Name of individual being assessed: _____ Date of assessment: _____

Who was present during assessment? _____

Location of assessment: _____ ***If minor, attach "Authorization to Treat Minor."***

1. Presenting Problem(s) and Requested Service(s):

A. What is the client's presenting problem / why are they here? (in client's own words when possible)

B. Describe precipitating events:

C. What service(s) is the client asking for?

2. Lifespan / Developmental History:

A. Health at birth:

B. Developmental milestones: ☐ Within normal limits *(use this box for adults only, complete section if child)*

C. Special services received during lifetime:

D. Other lifespan / developmental issues: *(include mid-life, senior/elder, other issues)*

Client Name: _____ **Case Number:** _____

3. Education and Occupation:

A. School currently attending, if applicable: _____ Grade: _____

B. Education history: *(include learning problems, school issues)*. Highest grade completed: _____

C. Occupation and employment history: *(present and past, include # of years worked, and reasons for periods of unemployment)*

D. Occupational skills / training:

4. Family of Origin History:

A. Family's current and past psychiatric history:

B. Family's and client's physical / sexual / emotional abuse history:

C. Family's substance use / abuse history:

5. Client's Current and Significant Past Social Supports, Family Supports, Significant Relationships, Religious and Spiritual Supports/Affiliations:

6. Other Agencies / Systems Client is Involved With or is Receiving Services From, i.e., Dept of Rehab., CalWORKs, ASOC, etc.: *(include the name of the agency and primary contact person–***ATTACH RELEASES)**

7. Client's Legal History: (ATTACH RELEASES)

☐ Informal Probation ☐ Formal Probation ☐ Parole ☐ Child Welfare Services

☐ Conservatorship ☐ D.U.I. ☐ Restraining order ☐ None reported

(describe and, if currently involved, give name of probation officer, parole office, or case manager and estimated start and end dates)

CONFIDENTIAL

Client Name: _____ **Case Number:** _____

8. Client's Substance Use: *(alcohol and other drugs, check all that apply)* ☐ No substance use reported

A.

☐ Caffeine
☐ Tobacco
☐ Over-the-counter medication
☐ Prescription medication
☐ Other; please identify:

☐ Alcohol
☐ Inhalants
☐ Hallucinogens
☐ Marijuana

☐ Stimulants
☐ Sedatives
☐ Tranquilizers
☐ Cocaine

☐ Barbiturates
☐ Methamphetamines
☐ Opiates
☐ Methadone

Substance	Age of 1st Use	Amount/ Frequency	Duration of Use	Date of Last Use	Period of Heaviest Use	Amount Used in Last 24 hrs.

B. Does client have a history of withdrawal, DTs, blackouts (loss of time), seizures, etc.? ☐ Yes ☐ No

C. Ask the client "What happens when you stop using?" What is the response?

D. What is the longest period of sobriety? _____ When? _____

E. Has the client received treatment for drug or alcohol issues? ☐ Yes ☐ No **(ATTACH RELEASES)**
(if yes, list in-patient providers, out-patient, providers, services received, dates of service; and outcomes)

9. Client's Mental Health Services History: (ATTACH RELEASES)

A. Current and past psychiatric history: ☐ Client reports no psychiatric history

B. Current service provider(s):

C. Past service provider(s): *(include in-patient, out-patient; provider names, dates, therapeutic interventions and outcomes)*

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Client Name: _____ **Case Number:** _____

10. Medical History: *(document significant past and present medical conditions, including allergies)* **(ATTACH RELEASES)**

☐ Client reports no outstanding medical problems
☐ Client reports no known allergies
☐ Client reports the following medical conditions: _____

Primary Care Physician's name and phone #: _____

Date of last physical examination: _____

List alternative treatments/therapies: *(i.e., biofeedback, acupuncture, hypnosis, etc.)*

11. If Lab Tests Were Done, Describe Results: ☐ Not applicable

12. Medication History: (ATTACH RELEASES)

A. Current psychiatric medications: ☐ None reported by client

Drug Name	Dose/ Frequency	Benefit/ Side Effects	Prescribed By: (Dr.'s Name)	When Prescribed?	When is Next Refill Required?

B. Past psychiatric medications: ☐ None reported by client

Drug Name	Dose/ Frequency	Benefit/ Side Effects	Prescribed By: (Dr.'s Name)	When Prescribed?	When is Next Refill Required?

C. Other medications: ☐ None reported by client
(include non-psychiatric prescriptions and alternative medications, i.e., homeopathic, herbal remedies)

Drug Name	Dose/ Frequency	Benefit/ Side Effects	Prescribed By: (Dr.'s Name)	When Prescribed?	When is Next Refill Required?

D. Medication allergies or adverse reactions: ☐ None known—per client report

Drug Name	Reaction

E. Does client follow medication regime? ☐ Yes ☐ No Explain: _____

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Client Name: _____ **Case Number:** _____

13. Current Symptoms/Problems: *(rate severity and duration for each)*

Key:					
	Severity Rating:	**1 = Mild**	**2 = Moderate**	**3 = Severe**	
	Duration Rating:	**1 = Less Than 1 Month**	**2 = 1 - 6 Months**	**3 = 7 - 11 Months**	**4 = More Than 1 Year**

	Severity	Duration		Severity	Duration
1. Anxiety			15. Bizarre Ideation		
2. Panic Attacks			16. Bizarre Behavior		
3. Phobia			17. Paranoid Ideation		
4. Obsessive Compulsive			18. Gender Issues		
5. Somatization			19. Eating Disorders		
6. Depression			20. Poor Judgement		
7. Impaired Memory			21. Lack of Support System		
8. Poor Self Care Skills			22. Poor Interpersonal Skills		
9. Loss of Interest			23. Conduct Problems		
10. Loss of Energy			24. School Problems		
11. Sexual Dysfunction			25. Family Problems		
12. Sleep Disturbance			26. Indep. Living Problems		
13. Appetite Disturbance			27. Unusual Body Movements		
14. Weight Change			28. Other: _____		

Please describe symptoms / problems above in detail:

14. Mental Status: *(please describe client's physical appearance, motor behavior, eye contact, mood, affect, speech pattern, thought processes, thought content, audio / visual / tactile hallucinations, intelligence, insight, judgment, and orientation)*

15. Assessment of Risk:

A. Current risk factors: *(check all that apply)*

- Suicidality: ☐ None ☐ Ideation ☐ Plan ☐ Intent w/o means ☐ Intent with means
- Homicidality: ☐ None ☐ Ideation ☐ Plan ☐ Intent w/o means ☐ Intent with means
- If risk exists, client is able to contract not to harm: ☐ Self ☐ Others
- Impulse control: ☐ Sufficient ☐ Moderate ☐ Minimal ☐ Inconsistent ☐ Explosive
- Substance abuse: ☐ None ☐ Abuse ☐ Dependence ☐ Unstable remission
- Medical risks: ☐ No ☐ Yes If "Yes", explain: _____

B. Risk history: *(explain any significant history of suicidal, homicidal, impulse control, medical or substance abuse behavior that may affect client's current level of risk or impairment to functioning. Include description of plan / ideation / intent checked above)*

16. Describe Client Strengths in Achieving Case Plan / Treatment Goals:

Client Name: _____ **Case Number:** _____

17. **Summary of Findings / Formulation:** (*identify problem areas and underlying dynamics. Include information used to make differential diagnosis.)*

18. **Recommended Services:** *(check all that apply.)*

- ☐ Community referrals made, no further services needed.
- ☐ Medication assessment ☐ By Primary Care Physician ☐ By ASOC or CSOC Psychiatrist
- ☐ Individual therapy, frequency recommended is _____ times per month . ☐Brief therapy ☐Long-term therapy
- ☐ Family therapy
- ☐ Collateral, describe reason: _____
- ☐ Group, specify type: _____
- ☐ Testing, specify type: *(i.e., Conner's, Beck, etc.)* _____
- ☐ Day rehab / treatment
- ☐ Other, specify: _____

19. **Services Provided:**

A. If community referrals were made, please describe: ☐ None

B. If client was placed on a 5150, please give details: *(i.e., which hospital, how transported, etc.)* ☐ Not applicable

20. **Are the Following Documents Attached?**

- ☐ Releases as needed
- ☐ Authorization to Treat a Minor *(mandatory for all minors under 12, minors 12 and older may consent for treatment if certain conditions apply)*
- ☐ Client Services Information Coversheet, CARE-015a *(mandatory)*
- ☐ Outcome Screen, CARE-011 or 012 *(mandatory)*
- ☐ Periodic Information Sheet, CARE-024 *(mandatory)*
- ☐ Test results or other related/relevant documents

Assessment completed by:

Counselor/Clinician/Practitioner Signature:
(include licensure, degree, or job title): _____ **Date:** _____

Print Name: _____ **Work Unit/ Organization:** _____ **Phone #** _____

Client Name: _____ **Case Number:** _____

Type of Diagnosis: ☐ **Admission** ☐ **Discharge** ☐ **Update**

Axis I: Clinical Disorders; Other Conditions That May Be a Focus of Clinical Attention (ICD-9-CM)

___ ___ ___ . ___ ___ _____ a.

___ ___ ___ . ___ ___ _____ b.

___ ___ ___ . ___ ___ _____ c.

___ ___ ___ . ___ ___ _____ d.

Substance Abuse/Dependency:

Does a substance abuse/dependency issue exist? ☐Yes ☐No ☐Unknown/Not Reported

If yes, which substance disorder is the primary substance abuse diagnosis? ☐a ☐b ☐c ☐d

Axis II: Personality Disorders; Mental Retardation (ICD-9-CM)

___ ___ ___ . ___ ___ _____ e.

___ ___ ___ . ___ ___ _____ f.

Covered Axis I or Axis II Diagnosis:

Which Axis I or Axis II Diagnosis is the Medi-Cal covered ICD-9 Diagnosis? ☐a ☐b ☐c ☐d ☐e ☐f

General Medical Condition: Summary by Client Report or Medical Record Documentation

☐ Allergies	☐ Carpal Tunnel	☐ Epilepsy/Seizures	☐ Migraines	☐ Physical Disability
☐ Anemia	☐ Chronic Pain	☐ Heart Disease	☐ Multiple Sclerosis	☐ Psoriasis
☐ Arterial Sclerotic Disease	☐ Cirrhosis	☐ Hepatitis	☐ Muscular Dystrophy	☐ STDs
☐ Arthritis	☐ Cystic Fibrosis	☐ Hypercholestoralemia	☐ No General Medical Condition	☐ Stroke
☐ Asthma	☐ Deaf/Hearing Impaired	☐ Hyperlipidemia	☐ Obesity	☐ Tinnitus
☐ Birth Defects	☐ Diabetes	☐ Hypertension	☐ Osteoporosis	☐ Ulcers
☐ Blind/Visually Impaired	☐ Digestive Disorders	☐ Hyperthyroid	☐ Other	☐ Unknown/ Not Reported
☐ Cancer	☐ Ear Infections	☐ Infertility	☐ Parkinson's Disease	

Axis IV: Psychosocial and Environmental Problems (DSM-IV TR). *Check yes or no for each problem.*

Primary Support Group	☐ Yes ☐ No	Occupational	☐ Yes ☐ No	Access to Health Care	☐ Yes ☐ No
Social Environment	☐ Yes ☐ No	Housing	☐ Yes ☐ No	Legal System/Crime	☐ Yes ☐ No
Educational	☐ Yes ☐ No	Economic	☐ Yes ☐ No	Other Problems	☐ Yes ☐ No

Trauma:

Has the client witnessed violence, lived through a natural disaster, been a combatant or civilian in a war zone, witnessed or been a victim of a severe accident, or been the victim of physical, emotional, or sexual abuse? ☐ Yes ☐ No ☐ Unknown

Axis V: Global Assessment of Functioning Scale (GAF – DSM-IV TR)

Current: Highest in last 12 months: Lowest in last 12 months:

Transcribed by: _____ **Date:** _____

Print Name of Diagnosing Practitioner: _____ **Date:** _____
(Must be Master's level or above)

Signature of Licensed Practitioner: _____ **Date:** _____
(Must include licensure after signature)