

Client First Name: Referred By: Funding Source:

Client Last Name: Date:

ID:

Date of Birth: Gender:

Phone Number: Address:

E-mail Address:

Age:

D Male D Female D Other

Social Security: Race:

County:

Responsible Party/Guardian:

Emergency Contact:

Primary Insured Information if other: Pharmacy

School Information:

Presenting Problem:

Level of Need for Services: Immediate Referrals Given:

Does the person meet criteria for services? If yes, recommended services:

If no, reason/comments:

Was client informed as to denial reasons? If denied, referred to:

Therapist:

Primary Diagnosis (From DSM-V) :

□Mild D Moderate D Severe OYes

DIndividual Counseling D Group Counseling

D Testing D Case Management D Other

D Yes 0 N/A

Case Manager:

D Family Counseling

0 **N/A**

Notes:

If admitted, date of scheduled intake:

Eligibility Verified? 0 Yes

O No



Date of Interview:

#### IDENTIFYING INFORMATION

Client First Name:

Client Last Name:

Address: Phone Number: Date of Birth: Gender:

E-mail Address:

Social Security No:

Age:

D Male D Female D Other Race:

Name and Relationship of Person Providing Information: Emergency contact:

#### PRESENTING PROBLEM

What is the problem you would like assistance with?

Age of onset of symptoms:

Are there any URGENT needs you need to address? (Include risk of self harm, risk of harm to others, issues with personal safety, etc)

Have you made any attempts to resolve this problem on your own?

□Yes

#### PRESENT LIFE SITUATION

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Number of people in current household:

Total family income:

Living arrangements: D Buying D Renting D Other

##### (Check all that apply)

D Parents

D Significant Other

D Extended Family

0 Siblings

D Foster Home

D Other

0 Step-Siblings

D Controlled Environment

Does the client have special needs or need accommodations (behavioral, physical, communication or transportation needs)?

Does the client have disabilities?

D Yes

D Yes

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## PRESENT LIFE SITUATION

Other significant information:

## PREVIOUS TREATMENT HISTORY

Does the client have a history of being tested for a disorder/diagnosis? Has the client ever seen an outpatient therapist/psychologist for services? Has the client ever been admitted to an inpatient psychiatric facility?

**RISK ASSESSMENT** (Refer to SAMHSA SAFE-T card)

Does the client have a history of suicidal ideations, plans, or attempts?

**Risk Factors:** 0 Suicidal Behavior O Current/Past psychiatric disorders

0 Children

OYes D Yes D Yes

D Yes

D Key Symptoms D Family History D Precipitants/Stressors/lnterpersonal

0 Change in Treatment

D Access to Means

**Protective Factors:**

**Internal:** D Coping Skills

D Other

D Religious Beliefs

D Frustration Tolerance

**External:**

D Responsibility to others (Children/Pets etc.)

D Social Supports D Other

0 Positive Therapeutic Relationships

**Current Suicide Inquiry:**

***Ideation:*** OYes ONo Suicide Risk Level per SAFE-T

***Plan:*** 0 Yes

0 High

0 No ***Behaviors:*** D Yes D No

0 Medium O Low

|  |  |  |
| --- | --- | --- |
| Safety Plan created and placed in a visible place for client use: | D | Yes |
| Other significant information: |  |  |
| Does the client have a history of homicidal ideations, plans or attempts? | 0 | Yes |
| Does the client have a history of aggression or violence towards others? | 0 | Yes |

***Intent:*** D Yes



### FEELING/MOOD/AFFECT (CAR Score #1)

**Is the client experiencing any of the following? (check all that apply)**

D Mood Liability D Poor Coping Skills D Suicidal Ideation

D Depression O Anger O Anxiety

D Change in Appetite O Change in Sleep Pattern O Other

D Homicidal Ideation

0 Euphoria

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Other significant information:

**How would you describe yourself? (check all that apply)**

D Outgoing D Shy/Quiet D Unpopular D Serious

D Rebellious OCalm

D Aggressive

D Other

D Awkward

D Nervous

0 Happy

D Temperamental

D Popular

D Unhappy

### THINKING/ MENTAL PROCESS (CAR Score #2)

**Does the client experience any of the following:**

D Memory Difficulties

D Delusions

D Other/Comments:

D Difficulty Concentrating

D Hallucinations

D Poor Judgement

D Learning Disability

D Obsessions

D Poor Impulse Control

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## MENTAL STATUS REVIEW PER CLINICIAN

|  |  |
| --- | --- |
| **Appearance:** |  |
| D Neat | D Unkempt | 0 Older Than | D Younger Than |
| D Clean | D Poor Hygiene | D Underweight | D Overweight |
| D Eccentric | D Seductive | D Well Groomed |  |
| D Other: |  |  |  |
| **Orientation:** |  |  |  |
| OTime | D Person | D Place | D Situation |
| **Affect:** |  |  |  |
| D Appropriate | D Restricted | 0 Flat | D Detached |
| D Blunted | D Content | D Other: |  |
| **Mood:** |  |  |  |
| D Cooperative | OCalm | D Anxious | D Cheerful |
| D Depressed | D Irritable | D Fearful | D Suspicious |
| 0 Labile | D Tearful | D Hostile | D Dramatic |
| D EuphoricD Other: | 0 Angry | 0 Guilty | D Pessimistic |

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|  |  |
| --- | --- |
| **Speech:** |  |
| 0 Normal | D Pressured | D Rambling | D Tangential |
| D Loud | OSlow | 0 Rapid | D Slurred |
| 0 Other: |  |  |  |
| **Intellectual Assessment:** |  |  |  |
| D Above Average | 0 Average | 0 Below Average | 0 Possible MR |
| 0 Documented MR | D Other: |  |  |
| **Thought Content/Perception:** |  |  |  |
| D Within Normal Limits | D Delusions | D Disorganized | D Paranoid |
| D Grandiose | 0 Flight of Ideas | D Compulsive | D Obsessive |
| 0 Bizarre | D Homicidal | D Suicidal | 0 Auditory Hallucinations |
| D Visual Hallucinations | D Other: |  |  |
| **Insight:**□Good | D Fair | 0 Poor | D Blaming |
| D Superficial | D Lacking | D Other: |  |
| **Judgment:** |  |  |  |
| OGood | DFair | D Poor | 0 Lacking |
| D Other: |  |  |  |
| **Memory:** |  |  |  |
| D Impaired Recent | D Impaired Remote | D Intact | D Poor |
| 0 Other: |  |  |  |
| **Behavior/Motor Activities:** |  |  |  |
| D Normal | D Restless | D Tremors | 0 Alert |
| D Overactive | D Poor Eye Contact | D Tics | D Agitated |
| D Tense | D Slowed | D Manipulative | D Repetitious |
| 0 Destructive | D Other: |  |  |

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Sensory/Physical Disabilities:

D Within Normal Limits

D Other:

D Hearing Impaired D Visually Impaired D Physically Impaired

### SUBSTANCE USE & HISTORY (CAR Score #3)

D **Client has no current or historical Alcohol/Other Drug Use/Addiction.**

D **Alcohol/Drug Use is the primary reason for the referral for services.**

|  |  |
| --- | --- |
| D **Alcohol/Drug Use is NOT the primary reason for the referral for services, but is Present or in history.** |  |
| Does the client currently use alcohol, drugs, or tobacco? | D Yes | 0 No |
| Does the client believe current use is causing impairments in daily functioning? | D Yes | 0 No |
| Does the client have previous use of alcohol, drugs or tobacco? | D Yes | □No |
| Has the client ever received treatment for substance abuse? | D Yes | 0 No |
| Referral for community Alcohol/ Drug use for client or family needed? | D Yes | □No |
| Family's history of drug and/or alcohol abuse? | D Yes | □No |
| Other significant information: |  |  |

### MEDICAL/HEALTH INFORMATION (CAR Score #4)

Current Physical Health Status: D Good Current Co-Occurring/Health concerns:

D Fair D Poor

Health History:

Current Known Medications:

Does the client feel like these medications work well for you?

Medication Allergies or Adverse Reactions (Include Medication and Food):

D Yes

Primary Care Physician:

List any previous or current problems with sleep (Include falling asleep, staying asleep, sleeping inadequate number of hours, etc):

Is the client currently pregnant? Has the client ever been pregnant?

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D Yes

D Yes

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## DEVELOPMENTAL HISTORY

Did the client meet developmental milestones within appropriate time frames? Complications during pregnancy or delivery?

Substance use or abuse during pregnancy?

Other significant information:

□Yes

□Yes

0Yes

### FAMILY/MARITAL/PERSONAL HISTORY (CAR Score #5)

##### Are your parents(check all that apply):

□Alive

D Divorced

D Abusive

D Deceased

D Remarried

D Married

D Abandoned Family

D Separated

D Financial Issues

 

|  |  |  |
| --- | --- | --- |
| Family history of mental illness?Family history of learning disorders? |  | D YesD Yes |
| Describe client's current interactions with family members: |  |  |
| Does the client have any children: Other significant information: | 0 **N/A** |  |

## PHYSICAL ABUSE/DOMESTIC VIOLENCE

D Client does not present with anyreported historical or current experience/witness of physical abuse/domestic violence concerns.

Has the client ever been physically abused or witnessed such abuse?

Has the client ever been the victim of/witnessed a random act of violence? Has the client ever witnessed domestic violence?

Has the client ever assaulted, engaged in, or witnessed physical fights with others?

Has the client experienced/witnessed neglect from caregivers? Other significant information:

D Yes D Yes D Yes D Yes D Yes

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### INTERPERSONAL INTERACTIONS & SUPPORT (CAR Score #6)

Who does the client rely on for emotional and/or social support?

Does the client experience any difficulty with the following?

□NIA

D Making/Keeping Friends

D Peers/Friends

D Conflict

D Social Interaction

D Trusting Friends

D Withdrawal

|  |  |  |
| --- | --- | --- |
| Does the client experience conflict with adults or authority figures? | D Yes | □No |
| Does the client have friends or family in whom you can confide, or call upon for support? | D Yes | □No |
| Does the client have positive/satisfying relationships in your family? | D Yes | □No |
| Does the client have positive/satisfying relationships outside your family? | D Yes | □No |
| Does the client have negative/conflicting relationships in your family? | D Yes | □No |
| Does the client have negative/conflicting relationships outside your family? | D Yes | □No |
| Does the client ever abused another person/people? | D Yes | □No |
| Does the client have a history of abusing animals?Does the client have a history of starting fires? | D YesD Yes | □No0 No |
| Other significant information: |  |  |

## SEXUAL HISTORY

D **Client does not present with any reported historical or current experience/witness of sexual abuse, molestation, rape or other sexually traumatic events.**

Does the client have gender/sexual orientation or gender identity issues? Has the client ever been raped, sexually assaulted or witnessed such abuse? Has the client ever been sexually abused, molested or witnessed such abuse? Is the client currently sexually active?

Other significant information:

D Yes D Yes D Yes D Yes

### ROLE PERFORMANCE (CAR Score #7)

|  |  |
| --- | --- |
| Education level: |  |
| Can the client read/write on grade level? |  |  | D Yes | 0 | No |
| Are you currently enrolled in school? |  | D Yes | 0 No | 0 | **N/A** |
| Is the client on an IEP? |  |  | D Yes | 0 | No |
| Plans for future education: D None | D |  |  |  |  |



Is the client serving in the military?

Has the client had a family member serve in the military? Other significant information:

□Yes

D Yes

## EMPLOYMENT HISTORY

Is the client employed? D Unemployed D Part-time

|  |  |  |  |
| --- | --- | --- | --- |
| Are you experiencing any problems related to your job/daily tasks? | D | Yes | □No |
| Plans for future employment? | D Yes D | No | 0 N/A |
| Referral for work program needed? | D | Yes | □No |
| Other significant information: |  |  |  |

D Full-time 0 Disabled O In School

### LEGAUCRIMINAL HISTORY (CAR Score #8)

Does the client have current legal charges? Is the client on probation or parole?

List historical legal history, including incarceration dates, charges, probation information, etc:

D Yes

D Yes

Does the client have any difficulty with any of the following: **(check all that apply)**

D Following Rules/Laws D Authority Issues D Legal Issues

D Antisocial Behaviors

D Aggression

## CULTURAURELIGIOUS BELIEFS

Does the client have any cultural or religious beliefs that will be used to guide treatment services? Is the client involved in a church/religion?

Are the client's religious beliefs a significant factor in their life? Other significant information:

□Yes

□Yes

OYes

## COMMUNICATION

Does the client need to utilize any assistive technology in order to participate in services? Primary method of communication: D English D Other language

□Yes

D Sign Language



### SELF-CARE/BASIC NEEDS (CAR Score #9)

Current Community Supports Present within the Home:

□NIA 0DHS 0CHBS D Systems of Care

D Latino Development Agency D Other

Current Social Benefits Present within the Home:

□NIA

D Advantage program

D Worker's Comp

# oss1

D Section 81Housing

# osso1

0TANF

0 Food Stamps

D VA Benefits

Names and numbers of community support workers:

**How often are the following needs met for client:**

Basic needs: 0 All times D Most times □ Sometimes D Seldom 0 Never

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Food: | 0 | All times | 0 | Most times | □ Sometimes | D | Seldom | 0 | Never |
| Clothing: | 0 | All times | 0 | Most times | □ Sometimes | D | Seldom | 0 | Never |
| Stable housing: 0 All times 0 | Most times | 0 | Sometimes | D | Seldom | 0 | Never |
| Transportation: D All times 0 | Most times | 0 | Sometimes | D | Seldom | 0 | Never |

How are client's basic needs met?

How does the client describe their quality of life?

What needs to happen to improve client's quality of life?

Please list client's strengths and abilities:

Please list client's liabilities:

Please list client's needs:

Please list client's ability to connecUengage in the community:

Please describe client's hobbies, social activities, etc.:

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#### ASSESSMENT CONCLUSIONS/INTERPRETATIONS

Urgent needs identified within assessment: D Yes

#### DIAGNOSTIC IMPRESSIONS

Medical Notes:

Axis IV Psychosocial and Environmental Problems:

D Primary Support Group

D Social Environment

D Educational D Occupational D Housing

D Economic

D Health Care Services DLegal System/Crime D Other Problems

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Axis V GAF Past Year: Current:

Clinical TreatmenUService Disposition:

Date

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