Health Services * Grievance/Appeal process * Notice of Privacy Practices | | | |
| **Presenting problems** *(What is the primary reason for current referral? Describe current precipitating event, primary stressors, primary symptoms, and functional impairment):* | | | |
| **Mental health history** *(including previous inpatient and/or outpatient treatment providers, dates, treatment outcomes, previous diagnoses, relevant family information, etc.):* | | | |
| **Client/family strengths** *(include personal strengths as well as support systems, etc. Show how the strengths can be applied practically to help client/family reach treatment goals):* | | | |
| **Experience of trauma** *(include historical and current domestic violence, physical abuse, sexual abuse, etc.):* | | | |
| **Initial mental status exam** *(Document appearance, attitude, behavior, speech, orientation, Mood/Affect, Thought Process, Memory/Thought Content, Insight/Judgment/Impulsivity, and additional observations):* | | | |
| **Risk assessment***(Include past and present danger to self and danger to others. Detail intent, plan, access to means, previous attempts, relevant risk factors - such as co-occurring disorders, loss, abuse, access to firearms, etc.):* | | | |
| **Relevant physical health conditions reported by client:** | | | |
| **Medications that have been prescribed to the client** *(If MD, include dosages of each medication, dates of initial prescriptions, client self-report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities):*  **Allergies:** | | | |
| **Primary Care Physician Information:** *(Document information for coordination of care. If client does not have a PCP, document referrals given):* | | | |
| **Developmental history** *(for children & adolescents only. Include birth and developmental milestone information):* | | | |
| **Cultural assessmen**t *(include any culture or sub-culture client identifies with, and how these cultural issues influence client's view of mental health treatment, mental illness, etc.):* | | | |
| **Substance use** *(include past and present use of alcohol, nicotine, and/or illicit drugs, as well as prescription and over the counter medications. Include, frequency, amount, consequences, and impact on client functioning):* | | | |
| **Social History** *(if applicable, include legal system involvement, work history, school/educational history, risk factors and relationship status including orientation):* | | | |
| **Community resources client is currently using** (*support groups, school-based services, social services, other social supports):* | | | |
| **Diagnosis** *(Document diagnosis. Substantiate with information regarding symptoms, frequency/length of symptoms, list rule-outs, indicate priority diagnosis for treatment. Remember an Included Diagnosis from Title 9 must be primary for Medical Necessity to be met for Medi-Cal services):* | | | |
| **Clinical Formulation** *(Include clinical judgments regarding intensity, length of treatment and recommendations for services. Include evaluation of client’s ability and willingness to solve the presenting problem):* | | | |
| **Clinician Signature** *(include credential. If signature cannot be read, include printed name):* | | | **Date:** |