

4. **Psychiatric Treatment History:** *(Include past and present inpatient/outpatient treatments and compliance)*

5. **Medical History:** *(Include medical, developmental issues and co-morbid conditions – treatment and compliance)*

Medication	Dosage	Frequency	Prescriber

6. **Family History:** *(Include family medical, psychiatric, developmental, legal issues, and attitude towards recipient)*

7. **Environmental Stressors, Family and Community Support**

8. **Academic** *(Include school performance, special accommodations, learning and behavioral issues)* **and Employment History**

9. **Legal Issues**

10. **Addiction Issues** *(if indicated, client must be evaluated using the SUBSTANCE ABUSE ASSESSMENT by a qualified addiction counselor)*

11. **Habits, Strengths, and Weaknesses** *(Include recipient's attitude towards treatment, desire to change and willingness for intervention)*

12. **Physical, Behavioral And Mental Status Examination**

Appearance	Eye Contact	Interaction	Speech	Mood	Affect	Consciousness
<input type="checkbox"/> Appropriate	<input type="checkbox"/> Good	<input type="checkbox"/> Engaged	<input type="checkbox"/> Normal	<input type="checkbox"/> Calm	<input type="checkbox"/> Appropriate	<input type="checkbox"/> Alert
<input type="checkbox"/> Overweight	<input type="checkbox"/> Fair	<input type="checkbox"/> Withdrawn	<input type="checkbox"/> Soft	<input type="checkbox"/> Remorseful	<input type="checkbox"/> Blunted	<input type="checkbox"/> Confused
<input type="checkbox"/> Underweight	<input type="checkbox"/> Poor	<input type="checkbox"/> Demanding	<input type="checkbox"/> Loud	<input type="checkbox"/> Sad	<input type="checkbox"/> Labile	<input type="checkbox"/> Distracted
<input type="checkbox"/> Bizarre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Rapid	<input type="checkbox"/> Angry	<input type="checkbox"/> Euphoric	<input type="checkbox"/> Lethargic
<input type="checkbox"/> Disheveled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Anxious	<input type="checkbox"/> Euthymic	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hostile	<input type="checkbox"/>	<input type="checkbox"/>

Recipient Name:

ID#:

Sensory Oriented to	Concentration	Memory	Thought Process	Delusions	Hallucination	Insight/Judgment
<input type="checkbox"/> Person	<input type="checkbox"/> Focused	<input type="checkbox"/> No impairment	<input type="checkbox"/> Appropriate	<input type="checkbox"/> Persecutory	<input type="checkbox"/> Auditory	<input type="checkbox"/> Good
<input type="checkbox"/> Place	<input type="checkbox"/> Pre-occupied	<input type="checkbox"/> Recent	<input type="checkbox"/> Circumstantial	<input type="checkbox"/> Paranoid	<input type="checkbox"/> Visual	<input type="checkbox"/> Impaired
<input type="checkbox"/> Time	<input type="checkbox"/> Short Attention	<input type="checkbox"/> Remote	<input type="checkbox"/> Tangential	<input type="checkbox"/> Grandiose	<input type="checkbox"/> Somatic	<input type="checkbox"/> Poor
<input type="checkbox"/> Situation	<input type="checkbox"/> Easily distracted	<input type="checkbox"/>	<input type="checkbox"/> Loose	<input type="checkbox"/> Denied	<input type="checkbox"/> Olfactory	<input type="checkbox"/>
<input type="checkbox"/> Future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Tactile	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Denied	<input type="checkbox"/>

Details:

13. Current Risk Factors: (Check all items that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Suicidal ideation with NO plans/attempts | <input type="checkbox"/> Dangerous behavior that places self/others at risk | <input type="checkbox"/> None |
| <input type="checkbox"/> Suicidal ideation with plans/attempts | <input type="checkbox"/> Patient on high dosage of anxiety/pain medication | <input type="checkbox"/> Physical abuse (by others) |
| <input type="checkbox"/> Homicidal ideation with NO plans/attempts | <input type="checkbox"/> Medical condition complicating mental health | <input type="checkbox"/> Physical abuse (to others) |
| <input type="checkbox"/> Homicidal ideation with plans/attempts | <input type="checkbox"/> Unable to care for self / personal neglect | <input type="checkbox"/> Sexual abuse (by others) |
| | | <input type="checkbox"/> Sexual abuse (to others) |

Explain Details:

14. Current Functioning: (Include recipient's ability to function daily in relation to school/work, peers, family, daily living, etc.)

DSM DIAGNOSIS

Diagnosis Code	Narrative Description	Diagnosis Code	Narrative Description
1)		2)	
3)		4)	

DC: 0-3 DIAGNOSIS If recipient is age 0-3 only

DC: 0-3 Code	Narrative Description	DC: 0-3 Code	Narrative Description
1)		2)	

ASSESSMENT	Score:	Level	Date:	Clinical Assessor	Credential
<input type="checkbox"/> CASII <input type="checkbox"/> LOCUS					
If CASII or LOCUS score > 19, please submit scoring sheet with this assessment.					
Other Assessment (specify): <input type="checkbox"/>					

SED/SMI DETERMINATION Yes No If yes, state your rationale here (or identify field reference # above), and submit the SED/SMI determination forms with this Mental Health Assessment. If you need blank SED/SMI forms, please contact HBI at (702) 248-8866.

RECOMMENDATION • TREATMENT GOALS/PLAN

Targeted Symptoms	Treatment Goal	Treatment Plan/Approach	Projected Date of Resolution
1)			
2)			
3)			
4)			
5)			

Recipient Name:

ID#:

