

Mental Health Assessment Form

Client Name:			
Date of Birth:		Medicaid Number:	
Address:			
City, State, Zip			
Parent/Guardian (if applicable):			
Phone Number:			

Date of Service:		Time of Service:	
Duration of Service:			
Presenting Concern/Chief Complaint (include symptoms, intensity and duration):			
Cultural Assessment/Strengths:			

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Mini Mental Status Exam:	
Presentation (include appearance, psychomotor activity, manner/attitude):	
Speech (include quality/quantity):	
Emotions (include mood, affect, impulse control):	
Thought Process (include productivity, continuity, orientation, memory, attention /concentration, judgment, insight):	
Thought Content (include preoccupations, perceptions, delusions):	
Somatic (include sleep, appetite, weight, energy):	

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Alcohol/Drug Assessment	
Tobacco Use (current and historical to include amount and frequency, age first used, current frequency of use, frequency in past 6 months, method of use):	
Alcohol Use (current and historical to include amount and frequency, age first used, current frequency of use, frequency in past 6 months, method of use):	
Other Drug Use (current and historical to include amount and frequency, age first used, current frequency of use, frequency in past 6 months, method of use):	Primary:
	Secondary:
	Tertiary:
Previous/Current Abuse Treatments:	

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Prior Treatment History (including high levels of treatment, such as residential, day treatment):

Current Medications (type, frequency, dosage):

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Risk Assessment:			
History of violence toward self or others:			
History of hospitalizations:			
Medical Concerns:			
Cause of dangerousness:	Suicidal Ideation	Homicidal Ideation	Grave Disability
If Suicidal Ideation:	Suicidal behavior:		
	Ideation: yes/no	Plan: yes/no	Intent: yes/no
	Precipitants/stressors/interpersonal triggers:		
	Change in current treatment		
	Access to weapons		
	Protective Factors:		
	Internal (ability to cope, frustration tolerance):	External (responsibility to children/pets, social supports):	

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Risk Assessment Continued:			
If Homicidal Ideation:	Identified target?	Notified/Duty to Warn?	
	Past assault history/legal history:		
	Access to weapons/plan/intent:		
	Psychotic disorder?		
	TBI		
	Cluster B traits/ conduct		
	Substances		
If Grave Disability:	Medical concerns directly related to GD:		
	Level of support needed to complete ADLs:		
	Able to have this level at home through supports:		
Overall Risk Level:	High	Medium	Low

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Crisis Plan (if applicable):**Social History**Early Childhood
Development:Current Psychosocial
Situation:

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Social History Continued:	
Abuse History:	
Crime Victimization:	
Family History of Mental Illness/Drug Use:	
Education:	
Current Occupational Assessment:	
Military History:	
Legal Status:	

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Diagnosis		
Primary	Code	
	Description	
	Rationale/DSM Criteria	
Secondary	Code	
	Description	
	Rationale/DSM Criteria	
Tertiary	Code	
	Description	
	Rationale/DSM Criteria	
Other	Code	
	Description	
	Rationale/DSM Criteria	
Disposition Plan:		
Clinical Impressions:		
Referred to / Recommendations:		
Additional Referrals/Recommendations:		
Signatures		Date
Clinician Name and Credentials (printed):		
Clinician Signature:		