

1096–Assessment

Assessment Date:

Assessment Time:

Practitioner:

Legal Status:

5150
 5250
 DTO
 DTS
 GD
 LPS
 T-CON
 VOL


Identification (paint a picture of the client)

Presenting Problem (client's perspective about the circumstances that led to admission):

Current Psychiatric Symptoms and Behavior (including onset and course of symptoms in support of DSM diagnosis):

NOTE: Annual updates must justify need for continued services based on current functioning.

Functional Impairments as a result of the above Signs/Symptoms and Behavior:

| | | | | |
|--|---|-------------------|-------------|--|
|  | DHHS-Behavioral Health 720 Wood Street Eureka, CA 95501 CONFIDENTIAL PATIENT INFORMATION (SEE CA W&I CODE 5328, 42 CFR PART 2) | Assessment | Client Name | |
| | | | Client ID | |
| | | | Client DOB | |

Living Situation:


Marital History/Children:

Education:

Occupation/Financial:

Legal History:

Military history:

| | | | | |
|---|--|--------------------------|-------------|--|
|  <p>DHHS Humboldt County Department of Health & Human Services</p> | <p>DHHS-Behavioral Health 720 Wood Street Eureka, CA 95501 CONFIDENTIAL PATIENT INFORMATION (SEE CA W&I CODE 5328, 42 CFR PART 2)</p> | <p>Assessment</p> | Client Name | |
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Supports (social, community, etc.):

Special Needs:


- Accessibility Issues Interpreter
 None Other
 Preferred Language

Other Special Need and/or Comments:

Medications: If client reports no medications enter None below.

| Current Medications | Dosage | Informed Consent Signed | Medication Comments/ Side Effects |
|---------------------|--------|-------------------------|--------------------------------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Medication Comments (General):

| | | | |
|---|-------------------|-------------|--|
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Over the Counter Medications: Yes No

OTC Description:

Psychiatric Med Adherence: No Yes

Medication Adherence Explanation:

Weight Increase or Decrease? Increase Decrease None

Number of Pounds Increase or Decrease:

Herbals: Yes No

Herbals Description:

Substances

Tobacco Use - Client Counseled to quit or tobacco cessation materials given?

Non-Smoker Yes No Refused

Does the client have a alcohol use disorder? Yes No Does the client have a substance use disorder? Yes No

Brief intervention given? Yes No Referral for SUD Services? Yes No


General Substance Use Disorder History - Specific Substances are are entered in next section.

Substance of Choice

Substance route of choice


Ingesting Injecting Smoking Other

History of use disorder treatment

| | | | |
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| | | | |
|--|--|--|--|
| Substance Name | | Substance Name | |
| Describe (Other, Unknown, or No Abuse as stated by Client) | | Describe (Other, Unknown, or No Abuse as stated by Client) | |
| Frequency | | Frequency | |
| Onset | | Onset | |
| Last Use | | Last Use | |
| Drug of Choice | | Drug of Choice | |
| Route of Choice | | Route of Choice | |
| History of Treatment | | History of Treatment | |

| | | | |
|--|--|--|--|
| Substance Name | | Substance Name | |
| Describe (Other, Unknown, or No Abuse as stated by Client) | | Describe (Other, Unknown, or No Abuse as stated by Client) | |
| Frequency | | Frequency | |
| Onset | | Onset | |
| Last Use | | Last Use | |
| Drug of Choice | | Drug of Choice | |
| Route of Choice | | Route of Choice | |
| History of Treatment | | History of Treatment | |

| | | | |
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Psychiatric History

Client's Psychiatric History (able to assess at this time?): Yes No

If "No," Reason:

Information obtained from the client in person? Yes No

Information received from another person? Yes No

If yes, name and relationship to client:

How was the information obtained? By Phone In Person


Client Psychiatric History:

- Anxiety
- Bipolar
- Depression
- Schizophrenia
- Suicide Attempt(s)
- Substance Use Disorder
- Other _____

Psychiatric History Detail:


Age of Onset (Approx.):

Treatment History:

| | | | |
|---|-------------------|-------------|--|
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Family Psychiatric History

| | |
|---|---|
| <p>Parent:</p> <p><input type="checkbox"/> Anxiety <input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Mania <input type="checkbox"/> Psychosis</p> <p><input type="checkbox"/> Suicide Attempt(s) <input type="checkbox"/> Substance Abuse</p> <p><input type="checkbox"/> Suicide <input type="checkbox"/> None reported</p> <p><input type="checkbox"/> Other: _____</p> <p>Describe:</p> | <p>Sibling:</p> <p><input type="checkbox"/> Anxiety <input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Mania <input type="checkbox"/> Psychosis</p> <p><input type="checkbox"/> Suicide Attempt(s) <input type="checkbox"/> Substance Abuse</p> <p><input type="checkbox"/> Suicide <input type="checkbox"/> None reported</p> <p><input type="checkbox"/> Other: _____</p> <p>Describe:</p> |
| <p>Children:</p> <p><input type="checkbox"/> Anxiety <input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Mania <input type="checkbox"/> Psychosis</p> <p><input type="checkbox"/> Suicide Attempt(s) <input type="checkbox"/> Substance Abuse</p> <p><input type="checkbox"/> Suicide <input type="checkbox"/> None reported</p> <p><input type="checkbox"/> Other: _____</p> <p>Describe:</p> | <p>Aunt/Uncle:</p> <p><input type="checkbox"/> Anxiety <input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Mania <input type="checkbox"/> Psychosis</p> <p><input type="checkbox"/> Suicide Attempt(s) <input type="checkbox"/> Substance Abuse</p> <p><input type="checkbox"/> Suicide <input type="checkbox"/> None reported</p> <p><input type="checkbox"/> Other: _____</p> <p>Describe:</p> |
| <p>Grandparents:</p> <p><input type="checkbox"/> Anxiety <input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Mania <input type="checkbox"/> Psychosis</p> <p><input type="checkbox"/> Suicide Attempt(s) <input type="checkbox"/> Substance Abuse</p> <p><input type="checkbox"/> Suicide <input type="checkbox"/> None reported</p> <p><input type="checkbox"/> Other: _____</p> <p>Describe:</p> | <p>Family Medical History:</p> <p><input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Disease</p> <p><input type="checkbox"/> Overweight <input type="checkbox"/> Seizure</p> <p><input type="checkbox"/> Stroke <input type="checkbox"/> None reported</p> <p><input type="checkbox"/> Other: _____</p> <p>Describe:</p> |

| | | | |
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Personal, Social and Developmental History

Childhood and Developmental History, if Relevant:

Trauma: Yes No Unknown

Comments: (If yes or unknown)

Relevant Cultural/Ethnic/Spiritual Issues:

Strengths:


Medical History and General Review of Systems

Client's Perception of their Physical Health:

Excellent Fair Good Poor

Has it changed in the past year? Yes No

Physical Health Change Description:

| | | | |
|---|-------------------|-------------|--|
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Does the client have or have they ever had any of the following conditions?

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Other Neurological |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> HIV | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Arteriosclerotic Disease | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Hypercholesterolemia | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> COPD | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Deaf/Hearing Impairment | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Blind/Visual Impairment | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> STD |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Infertility | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cardiac arrhythmia | <input type="checkbox"/> Dyslipidemia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tinnitus |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Chronic Lung Disorder | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Migraines | <input type="checkbox"/> Tuberculosis |
| | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Ulcers |
| | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Other_____ |
| | | <input type="checkbox"/> Obesity | |
| | | <input type="checkbox"/> Osteoporosis | |


Describe other conditions and further comments:

Allergies: Client has known drug allergies No known drug allergies

If Yes, complete the Allergies and Hypersensitivities form.

Vitals: Available Not Available

If Yes, complete the Vitals form.

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Complete the 1173 Mental Status Form Completed? Yes No
 Complete the Diagnosis Form Completed? Yes No

Clinical Summary and Recommendations

System of Care Determination

SMHS NSMHS SUD

Clinical Formulation (Clinical Summary, Recommendations, Diagnostic Impression, System of Care/Access Criteria) Details

SV Admit: Yes No


Reason:

Estimated Length of Stay:

Labs

Current or past labs reviewed: Yes No

Lab Results:

| | | | |
|---|-------------------|-------------|--|
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Reason for Medication (as applicable to your scope of practice)

If medication type or dose is being changed at this visit, indicate rational for change (more than one reason may be selected):


- No Medication Change
- Not Applicable
- Diagnosis Change
- Insufficient Improvements
- Patient Preference
- Side Effects
- SE Profile
- Symptoms Worsening
- Pattern of Associated Symptoms
- Past Response
- Other _____

Patient Education Completed? Yes No N/A
 Medication Consent Signed? Yes No N/A

Medication Consent, if no, reason:

Follow-up, if relevant: Yes No N/A

Recommend follow up appointment: Estimated follow-up date (Optional)

| | | | |
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