MENTAL HEALTH ASSESSMENT UPDATE

1. **Identifying Information** (age, gender, ethnicity, preferred language, relationship status, sexual orientation, gender identity, living arrangement): ______________________________

2. **Current Mental Health Problem** (current symptoms, behaviors, and stressors): ______________________________

3. **Treatment Update** (since last assessment; include successes and setbacks, progress toward treatment goals, transition plan): ______________________________

4. **Cultural Factors** (e.g., ethnicity, immigration, acculturation, language, religion, sexual orientation, etc.): ______________________________

   Do any cultural factors affect client's treatment? YES ☐ NO ☐
   If yes, describe:

Client's Name: ______________________________

Unicare #: ______________________________

Program (Cost Center): ______________________________

5. **Client Strengths** (e.g., skills, personality traits, intelligence, resiliency, insight, etc.): ______________________________

6. **Current Medical Status** (medical conditions, medication, primary care physician):______________________________

7. **Current Substance Use** (e.g., alcohol, stimulants, sedatives, hallucinogens, nicotine, caffeine, OTC, etc.):

8. **Mental Health History** (onset, symptoms, previous treatment):______________________________

9. **Psychosocial History** (prenatal, childhood, family, social relationships, education, vocation, inter-agency):__________________

Client's Name:______________________________

Unicare #:______________________________

Program (Cost Center): ______________________________

10. **Risk Factors** (CHECK ALL THAT APPLY):

Yes		If yes, please explain:
☐	Homicidal/Assaultive	
☐	Suicidal/Self-Harm	
☐	Access to Weapons	
☐	Trauma	
☐	Neglect/Abuse	
☐	Domestic Violence	
☐	Legal Issues	
☐	Crime/Gang Involvement	
☐	Runaway	
☐	Inappropriate/Risky Sexual Behavior	
☐	Substance Use/Abuse	
☐	Cognitive Impairment	
☐	Cultural Isolation	
☐	Potential for Victimization	
☐	Risk of Homelessness	

Comments: ____

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11. **Mental Status Exam** (CIRCLE ALL THAT APPLY):

Appearance:	clean	well-groomed	disheveled	bizarre	malodorous		
Motor:	normal	decreased	agitated	tremors	tics	repetitive	impulsive
Behavior:	cooperative	evasive	uncooperative	threatening	agitated	combative	guarded
Consciousness:	alert	lethargic	stuporous				
Orientation:	person	place	time: [day month year]		current situation		
Speech:	normal	slurred	loud	pressured	slow	mute	
Affect:	appropriate	labile	restricted	blunted	flat	congruent	incongruent
Mood:	normal	depressed	anxious	euphoric	irritable	congruent	incongruent
Thought Process:	coherent	tangential	circumstantial	loose	paranoid	concrete	
Delusions:	persecutory	grandiose	referential	somatic	religious		
Hallucinations:	auditory	visual	olfactory	gustatory	tactile		
Intellect:	average	above average	below average				
Memory:	good	poor recent	poor remote	confabulation			
Insight:	good	fair	poor	limited			
Judgment:	good	fair	poor	unrealistic	unmotivated	uncertain	

Comments/Additional Information: ____

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Client's Name:______________________

Unicare #:______________________

Program (Cost Center): ______________________

12. **Medical Necessity Criteria:**

a. Impairment

☐	**Area [**Check all that apply]	Brief description of impairment (if checked):
	Health [e.g., physical condition, activities of daily living]	
	Daily Activities [e.g., work, school, leisure]	
	Social Relationships [e.g., significant other, family, friends, support system]	
	Living Arrangement [e.g., homeless, maintaining current housing situation]	

b. Diagnosis Summary

The name of the disorder according to DSM 5 classification followed by the numerical ICD-10 code and description. Example:(Primary) DSM 5: Major Depressive Disorder, Moderate. ICD-10: F33.2, Recurrent Depressive Disorder, Current Episode Moderate.

Each diagnosis must be stated clearly and legibly, and primary and secondary diagnosis (if applicable) must be identified. Please follow the State guidelines for primary and secondary diagnoses for mental health clients. *(Please note that each diagnosis given and documented in this section must be substantiated and supported by symptoms, behaviors, and functional impairments in the assessment form under the appropriate sections, usually under presenting problems and medical necessity.)*

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Client's Name:____

Unicare #:____

Program (Cost Center): _____________________________________

13. **Mental Health Conclusions/Narrative Summary:**

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Person completing Assessment:

______________________	______________________	______________________
Signature	Discipline	Date

Review/Approval by Licensed Professional of the Healing Arts (if different from above):

______________________	______________________	______________________
Signature	Discipline	Date

See progress note dated __________________ for additional assessment information.

Client's Name:____
Unicare #:____
Program (Cost Center): __________________________________