Patient Name: _____

Initial Assessment Patient Name:	Date of Assessment:
Clinician Completing Assessment:	
Initial Information	
Chief Complaint:	
History of Present Illness:	
Current Symptoms:	
Previous Treatment History: (dates of treatment or hospitalization, clinician names, interventions & response to treatment, etc.)	
History of Risk: Any previous suicide attempts? □ Yes □ No If yes, enter dates and measures used for attempt:	
Past Psychiatric Medications: (include names of clinicians past/present, medications/dosages, when taken, who prescribed, and response)	

Patient Name: _____

History of Substance Use

(include age of onset, history and current use or denial of use, consequences of use)

Alcohol:

Drugs: (street, prescription, and over the counter)

Nicotine:

Family Substance Use History:

Medical History

Self:

☐ Stroke ☐ Seizures ☐ Migraines ☐ Liver Damage ☐ Thyroid Problems

☐ Anemia ☐ Diabetes ☐ Chronic Pain ☐ Chronic Fatigue ☐ Urinary Tract Infection

☐ Asthma ☐ Hepatitis ☐ Tuberculosis ☐ Eating Disorder ☐ Persistent flu-like symptoms

☐ Cancer ☐ Hypertension ☐ Cardiac Problems ☐ Communicable Diseases

☐ Other: _____

☐ Children/Adolescents:

Prenatal events, Childhood Diseases, Vaccination History, Developmental Milestones:

Family:

☐ Stroke ☐ Seizures ☐ Migraines ☐ Liver Damage ☐ Thyroid Problems

☐ Anemia ☐ Diabetes ☐ Chronic Pain ☐ Chronic Fatigue ☐ Urinary Tract Infection

☐ Asthma ☐ Hepatitis ☐ Tuberculosis ☐ Eating Disorder ☐ Persistent flu-like symptoms

☐ Cancer ☐ Hypertension ☐ Cardiac Problems ☐ Communicable Diseases

☐ Other: _____

☐ Children/Adolescents:

Prenatal events, Childhood Diseases, Vaccination History, Developmental Milestones:

Patient Name: _____

Current Medications:

Physical Exam in the past year? ☐ Yes ☐ No

Primary Care Physician: _____ ☐ No PCP

Consent for coordination of care? ☐ Yes ☐ No ☐ N/A

If no, state reason for refusal:

Food or drug allergies? ☐ Yes ☐ No

If yes, what specific allergies?

Based on information, a physical examination is recommended: ☐ Yes ☐ No

Psychosocial History

Spiritual/Religious Affiliation:

Education:

Legal History:

Sexual Orientation:

Employment History:

Cultural Influences:

Community Resources:

Patient Name: _____

Significant Life Events:

Marriage/Family: (marital history, including current/prior marriages/significant relationships; names/relationships with children)

Interests and Activities:

Strengths and Weaknesses:

Mental Status Exam:

Please skip this part. I will do this part after we meet.

Appearance: □ Well Groomed □ Unkempt □ Disheveled

Eye Contact: □ WNL □ Avoidant □ Intense

Thought Content: □ WNL □ Delusions □ Grandiose □ Somatic □ Other_____

Thought Process: □ Logical □ Incoherent □ Circumstantial □ Concrete □ Racing □ Other_____

Perception: □ WNL □ Impaired □ Hallucinations_____

Mood: □ WNL □ Depressed □ Anxious □ Angry/Irritable □ Euthymic □ Other_____

Affect: □ Full □ Labile □ Flat □ Blunted □ Inappropriate

Behavior: □ Cooperative □ Resistant □ Hyperactive □ Withdrawn □ Other_____

Insight/Judgment:

Patient Name: _____

Risk Assessment:

Homicidal/Suicidal Ideation

Nature of Plan & Intent

Availability of Means (address access to guns specifically)

Lethality of Method

Marked Change in Recent Behavior

Previous Attempts

Significant Other Attempts

Perception of Loss

Support System

History of Human-Induced Trauma

Legal Complications

Financial Problems

Active Substance Use/Abuse

Presence of Psychosis

Other Risk Issues

Safety Plan Reviewed (include client strengths that support current care plan)

Patient Name: _____

Please leave this blank, but do bring it in with you.

Assessment Summary:

Primary Diagnosis:

Secondary Diagnosis:

Co-morbid Medical Concerns:

Psychosocial stressors:

Functional Impairments:

Initial Treatment Plan:

_____ _____

Clinician Signature Date