Initial Assessment

Client Information:

Client Name	**Last, First**	Date of Assessment	**7/17/21**
Date of Birth	**2/19/76**	Referral Source	**PCP, Dr. Primary**
CPT Code/ Time Spent:	**90791**	Other Agencies Involved	**SMART recovery**
Source of Information:	**Client**	Preferred Language for treatment	**English**

Beneficiary Rights:
*(if not provided, please note why):*_____

X Explanation of the State Guide to Medi-Cal Mental Health Services
X Grievance/Appeal process
X Notice of Privacy Practices

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

Client is a 46-year-old, Caucasian, divorced, heterosexual male presenting for psychotropic medication to manage depressive symptoms. Client recently finalized divorce with his wife of 9 years, which he reports has increased depressive symptoms of irritability, anger, hopelessness, insomnia, and loss of appetite. Client reports passive SI with no intent. However, client reports he has struggled with depression for most of his life. Client has low motivation to engage with co-workers, friends, and family, which has resulted in client becoming isolated from most of his supports. Client drinks alcohol 5-6 times per week as his main coping skill, which impacts his productivity at work.

Mental health history *(including previous inpatient and/or outpatient treatment providers, dates, treatment outcomes, previous diagnoses, relevant family information, etc.):*

Client's diagnostic history began at 19 years old, to include Anxiety and Depression. Client has received therapeutic services intermittently since then. Client reports better outcomes with male clinicians, as he feels more comfortable with them. Client had one hospitalization in college for SI with intent by way of overdose. Client's medication history began at 20 years old and includes Xanax, Wellbutrin, and Prozac. Client's most recent prescribing psychiatrist was Dr. Psychiatrist, who recently retired. Client has intake with new psychiatrist next week. Client is currently prescribed Effexor 75mg bid. Client's grandfather had Dysthymia diagnosis and his aunt was diagnosed with Anxiety.

Client/family strengths *(include personal strengths as well as support systems, etc. Show how the strengths can be applied practically to help client/family reach treatment goals):*

Client has positive outcomes with treatment in the past. He has a desire to change. Client used to enjoy working out and playing basketball, and reports interest in returning to these activities. Client's parents and one sister live nearby and offer client support. Client will be encouraged to utilize supports and basketball to reduce isolation and improve mood.

Experience of trauma *(include historical and current domestic violence, physical abuse, sexual abuse, etc.):*

Client's parents divorced when client was in high school. No further trauma reported by client.

Initial mental status exam *(Document appearance, attitude, behavior, speech, orientation, Mood/Affect, Thought Process, Memory/Thought Content, Insight/Judgment/Impulsivity, and additional observations):*
During assessment, client presented with casual dress and disheveled appearance. Attitude was calm and cooperative. Poor eye contact, no abnormal movements or psychomotor agitation. Slow speech with low volume. Depressed and irritable mood. Linear thought process, no AH/VH/delusions reported. Passive SI with no intent. No HI. Client presented as drowsy, oriented x4, difficulty concentrating and was a fair historian. Fair insight and judgement.

Risk assessment *(Include past and present danger to self and danger to others. Detail intent, plan, access to means, previous attempts, relevant risk factors - such as co-occurring disorders, loss, abuse, access to firearms, etc.):*
Client has passive SI, reports no plan or intent with increasing inability to cope with daily stressors and recent divorce. No guns present in the home. Client has had one voluntary hospitalization in college, due to high level of stress and poor coping skills, resulting in plan to overdose with psychotropic medications. Client reports he engages in physical fights with others when under the influence. Risk factors include alcohol abuse, divorce, job instability and history of depression. Protective factors include supportive family members and desire to change. Provider will ensure ongoing risk-assessments with each appointment and will create a safety plan to promote stability.

Relevant physical health conditions reported by client:
Hypertension and high cholesterol. Both managed with medication.

Medications that have been prescribed to the client *(If MD, include dosages of each medication, dates of initial prescriptions, client self-report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities):*

HCTZ, Zocor, Xanax, Wellbutrin, and Prozac. No drug or food allergies were reported.

Allergies: NKDA

Primary Care Physician Information: *(Document information for coordination of care. If client does not have a PCP, document referrals given):*
Dr. Primary, 888-555-4567. Signed ROI faxed to PCP for coordination of care.

Developmental history *(for children & adolescents only. Include birth and developmental milestone information):*

N/A

Cultural assessment *(include any culture or sub-culture client identifies with, and how these cultural issues influence client's view of mental health treatment, mental illness, etc.):*
Client identifies as Christian but does not attend church regularly. Provider will continue to assess.

Substance use *(include past and present use of alcohol, nicotine, and/or illicit drugs, as well as prescription and over the counter medications. Include, frequency, amount, consequences, and impact on client functioning):*

Client reports he experimented with various substances in college. Client reports drinking alcohol 5-6 days a week to the point of becoming inebriated. Client engages in verbal and physical altercations with strangers when under the influence, which has resulted in two arrests in the past (no current charges) and minor injuries. Alcohol abuse also impacts client's timeliness, productivity, and relationships with coworkers at work, resulting in many warnings and potential for losing his job. No tobacco use reported.

Social History *(if applicable, include legal system involvement, work history, school/educational history, risk factors and relationship status including orientation):*
Client with history of arrest as a juvenile for shop lifting. No recent legal involvement. Client has GED and works part time on a food truck. Client not currently involved in a relationship, identifies as heterosexual.

Community resources client is currently using (*support groups, school-based services, social services, other social supports):*

Client denies any support from community resources. Identifies one or two friends that he is close with.

Diagnosis *(Document diagnosis. Substantiate with information regarding symptoms, frequency/length of symptoms, list rule-outs, indicate priority diagnosis for treatment):*

Major Depressive Disorder
Alcohol Abuse

Clinical Formulation *(Include clinical judgments regarding intensity, length of treatment and recommendations for services. Include evaluation of client's ability and willingness to solve the presenting problem):*
Individual therapy will focus on finding effective and healthy coping strategies to reduce substance use and depressive symptoms. SI will be closely monitored. Client will continue attending SMART Recovery to reduce alcohol use.
Provider will coordinate care with PCP and new psychiatrist (ROIs obtained) and refer to community resources as needed.

Clinician Signature *(include credential. If signature cannot be read, include printed name):*	**Date:**
Caring Provider, ***LCSW***	**7/17/21**