|  |  |
| --- | --- |
| **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 □ NoIf NO, please explain.  |
| **DESCRIPTION OF NEED** |
| **What is your reason for seeking services today?** *(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 specific needs do you currently have?** |
| **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**:*(Address hobbies, leisure activities, etc.)* |
| **Cultural / Ethnic / Spiritual interests, supports:** |
| **Support Needs** *(social supports, interpersonal, protective care, support groups, counseling, legal assistance, other):* |
| **Living Situation** |
| **What are your views on your current living arrangements (strengths and concerns)?** |
| **Individuals Living in Household** |
| Individual | Relationship to Client | Age | Quality of SupportAccording to the person (circle one) |
|  |  |  |  Good Fair Poor |
|  |  |  |  Good Fair Poor |
|  |  |  |  Good Fair Poor |
|  |  |  |  Good Fair Poor |
|  |  |  |  Good Fair Poor |
| Secondary Household (Minors Only) |
| Individual | Relationship to Client | Age | Quality of Support |
|  |  |  |  Good Fair Poor |
|  |  |  |  Good Fair Poor |
|  |  |  |  Good Fair Poor |
|  |  |  |  Good Fair Poor |
| **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 developmental milestones met? □ Yes □ No *(If no, explain)*  |
| Was the child’s first year of life difficult, easy, other? □ Yes *(If yes, explain)* □ No  |
| Describe any childhood accidents or injuries: |
| **School Functioning**(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) |
| Comments on Educational Classification / Placement (please indicate if client is home schooled, in gifted program, etc.): |
| Grades: | Attendance: | Previous Grade Retentions: | Suspensions / Expulsions: |
| Other Academic / School Concerns: |
| **Employment *(adults only)****(complete only if individual is not employed at the time of assessment)* |
| Barriers to Employment: |
| **Employment Related Needs:** |
| **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  |
| **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 □ NoIf 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other Pertinent Medical Information: |
| Additional Medical History or Health and Safety Issues: |
| **Health-Related Needs**: |
| **INDIVIDUAL MENTAL HEALTH HISTORY** |
| Previous or Current Diagnoses: |
| **Mental Health Needs**: |
| Family History of Psychiatric or Substance Use Disorder(s) □ Yes □ NoIf 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: |