



Courtesy of Capstone Behavioral Healthcare

INITIAL EVALUATION

Date: Time:

Co-occurring Mental Health Only Substance Abuse Only

Name: **DOB:** **Payor #:**

Age: **Gender**

Address:

Phone/Home: **Phone/Cell:**

Marital Status:

Legal Status:

Employer:

Occupation:

School: **Grade:** **Academic History:**

Referral Source:

Guardianship:

Family Members/Current Living Situation:

Name	Age	Gender	Relationship	Living with:
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Emergency Information:

Primary Care Physician:

Emergency Contact: Name: **Phone:**

Address:

City/State:

Intake Information

Consent for Treatment Signed: Client Rights Given: Other ROI:

Consent for PCP: Signed NA Declined / Client Initial _____

Name:

DOB:

Payor:

ASSESSMENT:

Presenting Problem (including onset, duration, and intensity):

Precipitating Event (“why now” for treatment):

Client Strengths and Limitations:

Client’s Baseline Functioning:

Client’s expressed wants and desired results for treatment:

Client and Therapist mutually agreed upon treatment focus and rationale:

MENTAL STATUS EXAM:

Appearance:

Speech:

Motor Activity:

Behavior:

Orientation:

Attention:

Concentration:

Memory:

Affect:

Mood:

Thought Content:

Thought Process:

Thought Disorder:

Intellect:

Insight:

Judgment:

Impulse Control:

MEDICAL AND PSYCHIATRIC HISTORY

Name:

DOB:

Payor:

Allergies:

Relevant Medical Conditions/Treating Physician (major illnesses, surgeries):

Current Medications:

Name:

Dosage:

Prescribing Physician:

Past Psychiatric History (mental health & substance abuse):

Hospitalizations:

Outpatient Therapy (include previous providers, treatment dates, previous interventions, response to treatment & medications):

PSYCHOSOCIAL INFORMATION

Support Systems:

Relevant Social/Family History:

Marital History:

Legal History:

Current Legal Status, Restrictions, or Requirements: (documentation must be in file):

None Guardianship Power of Attorney Conservatorship

Mental Health Commitment CINA Substance Abuse Commitment

Other relevant Court Orders requiring treatment or evaluation: (Specify):

Military History:

Cultural Preferences Assessment:

Description of Patient's Religious Preferences:

Substance Abuse Assessment (describe amount, frequency, 1st & Last Use, choice):

Alcohol Use:

Drug Use:

Nicotine:

Caffeine:

Prior Substance Abuse Treatment:

Referral for Treatment:

RISK ASSESSMENT

Suicidal Ideation:

Homicidal Ideation:

Past SI/HI History:

Non-compliance with treatment:

AMA/elopement potential:

Name:

DOB:

Payor:

Prior behavioral health inpatient admissions:

History of multiple behavioral diagnoses:

Domestic Violence:

Child Abuse:

Physical/Sexual Abuse:

Eating Disorder:

Access to weapons: Intervention:

Crisis/Safety Plan:

CHILDREN AND ADOLESCENTS

Developmental History (milestones met early, late, on target):

Prenatal History (problems during pregnancy, during labor/delivery, mother's use of medications/alcohol/drugs, lack of prenatal care):

DIAGNOSTIC IMPRESSION

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

Initial Treatment Plan:

Additional Referral to:

Goal (objective/measurable):

Intervention:

Time Frame:

Discharge Plan: Upon discharge Client will have developed resources needed to maintain and sustain treatment gains. Client will have developed a support system to encourage and support them self. Client will have identified specific triggers to stress, anxiety, and self defeating thinking and will have develop an array of coping skills to effectively deal with crisis and decision situations as they occur. Client will be aware that they may return to therapy if needed and will be informed how to access emergency services if needed

Clinical Summary:

First Follow-up Appointment:

Client/Guardian understanding/agreement: _____

Name:

DOB:

Payor:

Practitioner Signature: _____

Name:

DOB:

Payor: