

## Initial Assessment

### Client Information:

Client Name		Date of Assessment	
Date of Birth		Referral Source	
CPT Code/ Time Spent:		Other Agencies Involved	
Source of Information:		Preferred Language for treatment	

### Beneficiary Rights:

*(if not provided, please note why):* \_\_\_\_\_

- Explanation of the State Guide to Medi-Cal Mental Health Services
- Grievance/Appeal process
- 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):*

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

**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):*

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

**Initial mental status exam** (Document appearance, attitude, behavior, speech, orientation, Mood/Affect, Thought Process, Memory/Thought Content, Insight/Judgment/Impulsivity, and additional observations):

**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.):

**Relevant physical health conditions reported by client:**

**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):

**Allergies:**

**Primary Care Physician Information:** (Document information for coordination of care. If client does not have a PCP, document referrals given):

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

**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.):

**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):

**Social History** (if applicable, include legal system involvement, work history, school/educational history, risk factors and relationship status including orientation):

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

**Diagnosis** (Document diagnosis. Substantiate with information regarding symptoms, frequency/length of symptoms, list rule-outs, indicate priority diagnosis for treatment. Remember an Included Diagnosis from Title 9 must be primary for Medical Necessity to be met for Medi-Cal services):

**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):

**Clinician Signature** (include credential. If signature cannot be read, include printed name):

**Date:**