PSYCHIATRIC ASSESSMENT
(For use by MD's only)

1. **IDENTIFYING INFORMATION** (age, grade in school, sexual orientation, gender identity):

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____
____
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Source of Referral:

☐ Call Center ☐ Hospital ☐ School/Ch.26.5 (AB3632)
☐ Healthy Families/Healthy Kids ☐ Self/Family ☐ Other

Comments**:** ____

Gender: ☐ Male ☐ Female ☐ Other ☐ Unknown

Comments: ____

Marital Status: ☐ Married ☐ Single ☐ Divorced/Separated ☐ Widowed ☐ Cohabitating ☐ Other

Comments: ____

Living Arrangement: ☐ Self ☐ Foster Family ☐ Board and Care ☐ Shelter ☐ With Parents/Guardians ☐ Juvenile Hall/Ranch ☐ Extended Family ☐ Other ☐ Homeless

Comments: ____

Ethnicity: ☐ White ☐ Black/African American ☐ Vietnamese ☐ Latino/Hispanic ☐ Cambodian ☐ Filipino ☐ Chinese ☐ Other

Comments: ____

Preferred Language: ☐ English ☐ Vietnamese ☐ Spanish ☐ Tagalog ☐ Cantonese ☐ Mandarin ☐ Other

Comments: ____

Legal Status: ☐ Voluntary ☐ Guardian ☐ Conservatorship ☐ Ward of Court ☐ Other

Comments: ____

2. **PRESENTING PROBLEM** (current symptoms, behaviors, stressors, duration, severity):

____
____
____

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

Constitutional Symptoms:	Present	Past
Sleep Disturbance	☐	☐
Appetite/Weight Change	☐	☐
Concentration Disturbance	☐	☐

Comments: ____

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Mood Symptoms:	Present	Past
Normal Range	☐	☐
Depression	☐	☐
Mood Instability	☐	☐
Anxiety	☐	☐
Irritability	☐	☐
Dysphoria	☐	☐
Other	☐	☐

Comments: ____

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Suicidality/Homicidality:	Present	Past
Suicidal Ideation	☐	☐
Suicidal Behaviors	☐	☐
Homicidal Ideation	☐	☐
Harm to Others	☐	☐
Other	☐	☐

Comments: ____

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Psychotic Symptoms:	Present	Past
Thought Disorder	☐	☐
Delusions	☐	☐
Negative Symptoms	☐	☐
Hallucinations	☐	☐
Command Hallucinations	☐	☐
Other	☐	☐

Comments: ____

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	Present	Past
Anxiety Symptoms:		
Generalized Anxiety	☐	☐
Panic Attacks	☐	☐
Phobias	☐	☐
Obsessions/Compulsions	☐	☐
Other	☐	☐

Comments: ____

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	Present	Past
Eating Disorder Symptoms:		
Binge Eating/Purging Behaviors	☐	☐
Anorexia	☐	☐
Amenorrhea	☐	☐
Other	☐	☐

Comments: ____

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	Present	Past
Trauma/Abuse:		
Physical Abuse	☐	☐
Sexual Abuse	☐	☐
Emotional Abuse	☐	☐

Comments: ____

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	Present	Past
Relationship Problems:		
With Family/ Spouse/Parents	☐	☐
With Peers/Co-workers	☐	☐
With Authorities	☐	☐
With Others	☐	☐

Comments: ____

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	Present	Past
Cognitive Disturbances:		
Yes	☐	☐
No	☐	☐

Comments: ____

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Client's Name:______________________________

Unicare #:______________________________

Program (Cost Center): ______________________________

	Present	Past
Attention Disturbances:		
Inattention/Hyperactivity	☐	☐
School Problems	☐	☐
Other	☐	☐

Comments: ____

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	Present	Past
Developmental disorder:		
Autism	☐	
MR	☐	

Comments: ____

	Present	Past
Enuresis/Encopresis		
Yes	☐	☐
No	☐	☐

Comments: ____

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	Present	Past
Outpatient Treatment	☐	☐
Inpatient Treatment		☐
Regional Center		☐

Comments: ____

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3. **SUBSTANCE USE HISTORY** (e.g., alcohol, stimulants, sedatives, hallucinogens, nicotine, caffeine, inhalant, prescription etc.):

Type	Date of Last Use	Amount of Last Use	Frequency and Amount of Use	Length of Time Using	Age of First Use

DUI: ☐ No ☐ Yes # of times ____

Other Involvement: ☐ DADS ☐ Drug Tx Court ☐ Residential ☐ Community Tx e.g., AA

Treatment/Recovery History: ____

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Comments: ____

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Client's Name:______________________________

Unicare #:______________________________

Program (Cost Center): ______________________________

4. **FAMILY HISTORY:**

Medical History: ☐ Previous Surgery ☐ Cancer ☐ Diabetes ☐ Neurological ☐ Endocrine Problem ☐ Cardiovascular Disease ☐ Other

Comments: ____

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Psychiatric History ☐ Mood Disorders ☐ Anxiety Disorders ☐ Psychotic Disorders ☐ Substance Abuse ☐ Suicidality ☐ Harm to others ☐ Cognitive Disorders ☐ Other

Comments: ____

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5. **PSYCHOSOCIAL:**

Nature of Relationships (e.g., supportive, amicable, abusive):

Spouse/Partner ____

Parents ____

Siblings ____

Children ____

Extended Family ____

Friends ____

Other ____

(e.g., coworker, roommate etc.)

Comments**:**____

____

Past Living Arrangement: ☐ Homeless Shelter ☐ Family ☐ Assisted Living/Board & Care ☐ Children Shelter ☐ Foster Care ☐ Other

Comments: ____

____

Cultural Issues affecting Treatment:

☐ See Case Manager's Assessment

Comments**:** ____

____

Education: Current Grade _____ Graduated High School ☐ Yes ☐ No

Higher Education ☐ Yes ☐ No Special Ed ☐ Yes ☐ No

Comments: ____

____

Employment/Source of income:

Currently Employed ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Volunteer

Client's Name:____

Unicare #:____

Program (Cost Center): ____

☐ General Assistance

☐ SSI: ☐ Own Payee ☐ Rep. Payee ☐ Conserved

Comments: ____

____

Legal History: ☐ Previous Arrests/Incarceration ☐ Probation ☐ Parole ☐ Delinquencies

Comments: ____

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Inter-Agency Involvement: ☐ JPD ☐ Conservator ☐ Criminal Justice ☐ DFCS ☐ Other

Comments: ____

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6. **MEDICAL HISTORY** (Does the individual report any of the following? Check all that apply and describe below.):

☐ No major medical conditions

Primary Care Physician: ☐ Yes ☐ No

Name: ______________________ Phone #: ______________________

☐ Motor Vehicle Accidents

☐ Allergies/ Adverse reaction to meds ☐ OB-GYN problems ☐ Previous Surgery ☐ Birth Defects

☐ Head injury ☐ Respiratory problems ☐ Cancer ☐ Chronic pain

☐ Kidney disease ☐ Other

☐ Cardiovascular problems:

☐ Hypertension ☐ Arrhythmia ☐ Hyperlipidemia ☐ Stroke

☐ Infectious Diseases:

☐ Hepatitis Type: ____ ☐ HIV ☐ TB ☐ Parasites/scabies/lice ☐ STD

☐ Neurological:

☐ Head Injury/Loss of consciousness ☐ Seizures ☐ Stroke

☐ Endocrinological:

☐ Diabetes ☐ Thyroid problems

☐ Ophthalmological:

☐ Glaucoma ☐ Cataract

Comments: ____

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____

Lab Results: ☐ In Medical Chart Section ☐ Not Applicable

Ht: ______ Wt:______ ☐ Measured ☐ Patient Reported

Client's Name:______________________

Unicare #:______________________

Program (Cost Center): ______________________

Medications include prescribed, over-the-counter, alternative or herbal remedies:

Medication	Dosage	Date Started	OTC (y/n)	Reported Side Effects

Are there any medication compliance issues? YES ☐ NO ☐
Describe:

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7. **MENTAL STATUS EXAM** (CIRCLE ALL THAT APPLY):

Appearance:	well-groomed	bizarre	malodorous	disheveled		
Motor:	normal	decreased	hyperactive	tremors	tics	repetitive
Behavior:	cooperative	uncooperative	threatening	agitated	combative	guarded
Consciousness:	alert	lethargic				
Orientation:	x4	person	place	time:	[day/month/ year]	current situation
Speech:	fluent	dysarthric	loud	pressured	slowed	mute
Affect:	congruent	labile	restricted	blunted	flat	incongruent
Mood:	euthymic	depressed	anxious	euphoric	dysphoric	irritable
Thought Process:	directable	tangential	circumstantial	loose	concrete	organized

Thought Content:

Delusions:	persecutory	grandiose	referential	somatic	religious	erotomanic
Hallucinations:	auditory	visual	olfactory	gustatory	tactile	
Homicidal Ideations:	passive	intent	plan			
Suicidal Ideations:	passive	intent	plan			
Confabulation	☐ Yes	☐ No				
Obsessions	☐ Yes	☐ No				

Intellect:	average	above average	below average
Memory:	good	poor recent	poor remote
Insight:	good	fair	poor
Judgment:	good	fair	poor

Comments/Additional Information: ________________________________

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Client's Name:______________________________

Unicare #:______________________________

Program (Cost Center): ______________________________

8. 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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Comments: ____

9. **PLAN (e.g., Bio/Psycho/Social Approach):**

If no PCP, then referral made? ☐ Yes ☐ No

If yes, to whom? ____

Obtained and Reviewed Lab ☐ Yes ☐ No

Describe: ____

Client's Name: ______________________

Unicare #: ______________________

Program (Cost Center): ______________________

Assessment Summary and Informed Consent

- ☐ I reviewed the potential risks, benefits and alternatives to the recommended treatment, and the risks of not complying with treatment with the patient/client.
- ☐ I reviewed the emergency contact procedures with the client.
- ☐ Suicide/homicide risk assessment – positive – plan of action noted in chart.
- ☐ Suicide/homicide risk assessment – negative
- ☐ The client appears to understand and agrees with the treatment plan.

____ _______________________________

Signature/Credential Date

For additional assessment information, see progress note dated ___________________________