Initial Assessment

Community Counseling Services

Rev 01/17

Case Name _____

Case Id# _____

Admission/Assessment Date _____

Service Code _____ **Time In:** _____ **Time Out:** _____ **Total Time:** _____

Informant: ❑ Individual receiving services ❑Other Relationship to individual: _____

Does the person seeking service have an Outpatient Commitment Order? ❑**Yes** ❑**No**

Guardianship Information

Name of Guardian/Custodian:	Guardianship Documentation Verified: ❑**Yes** ❑**No**
Guardian/Custodian Address:	Guardian/Custodian Phone Number:

Is the family involved with the Department of Human Services? ❑**Yes** ❑**No**

If yes, has a consent to release information been obtained? ❑ ***Yes*** ❑ ***No***

If yes, please explain and indicate the name of the assigned case worker: _____

Confidentiality

Were the limits of confidentiality reviewed with individual and/or Guardian? ❑**Yes** ❑**No**

If NO, Please explain.

Description of Need

What is your reason for seeking services today? *(Onset, possible causes, duration, intensity & fluctuations of severity) Include a description/perception of difficulties according to the individual seeking services and any applicable family members/legal guardian.*

Are you having any suicidal thoughts at this time? ❑**Yes** ❑**No**

If yes, please explain and conduct a crisis assessment to determine level of severity)

Attempts of Suicide? ❑**Yes** ❑**No** *If yes, please explain and conduct a crisis assessment to determine level of severity)*

Are you having any homicide thoughts at this time? ❑**Yes** ❑**No** ***(indicate the need for "duty to warn")***

If yes, please explain and conduct a crisis assessment to determine level of severity)

Acts of Self-Harm? ❑**Yes** ❑**No**

If yes, please explain *and conduct a crisis assessment to determine level of severity)*

What specific needs do you currently have?

Is the reason for seeking services today related to substance use? ❑**Yes** ❑**No**

If yes, the substance use specific assessment must also be completed.

What previous coping skills have been helpful in the past?

Developmental History

Developmental History (Children & Youth up to age 21 and everyone with IDD):

During pregnancy ,did mother use alcohol or other drugs ☐ No ☐ Yes

if yes, indicate which ☐ alcohol ☐ cigarettes ☐ prescription medication ☐ illegal drugs

Describe any problems with the pregnancy or birth

Were there any developmental issues : ☐ No ☐ Yes *if yes, please explain*

Describe any childhood accidents or injuries:

Education (children & youth up to age 21)

Name of School attending _____

Does child/youth receive Special Education Services?

☐ *Yes (if yes, complete release of information to obtain a copy of the current Individualized Education Plan (IEP))*

☐ *No*

List all additional educational services child is receiving :

Any repeated Grades ☐ No ☐ Yes Explain:

Suspensions/Expulsions? ☐ No ☐ Yes Explain:

Learning Preferences/styles: Written material ☐ No ☐ Yes Video ☐ No ☐ Yes One on One instruction ☐ No ☐ Yes

Barriers to Learning ☐ Vision ☐ Hearing ☐ Language ☐ Confusion ☐ Other

Educational Issues/Needs (grades, attendance)

Employment (adults only)

Are you employed? ☐ Yes ☐ No

If no, do you want to be employed?

Employment Barriers/Related Needs?

Current Legal Status

Has the individual been involved with the legal system within the past twelve months? ☐ Yes ☐ No

Arrests: ☐ Yes ☐ No *If yes, indicate type and number of arrest(s):*

Number of arrests in the past 30 days:

Pending Charges: Yes No *If yes, indicate type and number of pending charges:*

Substance Use Related Legal Issues:

Is this person currently on parole and/or probation? ☐ Yes ☐ No

If applicable, indicate to whom reports should be submitted: _____

Medical History *(Record current medications on the Medication/Emergency Contact Information form):*

Allergies (food, plant, medication, etc.) ☐ ***No*** ☐***Yes*** ***Explain:***

Surgeries & dates ☐ ***No*** ☐***Yes*** ***Explain:***

Special diets ☐ ***No*** ☐***Yes*** ***Explain:***

Appetite issues or problems ☐ ***No*** ☐***Yes*** ***Explain:***

Sleep issues or problems☐ ***No*** ☐ ***Yes*** ***Explain:***

Additional Medical History or Health and Safety Issues: ☐ ***No*** ☐***Yes*** ***Explain:***

Any Health-Related Needs: ☐ ***No*** ☐ ***Yes*** ***Explain:***

Additional Medical Information:

Primary Physician or Medical Clinic:

_____

Pharmacy: _____

Referred to Physician? ☐Yes ☐No ***if not, explain***:_____

Current or Chronic Medical Diseases *(check all that apply)*

☐ Diabetes ☐ Heart Disease ☐ Hypertension ☐ Seizures ☐ Arthritis ☐ Ulcer/Gastrointestinal ☐ Cancer

☐ Hepatitis ☐ Glaucoma ☐ Tuberculosis ☐ Thyroid ☐ Sickle Cell ☐ Other _____ ☐ Other _____

Family Medical Diseases *(check all that apply)*

☐ Diabetes ☐ Heart Disease ☐ Hypertension ☐ Seizures ☐ Arthritis ☐ Ulcer/Gastrointestinal ☐ Cancer

☐ Hepatitis ☐ Glaucoma ☐ Tuberculosis ☐ Thyroid ☐ Sickle Cell ☐ Other _____ ☐ Other _____

Previous Assessment

Have psychological, Education or Functional assessments been completed in the last twelve months? No ☐

☐Yes (if yes, complete release of information to obtain a copy of the applicable assessment)

If yes, indicate the type of assessment below:

Mental Health History

Previous psychiatric issues **No** ☐ **Yes** ☐ **Explain:**

Family history of Psychiatric Disorder(s) **No** ☐ **Yes** ☐ **Explain:**

Family history of Substrance Use Disorder(s) **No** ☐ **Yes** ☐ **Explain:**

Other counseling and/or therapeutic experiences **No** ☐ **Yes** ☐ **Explain:**

Previous or Current Diagnoses:

Mental Heatlh Needs:

Outpatient Behavioral Health Agency

☐ None Reported

Treatment Agency	Services Received	Dates of Service	Has Consent to Release Information Been Requested?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Psychiatric Hospitalizations/Residential Treatment

☐ None Reported

Treatment Agency	Services Received	Dates of Service	Has Consent to Release Information Been Requested?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Social/Cultural History: *(Note or Describe as appropriate)*

Immediate household/family configuration

Marital status/history

Relationship with spouse or partner

Relationship with parents

Relationship with children

Relationship with siblings

Other family support

Interpersonal Relationship Patterns

Family and Social support available

Meaningful Activities, Cultural/Ethnic/Spiritual interests, Supports: *(Address hobbies, leisure activities etc.)*

Current Living Arrangements (*strengths and concerns*)? What are your views of your current arrangements?

Needs Related to Living Situation: (*money management, benefits, living arrangements, clothing, personal care, child care, rent, other)*

Initial Behavioral

Speech:	❑Appropriate	❑Slowed	❑Mechanical	❑Rapid	❑Other	
Behavior:	❑Appropriate	❑Withdrawn	❑Bizarre	❑Volatile	❑Other	
Appearance:	❑Appropriate	❑Disheveled	❑Unclean	❑Inappropriately dressed		❑Other
Mood:	❑Appropriate	❑Manic	❑Depressed	❑Labile	❑Irritable	❑Other
Affect:	❑Appropriate	❑Flat	❑Labile	❑Other		
Oriented to:	❑Time	❑Place	❑Situation	❑Person	❑Other	
Thought Content:	❑Appropriate	❑Incoherent	❑Obsessive	❑Other		
Memory:	❑Appropriate	❑Repressed	❑Confused	❑Other		
Intelligence:	❑Average	❑Above Average	❑Below Average			
Delusion	❑None	❑Paranoid	❑Other			
Description:_____						
Hallucination	❑None	❑Auditory	❑Visual	❑Tactile	❑Other	
Description:_____						
Judgment/Insight	❑Appropriate	❑Impaired	❑Suicidal	❑Homicidal	❑Other	

Summary/Recommendations

Health:

Home:

Community:

Purpose:

Other:

Additional Comments:

Indication of Functional Limitation(s): (*Check Major Life Areas Affected*)

	Basic living skills (eating, bathing, dressing, etc.)
	Instrumental living skills (maintain a household, managing money, getting around the community, taking prescribed medications, etc.)
	Social functioning (ability to function within the family, vocational or educational function, other social contexts, etc.)

Initial Diagnostic Impression

	DSM V Codes	ICD10 Codes	Description
Dx 1			
Dx 2			
Dx 3			
Dx 4			
Dx 5			
Dx 6			
Dx 7			

Signature/Credentials _____ Date _____

Physician/Clinical Psychologist/Nurse Practitioner, LCSW, LMFT,PA, Alzheimer's Day Program Supervisor, LPC _____ Date _____

Supervisor's Signature *(if applicable)* _____ Date _____