



Assessment

Client Name: Claus, Santa **Client ID:** 4
Clinician Name: Heckathorn, Jeremy **Date:** 1/8/2021
Assessment date: **Inquiry Date :**

Assessment type: ☒ Initial ☐ Update ☐ Annual
Population type: ☒ Adult ☐ Child
☐ DD ☐ SA ☐ MH ☐ Autism

☒ Does the client have a guardian?

Name: Reindeer, Rudolph

Phone:

Address:

Type:

Referral Type:

Mental Health

Current Living Arrangement:

Private residence - Independent

Current Employment Status

Retired

Current Primary Care Physician:

Presenting problem:

Presence or Absence of Relevant Legal Issues of the Client and/or Family

Desired Outcomes of Service (Hopes and Dreams) As Specified By The Person/Guardian:

Substance Use

Use of Alcohol ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

☐ Add Use of Alcohol to Needs List

Use of Tobacco/Nicotine ☐ Never ☐ Previously, but Quit: ☐ Type/Frequency

☐ Add Use of Tobacco/Nicotine to Needs List

Use of Illicit Drugs ☐ Never ☐ Type/Frequency:

☐ Add Use of illicit Drugs to Needs List

Prescription/OTC Drugs ☐ Never ☐ Type/Frequency:

☐ Add Prescription/OTC Drugs to Needs List

UNCOPE

☐ Yes ☐ No Is UNCOPE applicable? (If no, specify below)

- ☐ Yes ☐ No Have you spent more time drinking or using than you intended to?
- ☐ Yes ☐ No Have you ever neglected some of your usual responsibilities because of using alcohol or drugs?
- ☐ Yes ☐ No Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?
- ☐ Yes ☐ No Has your family, a friend, or anyone else ever told you they objected to your alcohol or drug use?
- ☐ Yes ☐ No Have you ever found yourself preoccupied with wanting to use alcohol or drugs?
- ☐ Yes ☐ No Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger or boredom?

Stage of Change:

Pre-Employment Activities

Education/Training

I understand the educational and training opportunities available to me and I am able to access them

- ☐ 1 - This is just like me ☐ 2 - This is mostly like me ☐ 3 - Somewhat like me ☐ 4 - Less like me ☐ 5 - Not at all like me

☐ Add Education/Training to Needs List

Personal Career Planning

I understand how to access services to assist me in career-related issues to gain employment

- ☐ 1 - This is just like me ☐ 2 - This is mostly like me ☐ 3 - Somewhat like me ☐ 4 - Less like me ☐ 5 - Not at all like me

☐ Add Personal Career Planning to Needs list

Employment Opportunities

I am able to identify and find employment opportunities consistent with my strengths, abilities, and preferences.

- ☐ 1 - This is just like me ☐ 2 - This is mostly like me ☐ 3 - Somewhat like me ☐ 4 - Less like me ☐ 5 - Not at all like me

☐ Add Employment Opportunities to Needs List

Support Employment and Work Practices

I understand my role at work and use job coaching and support at my work site.

- ☐ 1 - This is just like me ☐ 2 - This is mostly like me ☐ 3 - Somewhat like me ☐ 4 - Less like me ☐ 5 - Not at all like me

☐ Add Supported Employment to Needs List

Work History

I have worked consistently in the past and I am able to maintain employment.

- ☐ 1 - This is just like me ☐ 2 - This is mostly like me ☐ 3 - Somewhat like me ☐ 4 - Less like me ☐ 5 - Not at all like me

☐ Add Work History to Needs List

Gainful Employment

I understand how employment income will affect benefits.

- ☐ 1 - This is just like me ☐ 2 - This is mostly like me ☐ 3 - Somewhat like me ☐ 4 - Less like me ☐ 5 - Not at all like me

☐ Add Gainful Employment – Benefits to Needs List

I have been successful in the interview process and I am able to get and maintain a job.

☐ 1 - This is just like me ☐ 2 - This is mostly like me ☐ 3 - Somewhat like me ☐ 4 - Less like me ☐ 5 - Not at all like me

☐ Add Gainful Employment to Needs List

Psychosocial Adult

Family and Developmental History (past and current relational and family situation) ☐ Yes ☐ No Concerns ☐ Unknown

☐ Add health issues to needs list

Medications ☐ Initialize Medications ☐ List Medications ☐ No Medications ☐ Unknown

☐ Add Medications to Needs List

Note efficacy of current and historical medications and their side effect:

Client experienced abuse or neglect either as victim or perpetrator and / or has had a previous traumatic incident? ☐ Yes ☐ No Concerns ☐ Unknown

☐ Add Abuse / Neglect / Trauma to Needs List

Are there cultural / ethnic issues that are of concern or need to be addressed? Describe cultural / ethnic values / beliefs. ☐ Yes ☐ No Concerns ☐ Unknown

☐ Add Cultural / Ethnic Values to Needs List

Educational Challenges/Barriers

☐ Autistically Impaired ☐ Cognitively Impaired ☐ Emotionally Impaired
☐ Behavioral Concerns ☐ Learning Disabilities ☐ Physical/Other Health Impaired
☐ Has IEP ☐ No Challenges/Barriers Known

☐ Add Education Status to Needs List

Please discuss any issues with school, number of schools attended, and current and past academic performance.

Mental health treatment history. List previous diagnosis, family history, treatment history / efficacy, etc. ☐ Yes ☐ No history reported ☐ Unknown

☐ Add Mental Health History to Needs List

Please list previous diagnosis, family history, treatment history/efficacy, etc.

Customer is At risk of....

- | | |
|--|---------|
| ☐ Loss / lack of placement | Due to: |
| ☐ Loss of support? | Due to: |
| ☐ Expulsion from school? | Due to: |
| ☐ Hospitalization? | Due to: |
| ☐ Involvement with the criminal justice system? | Due to: |
| ☐ Elopement from home? | Due to: |
| ☐ Loss of financial status? | Due to: |

Communicable Disease Risk Assessment

Have you had any of the below factors that may have put you at risk for a communicable disease such as HIV/AIDs, STDs, Hepatitis B or C, or TB?

Unprotected sexual relations with more than one partner during the past 24 months? ☐

Sexual relations with anyone who is infected with HIV/AIDS, Hepatitis, or an STD? ☐

Sexual relations with anyone who injects drugs? ☐

Injected drugs or shared needles? ☐

Received money, drugs, or other favors for sexual relations? ☐

☐ Add Communicable Disease Risk to Needs List

Anxiety

Have your feelings caused you distress or interfered with your ability to get along socially with friends or family? ☐ Yes ☐ No

How often have you felt nervous, anxious, or on edge?

How often were you not able to stop worrying or controlling your worry?

How often is stress a problem for you handling such things as: Health, Finances, Family or Social Relations, Work

How often do you get the social and emotional support you need?

☐ Add Anxiety to Needs List

PHQ-9

Declined to Participate

Total Score :

Depression Severity :

Comments :

Additional Question

Please check any of the following THAT WILL occur within 1 day of this PHQ9 Assessment

Additional Evaluation For Depression Performed

Referral For Depression Ordered

Depression Medications Ordered

Suicide Risk Assessment Performed

Pharmacological Intervention

Other interventions or follow-up for the diagnosis or treatment of depression

Documentation of follow-up plan

Did Client refuse assessment or was it Contraindicated ? Yes No

Supports**Support 1**

- ☒ Current ☐ Not Current
☐ Paid Support ☐ Clinically Recommended
☐ Unpaid Support ☐ Customer desired

Mental Status**Risk Assessment****Suicidality / Other Risk to Self**

- ☐ Current Suicidality / Risk to Self ☐ Previous Attempts / History
☐ No Current or Previous History of Suicidality / Other Risk to Self

Details (list current and previous behaviors, dates, method and lethality)

- ☐ Add Suicidality/ Other Risk to Self to Needs List

Physical Aggression/ Sexual Aggression / Other Risk Factors

- ☐ Current Physical / Sexual Aggression/ Risk to Others
☐ Prior Physical Aggression / Sexual Aggression / Risk to Others
☐ Homicidal
☐ No Current or Previous History of Physical Aggression / Sexual Aggression / Risk to Others

- ☐ Add Homicidality / Physical Aggression / Risk to Others to Needs List

Other Risk Factors

- ☐ No known other risk factors

- ☐ Add Other Risk Factors to Needs List

Advance Directive

Does client have an Advance Directive? ☐ Yes ☐ No

Does client desire an Advance Directive plan? ☐ Yes ☐ No

Would client like more information about Advance Directive planning? ☐ Yes ☐ No

What information was the client given regarding Advance Directive?

- ☐ Add Advance Directive to Needs List

C-SSRS Adult Screener**SUICIDAL IDEATION DEFINITIONS AND PROMPTS**

Ask questions 1 and 2. if YES to 2, ask questions 3,4,5, and 6. If NO to 2, go directly to question 6.
Ask the questions that are bolded and underlined.

Since Last Visit

Diagnosis

Generalized anxiety disorder

DSM5/ICD10	F41.1	DSMIV/ICD9	300.02	SNOMED	21897009
ICD/ DSM Description	Generalized anxiety disorder				
Remission		Specifier		Type	Primary
Source		Severity	Medium	Order	1
Rule Out	No	Billable	Yes		

Additional Information

Screening Tools Used

Other General Medical Conditions

Psychosocial, Environmental, and Other Factors

Level of Functioning Score

GAF Score

WHODAS Score

CAFAS Score

Summary/Level of Care

Treatment

Does client meet criteria for services?

☐ Yes

☐ No

If client does not meet, was referral or other options offered?

☐ Yes

☐ No

Accommodations

Indicate any accommodations client requires for treatment

Strengths

Clinical Interpretive Summary

Integrate and interpret from a broader perspective all history and assessment information. Identify any co-occurring disabilities or disorders. Identify needs beyond the scope of the program and specify referrals for additional services. Include symptoms that justify the diagnosis and strengths that could contribute to stated outcomes. Include important biographical facts or events in the person’s life.

Transition/Level of Care/Discharge Plan

Level of Care (recommendation and justification):

Transition/Level of Care/Discharge Plan

Criteria – How will the staff/client/parent/guardian know that a change in level of care is indicated?

- ☐ Reduction in symptoms as evidenced by:
- ☐ Attainment of higher level of functioning as evidenced by:
- ☐ Treatment is no longer medically necessary as evidenced by:

☐ Other:

Estimated Discharge Date:

Disposition