

Client Name _____ Age/DOB _____

Date of Face to Face _____ Therapist _____

Sources of Information: Interview(s) of Client Review of previous Diagnostic Assessment

Interview(s) with Others (Family/supports) Health Records Review Observations

Comments _____

Who made the phone call to schedule this appointment or otherwise scheduled it? _____

What exactly was happening at this time and what was the motive for making the appointment? _____

CURRENT LIFE SITUATION

Emotional Dashboard : Please indicate if you have experienced any of these mood or mental conditions within the last week or since our last meeting. Please scale them from 0 (lowest level) to 10 (highest level):

____ Anger ____ Anxiety ____ Confusion
____ Depression ____ Grief ____ Guilt

Additional Life Situation Notes _____

Living Situation: Homeless Owns home Rental property Lives with others

Group Residential setting Subsidized housing Other _____

Client's Strengths and Resources _____

Client's Belief System and Significant Cultural Components _____

ECONOMIC/EDUCATION STATUS

Education: No formal education Some education (*HS diploma not obtained*)

HS diploma or GED equivalent Some post-secondary education (*no degree obtained*)

Associates degree Bachelors degree Masters degree or higher

Employment: Not employed Employed part-time Employed full-time Volunteer

Other _____

Financial: No income General assistance Receives SSI Job-related income

Representative payee Receives income from family, gift, or trust fund Other _____

Legal Status/Concerns: None Criminal/Traffic Civil/Family

Guardian/Conservator/Power of Attorney Other _____

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PHYSICAL HEALTH

Current Healthcare Resources: Primary Care Provider Not connected with health provider
 Dental Care Use or interest in complementary health approaches Physical healthcare directive
 None identified Other _____

Medical Concerns: Asthma COPD Heart disease Hypertension Cancer Diabetes
 Stroke Chronic Pain Seizures Traumatic brain injury Other _____

List of Medications: _____

MENTAL HEALTH EXAM

Thought Process: Linear Circular Intact Circumstantial Disorganized Tangential
 Loose associations Other _____

Thought Content: Within normal limits Delusions Hallucinations Disassociation
 Preservation Paranoia Bizarre Other _____

Memory: Intact Impaired/Recent Impaired/Remote Other _____

Mood: Calm Depressed Anxious Irritable Heightened Other _____

Insight: Intact Impaired/Mild Impaired/Moderate Impaired/Severe

Judgement: Intact Impaired/Mild Impaired/Moderate Impaired/Severe

RISK ASSESSMENT

Are you experiencing any suicidal thoughts, plans, intentions or self-injurious behavior? No Yes

Which are you experiencing? Thoughts Plans Intentions Self-injurious behavior

Have you attempted suicide in the past? No Yes

Can the client entertain options/future? No Yes

Is there access to lethal means of self-harm? No Yes Violent toward self or others? No Yes

Family history of suicide or violence? No Yes Support system available? No Yes

Do you or have you ever wanted to hurt someone, had homicidal thoughts, plans, intent, done damage to property?

No Yes Notes: _____

Action taken/referral given based on risk assessment? _____

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CLINICAL SUMMARY

SERVICE RECOMMENDATIONS

Meets Criteria for: Serious & Persistent Mental Illness Serious Mental Illness
 Severely Emotionally Disturbed

Recommended Assessments: Neuro-psychological Evaluation Chemical Health Assessment
 Elderly or CADI waiver TBI waiver Long term care Guardian or Conservator
 Physical/Wellness exam Dental Other _____

Mental Health Services Needed: Case Management Services Behavioral Health Home Services
 Partial Hospitalization Intensive Residential Treatment Services (IRTS) Day Treatment
 Adult Rehabilitative Mental Health Services (ARMHS) Adult Foster Care Individual Psychotherapy
 Psychiatry Crisis Stabilization ACT Services Other _____
Recommended frequency of individualized psychotherapy _____

DIAGNOSIS _____

Clinical Indicators/Justifications

Staff Signature

Date Completed