

# INITIAL MENTAL HEALTH ASSESSMENT

1. **Identifying Information** (age, gender, ethnicity, preferred language, relationship status, sexual orientation, gender identity, living arrangement): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. **Presenting Mental Health Problem** (referral source, current symptoms, behaviors, and stressors): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. **Mental Health History** (onset, symptoms, previous treatment – hospitalizations, providers, dates – in order): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. **Cultural Factors** (e.g., ethnicity, immigration, acculturation, language, religion, sexual orientation, etc.): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do any cultural factors affect client's treatment?      YES      NO  
        

If yes, describe:  
\_\_\_\_\_  
\_\_\_\_\_

5. **Client Strengths** (e.g., skills, personality traits, intelligence, resiliency, insight, etc.): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**6. Psychosocial History:**

a. **Prenatal/Birth** (e.g., pregnancy complications, exposure to substances, etc.): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

b. **Childhood/Adolescence** (e.g., developmental milestones, attachment, separation, temperament, peer relations): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

c. **Family History/Situation** (e.g., family members, financial issues, relationship issues, living arrangements, placement history, mental health, substance abuse, medical, etc.): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

d. **Social Relationships & Support** (e.g., significant others, friends, support system, etc.): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Client's Name: \_\_\_\_\_  
Unicare #: \_\_\_\_\_  
Program (Cost Center): \_\_\_\_\_

**6. Psychosocial History (cont.):**

e. Education/Vocation: (e.g., special needs, IEP, work history, etc.): \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

f. Inter-Agency Involvement (e.g., DSS, JPD, DADS, conservators, criminal justice, etc.): \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**7. Medical History** (Does the individual report any of the following? Check all that apply and describe below.):

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Head injury/stroke      | <input type="checkbox"/> Thyroid problems   | <input type="checkbox"/> Chronic pain (incl. location) | <input type="checkbox"/> STD                  |
| <input type="checkbox"/> Loss of consciousness   | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Enuresis/encopresis           | <input type="checkbox"/> Respiratory problems |
| <input type="checkbox"/> Kidney disease          | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Allergies                     | <input type="checkbox"/> Seizures             |
| <input type="checkbox"/> Heart/vascular problems | <input type="checkbox"/> Sleep disturbances | <input type="checkbox"/> Adverse reaction to meds      | <input type="checkbox"/>                      |
| <input type="checkbox"/> Hypertension            | <input type="checkbox"/> Appetite changes   | <input type="checkbox"/> Parasites/scabies/lice        | <input type="checkbox"/>                      |
| <input type="checkbox"/> Liver disease           | <input type="checkbox"/> Weight changes     | <input type="checkbox"/> Pregnancy                     | <input type="checkbox"/>                      |

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

No major medical conditions      Lab Results:  Not Applicable    In Medical Section    Other \_\_\_\_\_

Medications (include prescribed, over-the-counter, alternative or herbal remedies)

Medication	Dosage	Date Started	OTC (y/n)	Reported Side Effects

Are there any medication compliance/adherence issues?      YES      NO  
     

Describe: \_\_\_\_\_  
 \_\_\_\_\_

Name and phone number of Primary Care Physician: \_\_\_\_\_

If no PCP, then referral made?      YES      NO  
     

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8. **Substance Use History (e.g., alcohol, stimulants, sedatives, hallucinogens, nicotine, caffeine, etc.):**

Type	Date of Last Use	Amount of Last Use	Frequency and Amount of Use	Length of Time Using	Age of First Use

Treatment/Recovery History: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

9. **Risk Factors (CHECK ALL THAT APPLY):**

Yes	If yes, please explain:
<input type="checkbox"/> Homicidal/Assaultive	_____
<input type="checkbox"/> Suicidal/Self-Harm	_____
<input type="checkbox"/> Access to Weapons	_____
<input type="checkbox"/> Trauma	_____
<input type="checkbox"/> Neglect/Abuse	_____
<input type="checkbox"/> Domestic Violence	_____
<input type="checkbox"/> Legal Issues	_____
<input type="checkbox"/> Crime/Gang Involvement	_____
<input type="checkbox"/> Runaway	_____
<input type="checkbox"/> Inappropriate/Risky Sexual Behavior	_____
<input type="checkbox"/> Substance Use/Abuse	_____
<input type="checkbox"/> Cognitive Impairment	_____
<input type="checkbox"/> Cultural Isolation	_____
<input type="checkbox"/> Potential for Victimization	_____
<input type="checkbox"/> Risk of Homelessness	_____

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

10. **Mental Status Exam** (CIRCLE ALL THAT APPLY):

<b>Appearance:</b>	clean	well-groomed	disheveled	bizarre	malodorous		
<b>Motor:</b>	normal	decreased	agitated	tremors	tics	repetitive	impulsive
<b>Behavior:</b>	cooperative	evasive	uncooperative	threatening	agitated	combative	guarded
<b>Consciousness:</b>	alert	lethargic	stuporous				
<b>Orientation:</b>	person	place	time: [day	month	year]	current situation	
<b>Speech:</b>	normal	slurred	loud	pressured	slow	mute	
<b>Affect:</b>	appropriate	labile	restricted	blunted	flat	congruent	incongruent
<b>Mood:</b>	normal	depressed	anxious	euphoric	irritable	congruent	incongruent
<b>Thought Process:</b>	coherent	tangential	circumstantial	loose	paranoid	concrete	
<b>Delusions:</b>	persecutory	grandiose	referential	somatic	religious		
<b>Hallucinations:</b>	auditory	visual	olfactory	gustatory	tactile		
<b>Intellect:</b>	average	above average	below average				
<b>Memory:</b>	good	poor recent	poor remote	confabulation			
<b>Insight:</b>	good	fair	poor	limited			
<b>Judgment:</b>	good	fair	poor	unrealistic	unmotivated	uncertain	

Comments/Additional Information: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

11. **Medical Necessity Criteria:**

- a. Impairment (significant; probability of significant deterioration; or probability a child will not progress developmentally as individually appropriate) in a life functioning area as a result of the client's mental disorder(s):

Check all that apply:

/	Area	Brief description of impairment (if checked):
	<b>Health</b> [e.g., physical condition, activities of daily living]	
	<b>Daily Activities</b> [e.g., work, school, leisure]	
	<b>Social Relationships</b> [e.g., significant other, family, friends, support system]	
	<b>Living Arrangement</b> [e.g., homeless, maintaining current housing situation]	

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**11. Medical Necessity Criteria (cont.):**

b. Diagnosis Summary

The name of the disorder according to DSM 5 classification followed by the numerical ICD-10 code and description. Example:(Primary) DSM 5: Major Depressive Disorder, Moderate. ICD-10: F33.1, Recurrent Depressive Disorder, Current Episode Moderate.

Each diagnosis must be stated clearly and legibly, and primary and secondary diagnosis (if applicable) must be identified. Please follow the State guidelines for primary and secondary diagnoses for mental health clients. *(Please note that each diagnosis given and documented in this section must be substantiated and supported by symptoms, behaviors, and functional impairments in the assessment form under the appropriate sections, usually under presenting problems and medical necessity.)*

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**12. Mental Health Conclusions/Narrative Summary:**

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**Mental Health Conclusions/Narrative Summary (Continues):**

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**Person completing Assessment:**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Discipline

\_\_\_\_\_  
Date

**Review/Approval by Licensed Professional of the Healing Arts (if different from above):**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Discipline

\_\_\_\_\_  
Date

See progress note dated \_\_\_\_\_ for additional assessment information.