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:

Client's Name:_____

Unicare #:_____

Program (Cost Center): _____

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.): _____

_____

_____

_____

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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.):

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

Comments: _____

_____

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_____

☐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

Client's Name:_____

Unicare #:_____

Program (Cost Center): _____

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:
☐	Homicidal/Assaultive	
☐	Suicidal/Self-Harm	
☐	Access to Weapons	
☐	Trauma	
☐	Neglect/Abuse	
☐	Domestic Violence	
☐	Legal Issues	
☐	Crime/Gang Involvement	
☐	Runaway	
☐	Inappropriate/Risky Sexual Behavior	
☐	Substance Use/Abuse	
☐	Cognitive Impairment	
☐	Cultural Isolation	
☐	Potential for Victimization	
☐	Risk of Homelessness	

Comments: _____

_____

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

Appearance:	clean	well-groomed	disheveled	bizarre	malodorous		
Motor:	normal	decreased	agitated	tremors	tics	repetitive	impulsive
Behavior:	cooperative	evasive	uncooperative	threatening	agitated	combative	guarded
Consciousness:	alert	lethargic	stuporous				
Orientation:	person	place	time: [day month year]		current situation		
Speech:	normal	slurred	loud	pressured	slow	mute	
Affect:	appropriate	labile	restricted	blunted	flat	congruent	incongruent
Mood:	normal	depressed	anxious	euphoric	irritable	congruent	incongruent
Thought Process:	coherent	tangential	circumstantial	loose	paranoid	concrete	
Delusions:	persecutory	grandiose	referential	somatic	religious		
Hallucinations:	auditory	visual	olfactory	gustatory	tactile		
Intellect:	average	above average	below average				
Memory:	good	poor recent	poor remote	confabulation			
Insight:	good	fair	poor	limited			
Judgment:	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):
	Health [e.g., physical condition, activities of daily living]	
	Daily Activities [e.g., work, school, leisure]	
	Social Relationships [e.g., significant other, family, friends, support system]	
	Living Arrangement [e.g., homeless, maintaining current housing situation]	

Client's Name:_____

Unicare #:_____

Program (Cost Center): _____

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: F33.2, 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.)

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

Client's Name:_____

Unicare #:_____

Program (Cost Center): _____

Mental Health Conclusions/Narrative Summary (Continues):

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.

Client's Name:_____

Unicare #:_____

Program (Cost Center): _____