



INITIAL PSYCHIATRIC ASSESSMENT

NAME / MRN

Date of Service: _____ RU: _____

Staff #: _____ Hours: _____ Mins: _____

Code Activity: 361 EVAL/RX Location: 1 Office 2 Field 4 Home 5 School Satellite 18 Other

Service Strategies: (Please check up to three, if applicable)

- | | | | |
|-------------------------------------------------|--------------------------------------------------|------------------------------------------------|---------------------------------------------------------------------------------------|
| <input type="checkbox"/> 50 Peer/Fam Deliv Svcs | <input type="checkbox"/> 53 Supportive Education | <input type="checkbox"/> 56 Ptrnshp:Soc Svcs | <input type="checkbox"/> 59 Integrated Svcs:MH-Dvlp Disabled |
| <input type="checkbox"/> 51 Psych Education | <input type="checkbox"/> 54 Ptrnshp:LawEnfcm | <input type="checkbox"/> 57 Ptrnshp:Subs Abuse | <input type="checkbox"/> 60 Ethnic-Specific Service Strategy |
| <input type="checkbox"/> 52 Family Support | <input type="checkbox"/> 55 Ptrnshp:Health Care | <input type="checkbox"/> 58 IntSvcs:MH/Aging | <input type="checkbox"/> 61 Age-Spec Svc Strategy <input type="checkbox"/> 99 Unknown |

Assessment in language other than English: Spanish Other _____

Interpreter Name of Interpreter: _____

Is Client Pregnant? Yes No

Identifying Information:

Legal Name: _____ Age: _____ DOB: _____

Preferred Name: _____

Gender: Male Female Transgender F-M Transgender M-F Intersex Other _____

Marital Status Single Married Divorced Partnered Widowed

Address: _____

Phone #: _____

Emergency Contact/Significant Other: _____
Name Phone number

Primary concerns per consumer:

Presenting Problem/ Recent Course of Illness:

Consumer and Family Strengths (Positive factors to facilitate treatment e.g. faith, resilience, etc.):

Psychiatric History (include hospitalizations and dates, suicide attempts, history of intervention).

Psychiatric Medication History (Current and Past, side effects, adherences & outcomes) Current: None **Past:** None

Alcohol/ Drug Use History: (Check all appropriate and provide details.)

Unknown
 No Current Substance Abuse
 No Past Substance Abuse
 Currently Clean & Sober for: >3 Mos.
 >1 Yr

Alcohol	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Nicotine	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Caffeine	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Cocaine	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Marijuana	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Amphetamines	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Opiates	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Ecstasy	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Hallucinogens	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Sedatives	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Inhalants	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Energy Drinks	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Other:	<input type="checkbox"/> Past	<input type="checkbox"/> Present						

Specify: _____

Medical History (include illnesses, surgeries, CNS, head injuries):

Date of Last Physical: _____ Physician(s)/clinic: _____

Phone #: _____ Weight: _____ Height: _____ BMI: _____

Allergies (Meds & Other) / Adverse Reaction: _____

Active Medical Concerns, History of Hospitalizations/Surgeries: _____

Non-Psych Med/OTC _____

Review of Systems: No Significant issues revealed

CV
 Renal
 GI
 Hepatic
 CNS
 GU
 Metabolic
 CA
 PULM
 Gyn
 ID/HIV

Sexually Active
 Contraceptive Method _____
 Risk of Pregnancy
 Pregnant

Breast-Feeding
 LMP: _____

Pregnancy and Birth History (<18): _____

Developmental History (<18): _____

Family Psychiatric History:

Psychosocial History (e.g. education, family, vocational, military, legal):

Psychosocial Risk Factors: (Check all that apply.) Document details.

<input type="checkbox"/> Victim of Physical Abuse	<input type="checkbox"/> History of Self-injurious Behavior
<input type="checkbox"/> Victim of Sexual Abuse	<input type="checkbox"/> History of Suicidal Behavior
<input type="checkbox"/> Trauma or Loss in the Family	<input type="checkbox"/> Family History of Suicide
<input type="checkbox"/> Domestic Violence: Victim <input type="checkbox"/> Perpetrator <input type="checkbox"/>	<input type="checkbox"/> Access to Firearms (family, friends, self)
<input type="checkbox"/> History of Substance Abuse	<input type="checkbox"/> Access to Other Means of Suicide
<input type="checkbox"/> History of Assaultive Behavior	<input type="checkbox"/> Lack of Social Support
<input type="checkbox"/> History of Threatening Behavior	<input type="checkbox"/> History of Foster Care
<input type="checkbox"/> History of Inappropriate Sexual Behavior	<input type="checkbox"/> Homelessness
<input type="checkbox"/> Behavior Influenced by Delusions or Hallucinations	<input type="checkbox"/> Other

Comments:

MENTAL STATUS EXAMINATION

APPEARANCE/GROOMING	<input type="checkbox"/> Unremarkable	<input type="checkbox"/> Remarkable for: _____
PSYCHO-MOTOR ACTIVITY	<input type="checkbox"/> Unremarkable	<input type="checkbox"/> Remarkable for: _____
ATTITUDE/RELATEDNESS	<input type="checkbox"/> Unremarkable	<input type="checkbox"/> Remarkable for: _____
SPEECH	<input type="checkbox"/> Unremarkable	<input type="checkbox"/> Remarkable for: _____
MOOD	<input type="checkbox"/> Unremarkable	<input type="checkbox"/> Remarkable for: _____
AFFECT	<input type="checkbox"/> Unremarkable	<input type="checkbox"/> Remarkable for: _____
THOUGHT PROCESS	<input type="checkbox"/> Unremarkable	<input type="checkbox"/> Remarkable for: _____
THOUGHT CONTENT	<input type="checkbox"/> Unremarkable	<input type="checkbox"/> Remarkable for: _____
PERCEPTUAL DISTURBANCE	<input type="checkbox"/> Unremarkable	<input type="checkbox"/> Remarkable for: _____
ORIENTATION	<input type="checkbox"/> Unremarkable	<input type="checkbox"/> Remarkable for: _____
MEMORY/CONCENTRATION	<input type="checkbox"/> Unremarkable	<input type="checkbox"/> Remarkable for: _____
FUND OF KNOWLEDGE	<input type="checkbox"/> Unremarkable	<input type="checkbox"/> Remarkable for: _____
INTELLECT/ABSTRACT THINKING	<input type="checkbox"/> Unremarkable	<input type="checkbox"/> Remarkable for: _____
INSIGHT/ JUDGEMENT	<input type="checkbox"/> Unremarkable	<input type="checkbox"/> Remarkable for: _____
IMPULSE CONTROL	<input type="checkbox"/> Unremarkable	<input type="checkbox"/> Remarkable for: _____

Additional Observations:

Current Risk Assessment:

Danger to SELF (Intent, Plan Means): _____

Danger to OTHER (Intent, Plan Means): _____

Grave Disability: _____

Clinical Summary (Optional):

Diagnostic Impression: DSM Code and Narrative – Designate diagnosis which is primary focus of treatment with a “P”

DSM-5 Code: _____ (Primary) AND ICD-10 Code: _____

DSM-5

Diagnosis Title/Narrative: _____

DSM-5 Code: _____ (Secondary) AND ICD-10 Code: _____

DSM-5

Diagnosis Title/Narrative: _____

DSM Diagnosis by: _____

FUNCTIONAL IMPAIRMENT: (IF MODERATE OR ABOVE, MAY WARRANTS TARGETED CASE MANAGEMENT)									
	None	Mild	Mod	Severe		None	Mild	Mod	Severe
Family Relations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peer Relations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Academic/Vocational Performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TARGETED SYMPTOMS:									
	None	Mild	Mod	Severe		None	Mild	Mod	Severe
Cognition/Memory/Thought	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Perceptual Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attention/Impulsivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Antisocial Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Socialization/Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Destructive/Assaultive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressive Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mania/Agitation/Lability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety/Phobia/Panic Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Somatic Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Affect Regulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Initial Treatment Plan/Targeted Case Management:

Does consumer meet the criteria for TCM? (May include moderate or above Functional Impairment and/or risk of losing placement/housing, need for financial support, social support, prevocational/employment assistance, rehabilitation, AOD services, or other programs or services considered necessary.) No Yes

Explain:

Referral to Coordination of Care with:

- PCP Case Management Therapist Family/ Other Support Substance Abuse Tx
- Housing Community Agencies Vocational Rehab Social Security

Details:

Labs Ordered:

Medications Prescribed / Dosage / Frequency:

- Drug Information Sheet for each medication was given to consumer and family.
- Benefits/Risks/Possible adverse effects of medication and Alternatives to medication have been discussed.
- An opportunity was given to ask questions.
- The consumer and/or family appear to understand the information on the form.
- If appropriate, discuss the interaction of psychiatric medication with the following: Pregnancy, Lactation, Alcohol, Nutrition, and Non-Psychiatric Medications
- An Informed Consent was signed within the past two years.

Consumer (Family) is able to manage own medication: Yes No

If not, explain:

Additional Information:

MD/DO/NP Signature: _____ **Date:** _____

PRINT FULL NAME AND TITLE _____

Data Entry Clerk Initials