

**INITIAL MENTAL HEALTH ASSESSMENT**  
*CONFIDENTIAL*

Client Name:

Gender:

DOB:

Age:

Highest Level of Education:

Current Employment Status:

Current Marital Status:

Examiner's Name:

Supervisor's Name:

Date of Interview:

Date Report Written:

Date Report Submitted:

**Referral and Purpose of Evaluation:**

1. **Identifying Information** (ethnicity, preferred language, sexual orientation, gender identity, living arrangement): \_\_\_\_\_

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2. **Presenting Mental Health Problem**

- a. Current symptoms

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- b. When symptoms began-

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c. Stressors \_\_\_\_\_

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d. Duration and intensity of the present  
problem \_\_\_\_\_

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e. Impairments in life functioning caused by  
symptoms \_\_\_\_\_

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f. Suicidal Thought/Attempts?  
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g. Any symptoms that align with DSM-V

diagnoses \_\_\_\_\_

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**3. Mental Health History**

a. Psychiatric Hospitalizations (presenting symptoms, diagnosis, dates, locations, type of therapy/counseling)

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b. Outpatient Treatment (presenting symptoms, diagnosis, dates, locations, type of therapy/counseling)

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c. Medications (name, dose, effectiveness and duration of treatment)\_\_\_\_\_

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**4. Substance Use History:**

a. Alcohol Screening Questions:

- In the past year, how often did you have a drink containing alcohol (never, monthly, weekly or 4+ times/wk)

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- In the past year, how many drinks containing alcohol did you have on a typical day when drinking?

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- In the past year, how often did you have 6 or more drinks on one occasion?

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b. Drug Screening Questions (ever or within 6 months and duration of use):

- Nicotine

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- Caffeine

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- Prescriptions/OTC medications misused

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- Stimulants

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- Marijuana

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- Hallucinogens (MDMA, Ecstasy, LSD or PCP)

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- Intravenous

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- Other

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Treatment

History: \_\_\_\_\_

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Comments: \_\_\_\_\_

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5. **Medical History** (Does the individual report any of the following? Check all that apply and describe below.):

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Head injury/stroke/memory | <input type="checkbox"/> Thyroid problems   | <input type="checkbox"/> Chronic pain (incl. location) | <input type="checkbox"/> STD                  |
| <input type="checkbox"/> Loss of consciousness     | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Enuresis/encopresis           | <input type="checkbox"/> Respiratory problems |
| <input type="checkbox"/> Kidney disease            | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Allergies                     | <input type="checkbox"/> Seizures             |
| <input type="checkbox"/> Heart/vascular problems   | <input type="checkbox"/> Sleep disturbances | <input type="checkbox"/> Adverse reaction to meds      | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Hypertension              | <input type="checkbox"/> Surgeries          | <input type="checkbox"/> Regular Menstruation          | <input type="checkbox"/> Arrhythmias          |
| <input type="checkbox"/> Liver disease             | <input type="checkbox"/> Weight changes     | <input type="checkbox"/> Pregnancy                     | <input type="checkbox"/> Cardiac Disease      |

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

No major medical conditions      Lab Results:  Not Applicable  In Medical Section       Other \_\_\_\_\_

Medications (include prescribed, over-the-counter, alternative or herbal remedies, contraception)

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

Are there any medication compliance/adherence issues?      YES      NO  
     

Describe: \_\_\_\_\_  
 \_\_\_\_\_

Name and phone number of Primary Care Physician: \_\_\_\_\_  
 \_\_\_\_\_ If no PCP, then referral made?      YES      NO

**6. Psychosocial History:**

a. Birth (e.g., pregnancy complications, exposure to substances, location, etc.): \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
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b. Childhood/Adolescence (e.g., developmental milestones, attachment, separation, temperament, peer relations): \_\_\_\_\_

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e. Education/Vocation: (e.g. education history, work history, etc.): \_\_\_\_\_

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f. Legal History: \_\_\_\_\_

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g. Cultural Factors (e.g., ethnicity, immigration, acculturation, language, religion, sexual orientation,): \_\_\_\_\_

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YES NO

Do any cultural factors affect client's treatment?    
If yes, describe:

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

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

Comments: \_\_\_\_\_  
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\_\_\_\_\_

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

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

Comments/Additional Information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**9. Summary and Diagnosis:**

a. Client's Strengths (to assist with achieving treatment goals):

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