MENTAL HEALTH SERVICES

# Clinical/ Psychiatric Assessment

This form may be used for clients of any age.

NAME / MRN

Facility Name: ____________________ ID: _______ Program Name: ________________________ ID: _________

Provider: __________________ ID: _______ Service Date: ______________

Direct Service Time (Min): ________ Documentation Time (Min): ________ Travel Time (Min): ________

Number in Group: ________ CPT/HCPC Code: _____________ Quantity: ________

**Location of Service (**Please check one)

☐ Age-Specific Community Center
☐ Client's Job Site
☐ Correctional Facility
☐ Faith-Based
☐ Field
☐ Health Care/Primary Care
☐ Home
☐ Homeless/Emergency Shelter
☐ Inpatient
☐ Mobile Service
☐ Non-Traditional service location
☐ Office
☐ Other Community Location
☐ Phone–provided in client's home
☐ Phone–provided other than in client's home
☐ Residential Care - Adults
☐ Residential Care - Children
☐ School
☐ Telehealth/Video-provided in client's home
☐ Telehealth/Video-provided other than in Client's home
☐ Unknown/Not Reported

☐ Nontraditional Location ☐ Other ________________________________ ☐ Unknown

**Is this a billable service?** ☐ **Yes** ☐ **No**

**Did this service involve interactive complexity?** ☐ **Yes** ☐ **No**

**Was an Interpreter used?** ☐ **Yes** ☐ **No**

Name of Interpreter: ___________________________________

**<u>Language</u>**

Language service provided in other than English: ☐ Spanish ☐ Other ________________________________________

**Is the client pregnant?** ☐ **Yes** ☐ **No (If yes, please document how service was pregnancy-related)**

**EBP/Service Strategies:**

☐ Assertive Community Treatment
☐ Supportive Employment
☐ Supportive Housing
☐ Family Psychoeducation
☐ Integrated Dual Diagnosis Treatment
☐ Illness Management and Recovery
☐ Medication Management
☐ New Generation Medications
☐ Therapeutic Foster Care
☐ Multisystemic Therapy
☐ Functional Family Therapy
☐ Peer/Family Delivered Services
☐ Psychoeducation
☐ Family Support
☐ Supportive Education
☐ In Partnership w/ Law Enforcement
☐ In Partnership w/ Health Care
☐ In Partnership w/ Social Services
☐ In Partnership w/ SA Services
☐ Integrated Services for MH/Aging
☐ Integrated Services for MH/DD
☐ Ethnic-Specific Service Strategy
☐ Age-Specific Service Strategy
☐ Unknown Service Strategy

**(COUNTY STAFF ONLY) Evidence-based practice/tracking program?** ☐ **Yes** ☐ **No** **Program** ______________________________________________

**This service was provided via telehealth with the consent of the client or authorized representative.** ☐

Referred By: ___________________________________________________________________________

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NAME / MRN

## Identifying Information

Legal Name: ______________________ Age: _____ DOB: ______________

Preferred Name: ______________________________________________

**Gender**

☐ Male ☐ Female ☐ Transgender F-M ☐ Transgender M-F ☐ Nonbinary ☐ Other _____________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Widowed

Address:

__________________________________________________________________

Phone #: ______________________________

Emergency Contact: ______________________________ ______________________

Name Phone number

## Language

Primary Language:______________________ Other Languages spoken in home: ______________________

Language in which the service was provided (other than English): ☐ Spanish ☐ Other ______________________

☐ Interpreter Name of Interpreter: ______________________________

## Client Information

Entitlements: ☐ M/C ☐ Medicare ☐ BHC ☐ Other Health Care Info ______________________

☐ No Health Insurance Coverage

☐ SSI ☐ SSDI

Payee: ______________________________

Monthly Income _____________

Refer to a Financial Counselor? ☐ Yes ☐ No

**Living Situation** ☐ Independent Living ☐ Immediate Family ☐ Extended Family ☐ Shared Housing ☐ Board & Care ☐ Residential Care Facility ☐ **Homeless** ☐ Other

Support System Contacts: ______________________________________________

Other Agencies Involved: ☐ CC Provider Network ☐ CFS/APS ☐ Voc Services ☐ AOD ☐ Regional Center ☐ Homeless Services

☐ Other ___________________________

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**Presenting Problem:** What is the primary reason for current referral? Describe current precipitating event, primary stressors, primary symptoms, and functional impairment.

**Functional Impairments:**

**Mental Status Examination:** (appearance, mood, affect, attitude, thought process and content, sensorium, attention, memory, insight)

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**Behavioral Health and Treatment History:** (Past mental health conditions; inpatient/outpatient treatment; psychiatric medications)

**Substance Use:** (Use and related problems over the past 12 months. If an Initial assessment, full history)

**Medical History/Allergies/Medications:**

**Psychosocial Factors:** (Relevant family background, current family information, living situation, social support, work and school, cultural and linguistic factors, sexual orientation, and gender identity)

**Strengths, Criminal Justice History, Risk Assessment:**

**Clinical Summary:** (including whether client meets medical necessity for specialty mental health services)

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**Current Diagnosis:**

Primary
ICD-10 Code: _____________ DSM-5 Narrative: ____________________________________________

Secondary
ICD-10 Code: _____________ DSM-5 Narrative: ____________________________________________

**Recommendations, Plan, Referrals:**

**Is this late documentation?** ☐ Yes ☐ No

| | | |
|---|---|---|
| Staff Signature/License | Printed Name | Date |
| Co-Signature of Licensed Clinician | Printed Name | Date |

Data Entry Clerk Initials

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