

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Client First Name: |  |  | Client Last Name: | Date: |
| Referred By: |  |  |  |  |
| Funding Source:Date of Birth: |  |  | ID:Age: | Social Security: |
| Gender: | Male | Female | Other | Race: |
| Phone Number: |  |  |  |  |
| Address: |  |  |  | County: |
| E-mail Address: |  |
| Emergency contact: |
| Pharmacy |
| Presenting Problem: |

Level of Need for Services: Immediate Referrals Given:

Mild

**N/A**

Moderate Severe

Does the person meet criteria for services? Yes No

If yes, recommended services:

Individual Counseling Group Counseling

Family Counseling

Testing

Case Management

Other

If no, reason/comments:

Was client informed as to denial reasons?

Yes No N/A

N/A

If denied, referred to:

Therapist:

Primary Diagnosis (From DSM-V) :

Case Manager:

Notes:

If admitted, date of scheduled intake:

Eligibility Verified? Yes No

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**Mental Health Assessment & Psychosocial Evaluation**

**Looking Up Counseling Services, LLC**

Date of Interview:

#### IDENTIFYING INFORMATION

Client First Name: Address:

Phone Number: Date of Birth:

Client Last Name:

Social Security No: Age:

Gender:

E-mail Address:

Male Female Other Race:

Name and Relationship of Person Providing Information: Emergency contact:

#### PRESENTING PROBLEM

What is the problem you would like assistance with?

Are there any URGENT needs you need to address? (Include risk of self harm, risk of harm to others, issues with personal safety, etc)

##### If Yes, explain:

Yes No

Have you made any attempts to resolve this problem on your own?

#### PRESENT LIFE SITUATION

Number of people in current household:

Total family income:

Living arrangements: Buying Renting Other

##### (Check all that apply)

Parents Significant Other Extended

Spouse Alone Other

|  |  |
| --- | --- |
| Family |  |
| Do you have special needs or need accommodations (behavioral, physical, communication or transportation needs)? | Yes | No |
| Do you have disabilities? | Yes | No |

Children

Controlled Environment

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# PRESENT LIFE SITUATION

Other significant information:

# PREVIOUS TREATMENT HISTORY

Do you have a history of being tested for a disorder/diagnosis?

Have you ever seen an outpatient therapisUpsychologist for services? Have you ever been admitted to an inpatient psychiatric facility?

**RISK ASSESSMENT** (Refer to SAMHSA SAFE-T card)

Do you have a history of suicidal ideations, plans, or attempts? D

Yes No

Yes No

Yes No

Yes No

**Risk Factors:** Suicidal Behavior Key Symptoms Change in Treatment

CurrenUPast psychiatric disorders Family History

Access to Means

Children Precipitants/Stressors/ Interpersonal

##### Protective Factors: Internal:

Coping Skills Other

Religious Beliefs

Frustration Tolerance

##### External:

Responsibility to others (Children/Pets etc.) Positive Therapeutic Relationships Social Supports Other

##### Current Suicide Inquiry:

***Ideation:*** Yes No ***Plan:*** Yes No ***Behaviors:*** Yes No ***Intent*** Yes No

Suicide Risk Level per SAFE-T High Medium Low

Safety Plan created and placed in a visible place for client use: D Yes No Other significant information:

Do you have a history of homicidal ideations, plans or attempts? D Yes No

Do you have a history of aggression or violence towards others? D Yes No

# FEELING/MOOD/AFFECT (CAR Score #1)

##### Are you experiencing any of the following? (check all that apply)

Mood Liability Depression

Poor Coping Skills Anger

Suicidal Ideation Anxiety

Homicidal Ideation Euphoria

Change in Appetite

Change in Sleep Pattern

Other

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##### Other significant information:

**How would you describe yourself? (check all that apply)**

Outgoing Shy/Quiet Unpopular Serious

Rebellious Calm Aggressive Other

Awkward Nervous Happy

Temperamental Popular Unhappy

### THINKING/ MENTAL PROCESS (CAR Score #2)

##### Do you experience any of the following:

Memory Difficulties Delusions

Difficulty Concentrating Hallucinations

Poor Judgement Learning Disability

Obsessions

Poor Impulse Control

Other/Comments:

## MENTAL STATUS REVIEW PER CLINICIAN

##### Appearance:

|  |  |  |  |
| --- | --- | --- | --- |
| Neat | Unkempt | Older Than | Younger Than |
| Clean | Poor Hygiene | Underweight | Overweight |
| EccentricOther: | Seductive | Well Groomed |  |

**Orientation:**

Time Person Place Situation

##### Affect:

Appropriate Restricted Flat

Blunted

Content Other:

Detached

##### Mood:

|  |  |  |  |
| --- | --- | --- | --- |
| Cooperative | Calm | Anxious | Cheerful |
| Depressed | Irritable | Fearful | Suspicious |
| Labile | Tearful | Hostile | Dramatic |
| Euphoric | Angry | Guilty | Pessimistic |
| Other: |  |  |  |



Speech:

|  |  |  |  |
| --- | --- | --- | --- |
| Normal | Pressured | Rambling | Tangential |
| LoudOther: | Slow | Rapid | Slurred |

##### Intellectual Assessment:

Above Average Averag

Documented e

Below Average Possible MR

MR Other:

|  |  |
| --- | --- |
| **Thought Content/Perception:** |  |
| Within Normal Limits | Delusions | Disorganized | Paranoid |
| Grandiose | Flight of Ideas | Compulsive | Obsessive |
| Bizarre | Homicidal | Suicidal | Auditory Hallucinations |
| Visual Hallucinations | Other: |  |  |

##### Insight:

Good Fair Poor

Superfici Blaming

Lackin Other:

al g

##### Judgment:

Good

Other: Fair Poor Lacking

##### Memory:

Impaired

Recent Other: Impaired Remote Intact Poor

##### Behavior/Motor Activities:

Normal Overactive Tense Destructive

Restless

Poor Eye Contact Slowed

Other:

Tremors Tics Manipulative

Alert Agitated Repetitious

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Sensory/Physical Disabilities:

Within Normal Limits Hearing Impaired Visually Impaired Physically Impaired Other:

### SUBSTANCE USE & HISTORY (CAR Score #3)

**Client has no current** or **historical Alcohol/Other Drug Use/Addiction. Alcohol/Drug Use is the primary reason for the referral for services.**

**Alcohol/Drug Use is NQI the primary reason for the referral for services, but is Present or in history.**

|  |  |  |
| --- | --- | --- |
| Do you currently use alcohol, drugs, or tobacco? | Yes | No |
| Do you believe current use is causing impairments in daily functioning? | Yes | No |
| Do you have previous use of alcohol, drugs or tobacco? | Yes | No |
| Have you ever received treatment for substance abuse? | Yes | No |
| Referral for community Alcohol/ Drug use for client or family needed? | Yes | No |
| Family's history of drug and/or alcohol abuse? | Yes □ No |
| Other significant information: |  |  |

### MEDICAL/HEALTH INFORMATION (CAR Score #4)

Current Physical Health Status:

Current Co-Occurring/Health concerns:

Good Fair Poor

Health History:

Current Known Medications:

Do you feel like these medications work well for you?

Medication Allergies or Adverse Reactions (Include Medication and Food):

Yes No

Primary Care Physician:

List any previous or current problems with sleep (Include falling asleep, staying asleep, sleeping inadequate number of hours, etc):

|  |  |  |
| --- | --- | --- |
| Are you currently pregnant?Have you ever been pregnant? | Yes Yes | No No |
| **DEVELOPMENTAL HISTORY**Did you meet developmental milestones within appropriate time frames? Yes | No |

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Complications during pregnancy or delivery? Substance use or abuse during pregnancy? Other significant information:

Yes No

Yes No

### FAMILY/MARITAL/PERSONAL HISTORY (CAR Score #5)

##### Are your parents(check all that apply):

Alive Divorced Abusive

Family history of mental illness? Family history of learning disorders?

Deceased Remarried

Married Abandoned Family

Separated Financial Issues

Yes No

Yes No

Describe your current interactions with family members:

Are you currently:

Single Married

Separated

Divorced

Living with partner

Number of Marriages:

Number of Children:

Do you have problems with your children?

Length of time with Current Partner:

N/A

Yes

No N/A

Other significant information:

## PHYSICAL ABUSE/DOMESTIC VIOLENCE

Client does not present with anyreported historical or current experience/witness of physical abuse/domestic violence concerns.

|  |  |  |
| --- | --- | --- |
| Have you ever been physically abused or witnessed such abuse? | Yes | No |
| Have you ever been the victim of/witnessed a random act of violence? | Yes | No |
| Have you ever witnessed domestic violence? | Yes | No |
| Have you ever assaulted, engaged in, or witnessed physical fights with others? | Yes | No |
| Have you experienced/witnessed neglect from caregivers? | Yes | No |
| Other significant information: |  |  |

### INTERPERSONAL INTERACTIONS & SUPPORT (CAR Score #6)

Who do you rely on for emotional and/or social support?



Do you experience any difficulty with the following? **N/**

A

Making/Keeping Friends

Peers/Friends Conflict

Social Interaction Trusting Friends

Withdrawal

|  |  |  |
| --- | --- | --- |
| Do you experience conflict with adults or authority figures? | Yes | No |
| Do you have friends or family in whom you can confide, or call upon for support ? | Yes | No |
| Do you have positive/satisfying relationships in your family? | Yes | No |
| Do you have positive/satisfying relationships outside your family? | Yes | No |
| Do you have negative/conflicting relationships in your family? | Yes | No |
| Do you have negative/conflicting relationships outside your family? | Yes | No |
| Have you ever abused another person/people? | Yes | No |
| Do you have a history of abusing animals? | Yes | No |
| Do you have a history of starting fires? | Yes | No |
| Other significant information: |  |  |

# SEXUAL HISTORY

**Client does not present with any reported historical or current experience/witness of sexual abuse, molestation, rape or other sexually traumatic events.**

|  |  |  |
| --- | --- | --- |
| Do you have gender/sexual orientation or gender identity issues? | Yes | No |
| Have you ever been raped, sexually assaulted or witnessed such abuse? | Yes | No |
| Have you ever been sexually abused, molested or witnessed such abuse? | Yes | No |
| Are you currently sexually active?Other significant information: | Yes | No |

# ROLE PERFORMANCE (CAR Score #7)

Education level:

Can you read/write? Yes No

Are you currently enrolled in school? Plans for future education:

None

Yes

No N/A

Have you served in the military?

##### If Yes, explain:

Yes No

Have you had a family member serve in the military?

##### If Yes, explain:

Yes No



## EMPLOYMENT HISTORY

Are you employed? Unemployed Part-time

Full-time Disabled

|  |  |  |  |
| --- | --- | --- | --- |
| Are you experiencing any problems related to your job/daily tasks? |  | Yes | No |
| Plans for future employment? | Yes | No | *NIA* |
| Referral for work program needed?Other significant information: |  | Yes | No |

|  |  |  |
| --- | --- | --- |
| **LEGAL/CRIMINAL HISTORY** | **(CAR Score #8)** |  |
| Do you have current legal charges? | Yes | No |
| Are you on probation or parole? | Yes | No |
| List historical legal history, including incarceration dates, charges, probation information, etc: |  |  |
| Do you have any difficulty with any of the following: **(check** all **that apply)** |  |  |

Following Rules/Laws Authority Issues Legal

Issues Antisocial Behaviors □

Aggression

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Have you received a traffic ticket?Have you received a traffic ticket this year? Have you had a DUI?Have you had a DUI this year? | Yes Yes YesYes | No No NoNo | Once Once OnceOnce | 2-4 times2-4 times2-4 times2-4 times | More than 4 times More than 4 times More than 4 timesMore than 4 times |
| Do you feel you help out in the community? | All times | □ | Most times | Sometimes □ Seide Nevm er |
| Do you conform to societal rules and laws? | All times | □ | Most times | Sometimes □ Seldo Nevm er |

|  |  |
| --- | --- |
| **CULTURAL/RELIGIOUS BELIEFS** |  |
| Do you have any cultural or religious beliefs that will be used to guide treatment services? | Yes | No |
| Are you involved in a church/religion? | Yes | No |
| Are your religious beliefs a significant factor in your life? | Yes | No |

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Other significant information:

## COMMUNICATION

Do you need to utilize any assistive technology in order to participate in services?

Yes No

Primary method of communication:

English

Other language

Sign Language

### SELF-CARE/BASIC NEEDS (CAR Score #9)

Current Community Supports Present within the Home: N/

A OHS CHBS

Latino Development Agency Other

Systems of Care

Current Social Benefits Present within the Home:

N/A

Advantage program Worker's Comp

SSI

Section 8/Housing

SSDI TANF

Food Stamps VA Benefits

I am able to plan for and purchase my basic needs: □ All times Most times I am able to plan for and purchase food: □ All times Most times I am able to plan for and purchase clothing: □ All times Most times I am able to plan for and purchase housing: □ All times Most times

I am able to plan for and purchase transportation: □ All times Most times How are your basic needs met?

How would you describe your quality of life?

What needs to happen to improve your quality of life?

Please list your strengths and abilities:

Please list your liabilities:

Please list your needs:

Please list your ability to connecUengage in the community:

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Sometimes Seldom Never

Sometimes Seldom Never

Sometimes Seldom Never

Sometimes Seldom Never

Sometimes Seldom Never

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Please describe your hobbies, social activities, etc.:

#### ASSESSMENT CONCLUSIONS/INTERPRETATIONS

Urgent needs identified within assessment: Yes No

#### DIAGNOSTIC IMPRESSIONS

Medical Notes:

Axis IV Psychosocial and Environmental Problems:

Primary Support Group Social Environment Educational Occupational

Housing

Economic

Health Care Services Legal System/Crime Other Problems

Axis V GAF Past Year: Current:

Clinical TreatmenVService Disposition:

Date

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