CONTRA COSTA HEALTH
MENTAL HEALTH SERVICES

# Clinical/ Psychiatric Assessment

This form may be used for clients of any age.

NAME / MRN _____

Facility Name: _____ ID: _____ Program Name: _____ ID: _____

Provider: _____ ID: _____ Service Date: _____

**Service Category:**

☐ CPT/HCPC Service Provided ☐ Lockout - CPT/HCPC Service Provided

Direct Service Time (Min): _____ Documentation Time (Min): _____ Travel Time (Min): _____

Number in Group: _____ CPT/HCPC Code: _____ Quantity: _____

**Location of Service (**Please check one)

| | | |
|---|---|---|
| ☐ Age-Specific Community Center | ☐ Homeless/Emergency Shelter | ☐ Phone–provided other than in client's home |
| ☐ Client's Job Site | ☐ Inpatient | ☐ Residential Care - Adults |
| ☐ Correctional Facility | ☐ Mobile Service | ☐ Residential Care - Children |
| ☐ Faith-Based | ☐ Non-Traditional service location | ☐ School |
| ☐ Field | ☐ Office | ☐ Telehealth/Video-provided in client's home |
| ☐ Health Care/Primary Care | ☐ Other Community Location | ☐ Telehealth/Video-provided other than in Client's home |
| ☐ Home | ☐ Phone–provided in client's home | ☐ Unknown/Not Reported |
| ☐ Nontraditional Location | ☐ Other _____ | ☐ Unknown |

**Did this service involve interactive complexity? ☐ Yes ☐ No**

**Was an Interpreter used? ☐ Yes ☐ No** Name of Interpreter: _____

**Language**

Language service provided in other than English: ☐ Spanish ☐ Other _____

**Is the client pregnant? ☐ Yes ☐ No (If yes, please document how service was pregnancy-related)**

**EBP/Service Strategies:**

| | | |
|---|---|---|
| ☐ Assertive Community Treatment | ☐ Therapeutic Foster Care | ☐ In Partnership w/ Health Care |
| ☐ Supportive Employment | ☐ Multisystemic Therapy | ☐ In Partnership w/ Social Services |
| ☐ Supportive Housing | ☐ Functional Family Therapy | ☐ In Partnership w/ SA Services |
| ☐ Family Psychoeducation | ☐ Peer/Family Delivered Services | ☐ Integrated Services for MH/Aging |
| ☐ Integrated Dual Diagnosis Treatment | ☐ Psychoeducation | ☐ Integrated Services for MH/DD |
| ☐ Illness Management and Recovery | ☐ Family Support | ☐ Ethnic-Specific Service Strategy |
| ☐ Medication Management | ☐ Supportive Education | ☐ Age-Specific Service Strategy |
| ☐ New Generation Medications | ☐ In Partnership w/ Law Enforcement | ☐ Unknown Service Strategy |

**(COUNTY STAFF ONLY) Evidence-based practice/tracking program? ☐ Yes ☐ No Program** _____

**This service was provided via telehealth with the consent of the client or authorized representative.** ☐

Referred By: _____

NAME / MRN

**Identifying Information**

Legal Name: _____ Age: _____ DOB: _____

Preferred Name: _____

**Gender**
☐ Male ☐ Female ☐ Transgender F-M ☐ Transgender M-F ☐ Nonbinary ☐ Other _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Widowed

Address: _____

Phone #: _____

Emergency Contact: _____ _____
Name Phone number

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**Client Information**

Entitlements: ☐ M/C ☐ Medicare ☐ BHC ☐ Other Health Care Info _____
☐ No Health Insurance Coverage
☐ SSI ☐ SSDI Payee: _____

Monthly Income _____ Refer to a Financial Counselor? ☐ Yes ☐ No

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**Living Situation** ☐ Independent Living ☐ Immediate Family ☐ Extended Family ☐ Shared Housing ☐ Board & Care ☐ Residential Care Facility ☐ **Homeless** ☐ Other

Support System Contacts: _____

Other Agencies Involved: ☐ CC Provider Network ☐ CFS/APS ☐ Voc Services ☐ AOD ☐ Regional Center ☐ Homeless Services

☐ Other _____

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**Presenting Problem:** What is the primary reason for current referral? Describe current precipitating event, primary stressors, primary symptoms, and functional impairment.

NAME / MRN

**Functional Impairments:**

**Mental Status Examination:** (appearance, mood, affect, attitude, thought process and content, sensorium, attention, memory, insight)

**Behavioral Health and Treatment History:** (Past mental health conditions; inpatient/outpatient treatment; psychiatric medications)

**Substance Use:** (Use and related problems over the past 12 months. If an Initial assessment, full history)

**Medical History/Allergies/Medications:**

NAME / MRN

**Psychosocial Factors:** (Relevant family background, current family information, living situation, social support, work and school, cultural and linguistic factors, sexual orientation, and gender identity)

**Strengths, Criminal Justice History, Risk Assessment:**

**Clinical Summary:** (including whether client meets medical necessity for specialty mental health services)

**Current Diagnosis:**

Primary
ICD-10 Code: _____ DSM-5 Narrative: _____

Secondary
ICD-10 Code: _____ DSM-5 Narrative: _____

**Recommendations, Plan, Referrals:**

NAME / MRN

**Is this late documentation?** ☐ Yes ☐ No

| Staff Signature/License | Printed Name | Date |
|---|---|---|
| Co-Signature of Licensed Clinician | Printed Name | Date |

Data Entry Clerk Initials