Annual Clinical Assessment - Clients Age 21 and Above

NAME / MRN

Billing Information

Program Name:____ Fac/Prog:______________ Date: __________

Staff #: __________________ Hours: ______ Mins: _____ Code Activity: ☐ **331** Assessment ☐ **580** Lockout

Travel Time To/From included in above (if applicable) Hrs ______ Mins ______

Location of Services: (Please check one)

☐ Office	☐ School	☐ Faith-Based	☐ LicCommCarefac (adult)	☐ Telehealth – Pt Home
☐ Field	☐ Cor Fac	☐ Healthcare	☐ Mobile Service	☐ Telehealth – Other than Pt Home
☐ Phone	☐ Inpatient	☐ Age-spec Com ctr	☐ Non Trad Svc Loc	☐ Other _______________________
☐ Home	☐ Homeless/shelter	☐ Client's job site	☐ Res Tx Ctr (child)	☐ Unknown

Service Strategies: (Please check up to three, if applicable)

☐ 50 Peer/Fam Deliv Svcs	☐ 53 Supportive Education	☐ 56 Ptnrshp: Soc Svcs	☐ 59 Integrated Svcs: MH-Dvlp Disabled
☐ 51 Psych Education	☐ 54 Prtnrshp: Law Enfcmt	☐ 57 Ptnrshp: Subs Abuse	☐ 60 Ethnic-Specific Service Strategy
☐ 52 Family Support	☐ 55 Ptnrshp: Health Care	☐ 58 IntSvcs : MH / Aging	☐ 61 Age-Spec Svc Strategy ☐ 99 Unknown

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

☐ **Interpreter** Name of Interpreter: ____

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

Identifying Information:

Name:____ Age:_____ DOB:___________

Address:____ Phone________________________

Emergency Contact/Name & Phone: ____

MH Provider: ____

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

Current Mental Health Functioning: (Include current symptoms, improvements in functioning, ongoing functional impairments, hospitalizations and other pertinent changes in past year.)

Strengths:

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Family/Social/Economic Update: (Include living situation, income, socialization, work or educational activity, judicial involvement, support system and any changes in life circumstances.)

CHECK THIS BOX IF CLIENT IS HOMELESS ☐

Current Medical Status:

Primary Care Provider:	Last Physical Exam:	Last Dental Exam:
Psychiatrist	Location	
List all Medical Conditions:		
Allergies/Drug Reactions:		
Med Compliant? ☐ Yes ☐ No ☐ Unknown List name of medication(s) client is taking at this time. (List all current meds including OTC, herbal, and homeopathic. Include start date/dose/frequency.)		

Current Substance Use:

☐ No Substance use ☐ Actively Using Substances ☐ Currently Clean & Sober for: ____________

Please list all substance being used or list current treatment interventions.

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Risk Assessment:

Danger to Self (Intent, Plan, Means): ____

Past: ____

Danger to others: (Intent, Plan, Means): ____

Past: ____

Grave Disability (unable to make use of available resources): ____

☐ 5150 Initiated ☐ CPS Referral ☐ APS Referral ☐ Tarasoff ☐ Arrests/Incarcerations in last 12 months

Additional Risk Factors: (Check all that apply.) Document details.

☐ Physical Abuse/Emotional Abuse
☐ Family History of Suicide
☐ Assaultive Behavior
☐ Inappropriate Sexualized Behavior
☐ History of Domestic Violence
☐ Impulsivity/Threatening Behavior
☐ Sexual Abuse
☐ Animal Cruelty
☐ Fire Setting
☐ Emotional/Physical Neglect
☐ Adverse Childhood Experience
☐ Substance Abuse
☐ Self-injurious Behavior
☐ Trauma or Loss in Family
☐ Access to Firearms (family, friends)
☐ Behavior Influenced by Delusions or Hallucinations
☐ Severe Hopelessness
☐ Other ____________________

Comments:

Mental Status:

General (Appearance, attitude, behavior, speech) : ____

Orientation : ____

Mood/Affect : ____

Thought Process : ____

Memory/Thought Content : ____

Insight/ Judgment/ Impulsivity : ____

Additional Observations :

Diagnostic Impression: DSM-5 Diagnosis, ICD-10 Code and Narrative

ICD-10 Code: ____________________ DSM-5 Diagnosis: ____________________ (Primary)

DSM-5 Narrative Diagnosis: ____

ICD-10 Code: ____________________ DSM-5 Diagnosis: ____________________ (Secondary)

DSM-5 Narrative Diagnosis: ____

DSM-5 Diagnosis by: ______________________________
(Name of Diagnosing Clinician/Licensure)

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Functional Impairment:

	None	Mild	Mod	Severe		None	Mild	Mod	Severe
Family Relations	☐	☐	☐	☐	Social Relations	☐	☐	☐	☐
Employment / School Performance	☐	☐	☐	☐	Physical Health	☐	☐	☐	☐
Recreational / Leisure Activities	☐	☐	☐	☐	Substance Abuse	☐	☐	☐	☐
Food/Shelter	☐	☐	☐	☐	Activities of Daily Living	☐	☐	☐	☐

Additional Comments:

Justification for Continued Care Services

Discharge Plan Update: (Clinical Presentation)

______________________________ Signature/License/Designation

______________________________ Printed Name

______________________________ Date

______________________________ Co-Signature/License (if applicable)

______________________________ Printed Name

______________________________ Date

______________________________ Data Entry Clerk Initials