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:

Living Situation:

Marital History/Children:

Education:

Occupation/Financial:

Legal History:

Military history:

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):

Over the Counter Medications: ☐ Yes ☐ No

OTC Description:

Psychiatric Med Adherence: ☐ Yes ☐ No

Medication Adherence Explanation:

Weight Increase or Decrease? ☐ Increase ☐ Decrease ☐ None

Number of Pounds Increase or Decrease: _____

Herbals: ☐ Yes ☐ No

Herbals Description:

Substances

Does the client have a substance use issue? ☐ Yes ☐ No

Referral to SUD Services? ☐ Yes ☐ No

If client reports no substance use, enter None on next page.

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	

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:

Family Psychiatric History

Parent: ☐ Anxiety ☐ Depression ☐ Mania ☐ Psychosis ☐ Suicide Attempt(s) ☐ Substance Abuse ☐ Suicide ☐ None reported ☐ Other:_____ Describe:	Sibling: ☐ Anxiety ☐ Depression ☐ Mania ☐ Psychosis ☐ Suicide Attempt(s) ☐ Substance Abuse ☐ Suicide ☐ None reported ☐ Other:_____ Describe:
Children: ☐ Anxiety ☐ Depression ☐ Mania ☐ Psychosis ☐ Suicide Attempt(s) ☐ Substance Abuse ☐ Suicide ☐ None reported ☐ Other:_____ Describe:	Aunt/Uncle: ☐ Anxiety ☐ Depression ☐ Mania ☐ Psychosis ☐ Suicide Attempt(s) ☐ Substance Abuse ☐ Suicide ☐ None reported ☐ Other:_____ Describe:
Grandparents: ☐ Anxiety ☐ Depression ☐ Mania ☐ Psychosis ☐ Suicide Attempt(s) ☐ Substance Abuse ☐ Suicide ☐ None reported ☐ Other:_____ Describe:	Family Medical History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Overweight ☐ Seizure ☐ Stroke ☐ None reported ☐ Other:_____ Describe:

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:

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

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

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.

Humboldt County Department of Health & Human Services	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	

Complete the 1173 Mental Status Form

Complete the Diagnosis Form

Medical Necessity

Client meets Specialty Mental Health Medical Necessity criteria: ☐ Yes ☐ No

Level: ☐ I ☐ II ☐ III

Plan:

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:
