MENTAL HEALTH PLAN ASSESSMENT FORM

Every item must be completed.

Date______________ **Provider**____________________________ **Phone**____________

Provider Office Address____

Client Name ______________________________ **D.O.B.**____________ **SSN**________________

Consent to treat given by: ☐ Self ☐ Parent/Guardian ☐ Conservator

Referral ☐ Self ☐ School ☐ Probation ☐ Court ☐ CPS ☐ APS ☐ Parent/Guardian/Conservator ☐ Access Unit ☐ Other ____

Living Arrangement ☐ Own House ☐ Bio Family ☐ Foster Family ☐ Group Home ☐ SNF ☐ B&C

Ethnicity________________________ **Language Preferred for Services**______________________

Emergency Contact_____________________ **Relationship**________________ **Phone**__________

Address____

Presenting Problem (nature and history)

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Risk Assessment

Current harm to self-risk ☐ N/A ☐ Ideation ☐ Intent ☐ Plan ☐ Means Describe:

History of:

Current harm to others risk ☐ N/A ☐ Ideation ☐ Intent ☐ Plan ☐ Means: Describe:

History of:

Describe: (note if a particular person is at risk)

Assaultive/Combative ☐ No ☐ Yes If yes, describe:

At risk of abuse or victimization ☐ No ☐ Yes Describe:

Have all mandated reporting requirements been met?
☐ Yes, by this Provider Yes, by : ______________________________
☐ No (Explain) ______________________________
Other:

Client Strengths

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Client Name: ______________________________

Culture/Diversity: Assess unique aspects of the client, including culture, background, and sexual orientation, that are important for understanding and engaging the client and for care planning.

Preferred language for receiving our services: ______________________________

Culture client most identifies with: ______________________________

Problems client has had because his/her cultural background: ☐ None

____

Sexual orientation issues: ☐ None

Support/ involvement of family in client's life: ☐

____

Desire of client involvement of family or others in treatment: ☐ Desires

____

Psychiatric History (Medication(s) and dosage (current))

____

Medication(s) (past):

____

History of Mental Illness in Family ☐ No ☐ Yes If yes, describe:

____

Prior Hospitalization(s) ☐ No ☐ Yes If yes, when, where

____

Prior Outpatient Treatment ☐ No ☐ Yes If yes, when and with whom:

____

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Client Name: ____

Medical History Health Problems (current) ☐ No ☐ Yes If yes, describe:

Height: ____________ Weight : ____________ (Mandatory if client is a MINOR)

Sleep Disturbance ☐ No ☐ Yes If yes, describe:

Appetite ☐ Too Little ☐ Too Much Weight gain: ________ lbs. Weight Loss: ______ lbs.

Disability ☐ Developmental ☐ Physical ☐ Cognitive Describe:

Allergies ☐ No ☐ Yes Describe:

Adverse response to medications ☐ No ☐ Yes If yes, describe:

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Substance Use/ Abuse

	No Use	Frequency	Amount	Last Use
Nicotine	☐			
Caffeine	☐			
Alcohol	☐			
Marijuana	☐			
Amphetamines	☐			
Hallucinogens	☐			
Cocaine/Crack	☐			
Heroin	☐			
Prescription Meds	☐			
Other:	☐			

Mental Status			
Appearance:	☐ Clean ☐ Disheveled	☐ Well-groomed ☐ Inappropriate clothing	☐ Dirty
Orientation:	☐ Person ☐ Situation	☐ Place ☐ Disoriented	☐ Time
Speech:	☐ Organized/Clear ☐ Slowed	☐ Coherent ☐ Mumbling	☐ Rapid
Thought Process:	☐ Organized ☐ Thought Blocking ☐ Poor Concentration	☐ Coherent ☐ Flight of Ideas ☐ Obsessive	☐ Tangential
Thought Content:	☐ Normal ☐ Other	☐ Delusional	☐ Grandiose
Perceptual Process:	☐ Normal ☐ Visual hallucinations	☐ Auditory hallucinations ☐ Other	
Insight:	☐ Good ☐ None	☐ Average	☐ Poor
Judgment:	☐ Good ☐ None	☐ Average	☐ Poor
Mood:	☐ Normal ☐ Elevated ☐ Anxious	☐ Hopeless ☐ Labile ☐ Sad	☐ Irritable ☐ Depressed ☐ Manic
Affect:	☐ Appropriate ☐ Flat	☐ Inappropriate ☐ Tearful	☐ Blunted
Memory:	☐ Intact ☐ Recent Memory Problem	☐ Immediate Memory Problem ☐ Remote Memory	
Estimated Intellectual Functioning:	☐ Average	☐ Below Average	☐ Above Average
Cognitive Deficits:	☐ None	☐ Cognitive Deficits Present	
	☐ Concentration Deficits Present		

MENTAL HEALTH PLAN ASSESSMENT FORM

Client Name: ____

Impairments requiring Mental Health Treatment: ______________________________

____

Dysfunction Rating	☐ None	☐ Mild	☐ Moderate	☐ Severe
Describe how symptoms impair functioning:				

____

Employment/ Education:	**Occupation:**	
☐ Competitive job market, 35 hours or more per week	☐ Rehabilitative work, less than 20 hours per week.	☐ Volunteer Work
☐ Competitive job market, less than 20 hours per week	☐ School, full time	☐ Retired
☐ Full-time homemaking responsibility	☐ Job training, full time	☐ Resident/Inmate
☐ Rehabilitative work, 35 hours or more per week	☐ Part-time school/job training	☐ Unknown
☐ Not in Labor force	☐ Highest Grade completed__________	

Medical Necessity

- * ☐ Qualifying mental health diagnosis
- ☐ Qualifying impairment is an important area of life functioning
- ☐ Probability of a significant deterioration in an important area of life functioning
- ☐ (Children only) Probability that child will not progress developmentally as individually appropriate
- ☐ EPSDT – Qualified
- * ☐ Planned interventions will address impairment conditions
- * ☐ Client is reasonably expected to benefit and improve with respect to impairments
- * ☐ Condition would not be responsive to physical health care-based treatment

*All asterisked items must be present, plus 1 more and must be supported by documentation in record

Other Providers/ Agencies client is involved with: ____________________________

____

Signature of Provider______________________________________ Date________________________

Printed Name_______________________________________