

MH 532
Revised 10/1/15

ADULT FULL ASSESSMENT

Date of first assessment contact: _____

Assessing Practitioner (Name and Discipline): _____

Client/Others Interviewed: _____

I. Demographic Data & Special Service Needs:

DOB: _____ Gender: _____ Ethnicity: _____ Marital Status: _____

Referral Source: _____

Non-English Speaking, specify language used for this interview: _____

Were Interpretive Services provided for this interview? Yes No

Cultural Considerations, specify: _____

Physically challenged (wheelchair, hearing, visual, etc.) specify: _____

Access issues (transportation, hours), specify: _____

II. Reason for Referral/Chief Complaint

Describe precipitating event(s)/Reason for Referral,

Current Symptoms and Behaviors (intensity, duration, onset, frequency) and Impairments in Life Functioning caused by the symptoms/behaviors (from perspective of client and others):

Client Strengths (to assist in achieving treatment goals)

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III. Mental Health History:

History of Problem Prior to Precipitating Event: Include treated & non-treated history.

Impact of treatment and non-treatment history: on the client's level of functioning, e.g., ability to maintain residence, daily living and social activities, health care, and/or employment.

Psychiatric Hospitalizations: Yes No Unable to Assess
 If yes, describe dates, locations, and reasons

Outpatient Treatment: Yes No Unable to Assess
 If yes, describe dates, locations and reasons.

Suicidal/Homicidal Thoughts/Attempts

Columbia Suicide Risk Severity Scale Completed? Yes No (For Directly-Operated)

If Columbia Suicide Risk Severity Scale NOT completed, describe below and include dates, threat, intent, plan, target(s), access to lethal means, method used:

Self-Harm (without statement of suicidal intent) Yes No Unable to Assess
 If yes, describe

Trauma or Exposure to Trauma: Yes No Unable to Assess

Has client ever (1) been physically hurt or threatened by another, (2) been raped or had sex against their will, (3) lived through a disaster, (4) been a combat veteran or experienced an act of terrorism, (5) been in a severe accident, or been close to death from any cause, (6) witnessed death or violence or the threat of violence to someone else, or (7) been the victim of a crime?

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IV. Medications

List "all" past and present psychotropic medications used, prescribed/non-prescribed, by name, dosage, frequency. Indicate from client's perspective what seems to be working and not working.

<u>Medication</u>	<u>Dosage/Frequency</u>	<u>Period Taken</u>	<u>Effectiveness/Response/Side Effects/Reactions</u>

General Medication Comments (include significant non-psychotic medication issues/history):

V. Substance Use/Abuse

"MH659 -Co-Occurring Joint Action Council Screening Instrument"

1. Were any of the questions checked "Yes" in Section 2 "Alcohol & Drug Use"? Yes* No **If yes, complete MH633**

2. Were any of the questions checked "Yes" in Section 3 "Trauma/Domestic Violence"? Yes No **If yes, answer 2a**

2a. Was the Trauma or Domestic Violence related to substance use? Yes* No **If yes, complete MH633**

Be sure to document re: Trauma or Domestic Violence in Part A of "Psychosocial History" on page 3 of the Initial Assessment.

Does the client currently appear to be under the influence of alcohol or drugs? Yes No Unable to Assess

If yes, When was the last time the client used alcohol or drugs?

Has the client ever received professional help for his/her use of alcohol or drugs? Yes No Unable to Assess

Comments on alcohol/drug use:

How is Mental Health impacted by substance use (Clinician's Perspective)? Must be completed if any services will be directed towards Substance Use/Abuse.

* MH 633 "Supplemental Co-Occurring Disorders Assessment" completed on: _____

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Legal History and Current Legal Status

Arrests/DUI, probation, convictions, divorce, conservatorship, parole, child custody, etc:

Current Living Arrangement and Social Support Systems

Type of living setting, problems at setting, community, religious, government agency, or other types of support, etc:

Dependent Care Issues

Number of Dependent Adults: _____ Number of Dependent Children: _____

Ages of children, school attendance/behavior problems of children, special needs of dependents, foster care/group home placement issues, child support, etc:

Family and Relationships

History of Mental Illness in Immediate Family: Yes No Unable to Assess

Alcohol/Drug Abuse in Immediate Family: Yes No Unable to Assess

Family constellation, family of origin, family dynamics, cultural factors, nature of relationships, domestic violence, physical or sexual abuse, home safety issues, family medical history, family legal/criminal issues

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VIII. Mental Status Evaluation

Instructions: Check all descriptions that apply

<u>General Description</u>	<u>Mood and Affect</u>	<u>Thought Content Disturbance</u>
<p>Grooming & Hygiene: <input type="checkbox"/> Well Groomed <input type="checkbox"/> Average <input type="checkbox"/> Dirty <input type="checkbox"/> Odorous <input type="checkbox"/> Disheveled <input type="checkbox"/> Bizarre Comments:</p> <p>Eye Contact: <input type="checkbox"/> Normal for culture <input type="checkbox"/> Little <input type="checkbox"/> Avoids <input type="checkbox"/> Erratic Comments:</p> <p>Motor Activity: <input type="checkbox"/> Calm <input type="checkbox"/> Restless <input type="checkbox"/> Agitated <input type="checkbox"/> Tremors/Tics <input type="checkbox"/> Posturing <input type="checkbox"/> Rigid <input type="checkbox"/> Retarded <input type="checkbox"/> Akathesis <input type="checkbox"/> E.P.S. Comments:</p> <p>Speech: <input type="checkbox"/> Unimpaired <input type="checkbox"/> Soft <input type="checkbox"/> Slowed <input type="checkbox"/> Mute <input type="checkbox"/> Pressured <input type="checkbox"/> Loud <input type="checkbox"/> Excessive <input type="checkbox"/> Slurred <input type="checkbox"/> Incoherent <input type="checkbox"/> Poverty of Content Comments:</p> <p>Interactional Style: <input type="checkbox"/> Culturally congruent <input type="checkbox"/> Cooperative <input type="checkbox"/> Sensitive <input type="checkbox"/> Guarded/Suspicious <input type="checkbox"/> Overly Dramatic <input type="checkbox"/> Negative <input type="checkbox"/> Silly Comments:</p> <p>Orientation: <input type="checkbox"/> Oriented <input type="checkbox"/> Disoriented to: <input type="checkbox"/> Time <input type="checkbox"/> Place <input type="checkbox"/> Person <input type="checkbox"/> Situation Comments:</p> <p>Intellectual Functioning: <input type="checkbox"/> Unimpaired <input type="checkbox"/> Impaired Comments:</p> <p>Memory: <input type="checkbox"/> Unimpaired <input type="checkbox"/> Impaired re: <input type="checkbox"/> Immediate <input type="checkbox"/> Remote <input type="checkbox"/> Recent <input type="checkbox"/> Amnesia Comments:</p> <p>Fund of Knowledge: <input type="checkbox"/> Average <input type="checkbox"/> Below Average <input type="checkbox"/> Above Average Comments:</p>	<p>Mood: <input type="checkbox"/> Euthymic <input type="checkbox"/> Dysphoric <input type="checkbox"/> Tearful <input type="checkbox"/> Irritable <input type="checkbox"/> Lack of Pleasure <input type="checkbox"/> Hopeless/Worthless <input type="checkbox"/> Anxious <input type="checkbox"/> Known Stressor <input type="checkbox"/> Unknown Stressor Comments:</p> <p>Affect: <input type="checkbox"/> Appropriate <input type="checkbox"/> Labile <input type="checkbox"/> Expansive <input type="checkbox"/> Constricted <input type="checkbox"/> Blunted <input type="checkbox"/> Flat <input type="checkbox"/> Sad <input type="checkbox"/> Worried Comments:</p> <p style="text-align: center;"><u>Perceptual Disturbance</u></p> <p><input type="checkbox"/> None Apparent</p> <p>Hallucinations: <input type="checkbox"/> Visual <input type="checkbox"/> Olfactory <input type="checkbox"/> Tactile <input type="checkbox"/> Auditory: <input type="checkbox"/> Command <input type="checkbox"/> Persecutory <input type="checkbox"/> Other Comments:</p> <p>Self-Perceptions: <input type="checkbox"/> Depersonalizations <input type="checkbox"/> Ideas of Reference Comments:</p> <p style="text-align: center;"><u>Thought Process Disturbances</u></p> <p><input type="checkbox"/> None Apparent</p> <p>Associations: <input type="checkbox"/> Unimpaired <input type="checkbox"/> Loose <input type="checkbox"/> Tangential <input type="checkbox"/> Circumstantial <input type="checkbox"/> Confabulous <input type="checkbox"/> Flight of Ideas <input type="checkbox"/> Word Salad Comments:</p> <p>Concentration: <input type="checkbox"/> Intact <input type="checkbox"/> Impaired by: <input type="checkbox"/> Rumination <input type="checkbox"/> Thought Blocking <input type="checkbox"/> Clouding of Consciousness <input type="checkbox"/> Fragmented Comments:</p> <p>Abstractions: <input type="checkbox"/> Intact <input type="checkbox"/> Concrete Comments:</p> <p>Judgments: <input type="checkbox"/> Intact <input type="checkbox"/> Impaired re: <input type="checkbox"/> Minimum <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Comments:</p> <p>Insight: <input type="checkbox"/> Adequate <input type="checkbox"/> Impaired re: <input type="checkbox"/> Minimum <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Comments:</p> <p>Serial 7's: <input type="checkbox"/> Intact <input type="checkbox"/> Poor Comments:</p>	<p><input type="checkbox"/> None Apparent</p> <p>Delusions: <input type="checkbox"/> Persecutory <input type="checkbox"/> Paranoid <input type="checkbox"/> Grandiose <input type="checkbox"/> Somatic <input type="checkbox"/> Religious <input type="checkbox"/> Nihilistic <input type="checkbox"/> Being Controlled Comments:</p> <p>Ideations: <input type="checkbox"/> Bizarre <input type="checkbox"/> Phobic <input type="checkbox"/> Suspicious <input type="checkbox"/> Obsessive <input type="checkbox"/> Blames Others <input type="checkbox"/> Persecutory <input type="checkbox"/> Assaultive Ideas <input type="checkbox"/> Magical Thinking <input type="checkbox"/> Irrational/Excessive Worry <input type="checkbox"/> Sexual Preoccupation <input type="checkbox"/> Excessive/Inappropriate Religiosity <input type="checkbox"/> Excessive/Inappropriate Guilt Comments:</p> <p style="text-align: center;"><u>Behavioral Disturbance</u></p> <p>Behavioral Disturbances: <input type="checkbox"/> None <input type="checkbox"/> Aggressive <input type="checkbox"/> Uncooperative <input type="checkbox"/> Demanding <input type="checkbox"/> Demeaning <input type="checkbox"/> Belligerent <input type="checkbox"/> Violent <input type="checkbox"/> Destructive <input type="checkbox"/> Self-Destructive <input type="checkbox"/> Poor Impulse Control <input type="checkbox"/> Excessive/Inappropriate Display of Anger <input type="checkbox"/> Manipulative <input type="checkbox"/> Antisocial Comments:</p> <p style="text-align: center;"><u>Suicidality/Homicidality</u></p> <p>Suicidal: <input type="checkbox"/> Denies <input type="checkbox"/> Ideation Only <input type="checkbox"/> Threatening <input type="checkbox"/> Plan Comments:</p> <p>Homicidal: <input type="checkbox"/> Denies <input type="checkbox"/> Ideation Only <input type="checkbox"/> Threatening <input type="checkbox"/> Target <input type="checkbox"/> Plan Comments:</p> <p style="text-align: center;"><u>Other</u></p> <p>Passive: <input type="checkbox"/> Amotivational <input type="checkbox"/> Apathetic <input type="checkbox"/> Isolated <input type="checkbox"/> Withdrawn <input type="checkbox"/> Evasive <input type="checkbox"/> Dependent Comments:</p> <p>Other: <input type="checkbox"/> Disorganized <input type="checkbox"/> Bizarre <input type="checkbox"/> Obsessive/compulsive <input type="checkbox"/> Ritualistic <input type="checkbox"/> Excessive/Inappropriate Crying Comments:</p>

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IX. Summary and Diagnosis

I. Diagnostic Summary: (Be sure to include assessment for risk of suicidal/homicidal behaviors, significant strengths/weaknesses, observations/descriptions, symptoms/impairments in life functioning, i.e., Work, School, Home, Community, Living Arrangements, etc, and justification for diagnosis)

II. Diagnostic Descriptor

ICD Diagnosis Code (check at least one Primary)

Primary Code _____

Sec Code _____

III. Specialty Mental Health Services Medical Necessity Criteria:

- 1. Medi-Cal Specialty Mental Health Included Diagnosis Yes No
- 2. Significant impairment in life functioning due to the Included Diagnosis Yes No
- 3. Expectation that proposed interventions can impact the client's condition Yes No
- 4. Mental Health Condition will not be responsive to physical health care based treatment Yes No

IV. Disposition/Recommendations/Plan

V. Signatures

Assessor's Signature & Discipline

Date

Co-Signature & Discipline

Date

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