|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Initial Assessment** | | | | | | | Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ID Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Admission Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Assessment Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Time In: Time Out: Total Time: | | | | |
| **Informant:**  □ Individual Receiving Services □ Other: Relationship to Individual\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Does the person seeking services have an Outpatient Commitment Order? □ Yes □ No | | | | | | | | | | | |
| **GUARDIANSHIP INFORMATION** | | | | | | | | | | | |
| Name of Guardian / Custodian: | | | | | | | | Guardianship Documentation Verified:  □ Yes □ No | | | |
| Guardian / Custodian Address: | | | | | | | | Guardian / Custodian Phone Number: | | | |
| Is the family involved with the Department of Human Services? □ Yes □ No    *If yes, has a consent to release information been obtained?* □ Yes □ No  *If yes, please explain and indicate the name of the assigned case worker*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
| **CONFIDENTIALITY** | | | | | | | | | | | |
| Were the limits of confidentiality reviewed with Individual and/or Guardian? □ Yes □ No  If NO, please explain. | | | | | | | | | | | |
| **DESCRIPTION OF NEED** | | | | | | | | | | | |
| **What is your reason for seeking services today?** **What specific needs do you currently have?**  *(Include a description/perception of difficulties according to the individual seeking services and any applicable family members/legal guardian.)* | | | | | | | | | | | |
| **Is the reason for seeking services today related to substance use?** □ Yes □ No  *If yes, the substance use specific assessment must also be completed.* | | | | | | | | | | | |
| **What previous coping skills have been helpful in the past?** | | | | | | | | | | | |
| **Thoughts of Suicide:** □ Yes *(If yes, explain)* □ No | | | | | | | | | | | |
| **Attempts of Suicide:** □ Yes *(If yes, explain)* □ No | | | | | | | | | | | |
| **Thoughts of Homicide:** □ Yes *(If yes, explain)* □ No  *(Indicate the need for “duty to warn”)* | | | | | | | | | | | |
| **Acts of Self-Harm:** □ Yes *(If yes, explain)* □ No | | | | | | | | | | | |
| **SOCIAL / CULTURAL** | | | | | | | | | | | |
| **Identification of Support Systems:**  *(Address family relationships, interpersonal relationships, and community support systems)* | | | | | | | | | | | |
| **Meaningful Activities, Cultural / Ethnic / Spiritual interests, Supports:**  *(Address hobbies, leisure activities, etc.)* | | | | | | | | | | | |
| **Living Situation** | | | | | | | | | | | |
| **What is your current living arrangement (strengths and concerns)? Who lives with you? What are your views on your current arrangement?** | | | | | | | | | | | |
| **Needs Related to Living Situation**  *(money management, benefits, living arrangements, clothing, personal care, child care, rent, other)* | | | | | | | | | | | |
| **Developmental History**  (Complete only for Children & Youth up to age 21 and everyone with ID/DD) | | | | | | | | | | | |
| During pregnancy, did mother use alcohol or other drugs? □ Yes □ No | | | | | | | | | | | |
| Describe any problems with the pregnancy or birth: | | | | | | | | | | | |
| Were there any developmental issues? □ Yes □ No *(If yes, explain)* | | | | | | | | | | | |
| Describe any childhood accidents or injuries: | | | | | | | | | | | |
| **Education** (Children & Youth up to age 21) | | | | | | | | | | | |
| Name of school: | | | | | | | | | | | |
| Does child/youth receive Special Education Services?  □ Yes *(If yes, complete release of information to obtain a copy of the current Individualized Education Plan (IEP))*  □ No | | | | | | | | | | | |
| ***Additional Information*** (Children & Youth up to age 21) | | | | | | | | | | | |
| Educational Issues/ Needs ( grades, attendance, suspensions, expulsions) | | | | | | | | | | | |
| **Employment *(adults only)*** | | | | | | | | | | | |
| Are you employed? □ Yes □ No | | | | | | | | | | | |
| If no, do you want to be employed? | | | | | | | | | | | |
| Employment Barriers/ Related Needs? | | | | | | | | | | | |
| **Current Legal Status** | | | | | | | | | | | |
| Has the individual been involved with the legal system within the past twelve months?  □ Yes □ No | | | | | | | | | | | |
| Arrests: □ Yes □ No | | | | If yes, indicate type and number of arrest(s): | | | | | | | |
| Number of arrests in the past 30 days: | | | | | | | | | | | |
| Pending Charges: □ Yes □ No | | | | If yes, indicate type and number of pending charges: | | | | | | | |
| Substance Use Related Legal Issues: | | | | | | | | | | | |
| Is this person currently on parole and/or probation? □ Yes □ No  If applicable, indicate to whom reports should be submitted: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
| **MEDICAL HISTORY** | | | | | | | | | | | |
| Appetite Issues: | | | | | | | | | | | |
| Sleep Issues: | | | | | | | | | | | |
| Current or Chronic Diseases | | | □ high blood pressure □ diabetes □ thyroid □ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| Family History | | | □ high blood pressure □ diabetes □ thyroid □ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| Additional Medical History or Health and Safety Issues: | | | | | | | | | | | |
| **Health-Related Needs**: | | | | | | | | | | | |
| **INDIVIDUAL MENTAL HEALTH HISTORY** | | | | | | | | | | | |
| **Previous Assessment History** | | | | | | | | | | | |
| Have psychological, educational or functional assessments been completed in the last twelve months?  □ Yes *(If yes, complete release of information to obtain a copy of the applicable assessment.)*  If yes, indicate type of assessment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ No | | | | | | | | | | | |
| **Previous or Current Diagnoses:** | | | | | | | | | | | |
| **Mental Health Needs**: | | | | | | | | | | | |
| Family History of Psychiatric or Substance Use Disorder(s) □ Yes □ No  If yes, please describe. | | | | | | | | | | | |
| ***Outpatient Behavioral Health Agency*** | | | | | | | | | | | |
| □ None Reported | | | | | | | | | | | |
| Treatment Agency | | | | | | Services Received | | | Dates of Service | Has Consent to Release Information Been Requested? | |
|  | | | | | |  | | |  | □ Yes □ No | |
|  | | | | | |  | | |  | □ Yes □ No | |
|  | | | | | |  | | |  | □ Yes □ No | |
| ***Psychiatric Hospitalizations / Residential Treatment*** | | | | | | | | | | | |
| □ None Reported | | | | | | | | | | | |
| Treatments | | | | | Reason (suicidal, depressed, etc.) | | | | Dates of Service | Has Consent to Release Information Been Requested? | |
|  | | | | |  | | | |  | □ Yes □ No | |
|  | | | | |  | | | |  | □ Yes □ No | |
|  | | | | |  | | | |  | □ Yes □ No | |
| **Initial Observations** | | | | | | | | | | | |
| General Observations | Appearance:  □ Appropriate □ Disheveled □ Unclean □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| Speech:  □ Appropriate □ Slow □ Mechanical □ Rapid □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| Affect:  □ Appropriate □ Flat □ Labile □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| Delusions: | □ N/A  □ Description: | | | | | | | | | | |
| Hallucinations: | □ N/A  □ Description: | | | | | | | | | | |
| Mood | □ Appropriate □ Manic □ Depressed □ Labile □ Irritable □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| Orientation | □ Person □ Place □ Time □ Situation □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| **Indication Of Functional Limitation(s):**  **(Check Major Life Areas Affected)** | | | | | | | | | | | |
|  | Basic living skills (eating, bathing, dressing, etc.) | | | | | | | | | | |
|  | Instrumental living skills (maintain a household, managing money, getting around the community, taking prescribed medications, etc.) | | | | | | | | | | |
|  | Social functioning (ability to function within the family, vocational or educational function, other social contexts, etc.) | | | | | | | | | | |
| **SUMMARY / RECOMMENDATIONS** | | | | | | | | | | | |
| Health:  Home:  Community:  Purpose:  Other: | | | | | | | | | | | |
| **INITIAL DIAGNOSTIC IMPRESSION** | | | | | | | | | | | |
| Codes: | | Description: | | | | | | | | |
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| **SIGNATURES / CREDENTIALS** | | | | | | | | | | | |
| X Date: X Date: | | | | | | | | | | | |
| X Date: X Date: | | | | | | | | | | | |