CONTRA COSTA
BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

Initial Psychiatric Assessment

NAME / MRN _____

DATE: _____

Facility Name: _____ ID: _____

Program Name: _____+_____ ID: _____

Provider #: _____ Min(s): _____ Code Activity: ☐ 361 EVAL/RX

Place of Service:

☐ Office ☐ Field ☐ Phone	☐ Home ☐ School ☐ Correctional Facility	☐ Inpatient ☐ Other _____	☐ Telehealth – Pt Home ☐ Telehealth – Other than Pt Home

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 Disbled
☐ **51** Psych Education	☐ **54** Prtnrshp:LawEnfcmt	☐ **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 Client Pregnant? ☐ **Yes** ☐ **No**

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

☐ **Interpreter** **Name of Interpreter:** _____

Identifying Information:

Legal Name: _____ Age: _____ DOB: _____

Preferred Name: _____

Gender: ☐ Male ☐ Female ☐ Transgender F-M ☐ Transgender M-F ☐ Intersex ☐ Other _____

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

Address: _____

Phone #: _____

Emergency Contact/Significant Other: _____ _____
Name Phone number

Primary concerns per client:

Presenting Problem/ Recent Course of Illness:

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Client and Family Strengths (Positive factors to facilitate treatment e.g. faith, resilience, etc.):

Psychiatric History (include hospitalizations and dates, suicide attempts, history of intervention):

Psychiatric Medication History (Current and Past, side effects, adherences & outcomes) Current: ☐None Past: ☐None

Alcohol/ Drug Use History: (Check all appropriate and provide details.)

☐Unknown ☐No Current Substance Abuse ☐No Past Substance Abuse ☐Currently Clean & Sober for: ☐>3 Mos. ☐>1 Yr

Alcohol	☐ Past	☐ Present	Nicotine	☐ Past	☐ Present	Caffeine	☐ Past	☐ Present
Cocaine	☐ Past	☐ Present	Marijuana	☐ Past	☐ Present	Amphetamines	☐ Past	☐ Present
Opiates	☐ Past	☐ Present	Ecstasy	☐ Past	☐ Present	Hallucinogens	☐ Past	☐ Present
Sedatives	☐ Past	☐ Present	Inhalants	☐ Past	☐ Present	Energy Drinks	☐ Past	☐ Present
Other:	☐ Past	☐ Present						

Specify:

Medical History (include illnesses, surgeries, CNS, head injuries):

Date of Last Physical: _____ Physician(s)/clinic: _____

Phone #: _____ Weight: _____ Height: _____ BMI: _____

Allergies (Meds & Other) / Adverse Reaction: _____

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Active Medical Concerns, History of Hospitalizations/Surgeries:

Non-Psych Med/OTC:

Review of Systems: ☐ No Significant issues revealed

☐ CV ☐ Renal ☐ GI ☐ Hepatic ☐ CNS ☐ GU ☐ Metabolic ☐ CA ☐ PULM ☐ Gyn ☐ ID/HIV

☐ Sexually Active Contraceptive Method _____ ☐ Risk of Pregnancy ☐ Pregnant

☐ Breast-Feeding LMP: _____

Pregnancy and Birth History (<18): _____

Developmental History (<18): _____

Family Psychiatric History:

Psychosocial History (e.g. education, family, vocational, military, legal):

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

☐ Victim of Physical Abuse	☐ History of Self-injurious Behavior
☐ Victim of Sexual Abuse	☐ History of Suicidal Behavior
☐ Trauma or Loss in the Family	☐ Family History of Suicide
☐ Domestic Violence: Victim ☐ Perpetrator ☐	☐ Access to Firearms (family, friends, self)
☐ History of Substance Abuse	☐ Access to Other Means of Suicide
☐ History of Assaultive Behavior	☐ Lack of Social Support
☐ History of Threatening Behavior	☐ History of Foster Care
☐ History of Inappropriate Sexual Behavior	☐ Homelessness
☐ Behavior Influences by Delusions or Hallucinations	☐ Other

Comments:

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MENTAL STATUS EXAMINATION

APPEARANCE/GROOMING	☐ Unremarkable	☐ Remarkable for: _____
PSYCHO-MOTOR ACTIVITY	☐ Unremarkable	☐ Remarkable for: _____
ATTITUDE/RELATEDNESS	☐ Unremarkable	☐ Remarkable for: _____
SPEECH	☐ Unremarkable	☐ Remarkable for: _____
MOOD	☐ Unremarkable	☐ Remarkable for: _____
AFFECT	☐ Unremarkable	☐ Remarkable for: _____
THOUGHT PROCESS	☐ Unremarkable	☐ Remarkable for: _____
THOUGHT CONTENT	☐ Unremarkable	☐ Remarkable for: _____
PERCEPTUAL DISTURBANCE	☐ Unremarkable	☐ Remarkable for: _____
ORIENTATION	☐ Unremarkable	☐ Remarkable for: _____
MEMORY/CONCENTRATION	☐ Unremarkable	☐ Remarkable for: _____
FUND OF KNOWLEDGE	☐ Unremarkable	☐ Remarkable for: _____
INTELLECT/ABSTRACT THINKING	☐ Unremarkable	☐ Remarkable for: _____
INSIGHT/ JUDGEMENT	☐ Unremarkable	☐ Remarkable for: _____
IMPULSE CONTROL	☐ Unremarkable	☐ Remarkable for: _____

Additional Observations:

Current Risk Assessment:

Danger to SELF (Intent, Plan Means): _____

Danger to OTHER (Intent, Plan Means): _____

Grave Disability: _____

Clinical Summary (Optional):

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Diagnostic Impression: DSM Code and Narrative – Designate diagnosis which is primary focus of treatment with a "P"

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

DSM-5 Narrative Diagnosis: _____

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

DSM-5 Narrative Diagnosis: _____

DSM Diagnosis by: _____

FUNCTIONAL IMPAIRMENT: (IF MODERATE OR ABOVE, MAY WARRANTS TARGETED CASE MANAGEMENT)

	None	Mild	Mod	Severe		None	Mild	Mod	Severe
Family Relations	☐	☐	☐	☐	**Peer Relations**	☐	☐	☐	☐
Academic/Vocational Performance	☐	☐	☐	☐	**Physical Health**	☐	☐	☐	☐
Self Care	☐	☐	☐	☐	**Substance Abuse**	☐	☐	☐	☐

TARGETED SYMPTOMS:

	None	Mild	Mod	Severe		None	Mild	Mod	Severe
Cognition/Memory/Thought	☐	☐	☐	☐	**Perceptual Disturbance**	☐	☐	☐	☐
Attention/Impulsivity	☐	☐	☐	☐	**Antisocial Behavior**	☐	☐	☐	☐
Socialization/Communication	☐	☐	☐	☐	**Destructive/Assaultive**	☐	☐	☐	☐
Depressive Symptoms	☐	☐	☐	☐	**Mania/Agitation/Lability**	☐	☐	☐	☐
Anxiety/Phobia/Panic Attack	☐	☐	☐	☐	**Somatic Disturbance**	☐	☐	☐	☐
Affect Regulation	☐	☐	☐	☐	**Other:**	☐	☐	☐	☐

_____

Initial Treatment Plan/Targeted Case Management:

Does client meet the criteria for TCM? (May include moderate or above Functional Impairment and/or risk of losing placement/housing, need for financial support, social support, prevocational/employment assistance, rehabilitation, AOD services, or other programs or services considered necessary.) ☐ No ☐ Yes

Explain:

Referral to Coordination of Care with:

☐ PCP ☐ Case Management ☐ Therapist ☐ Family/ Other Support ☐ Substance Abuse Tx

☐ Housing ☐ Community Agencies ☐ Vocational Rehab ☐ Social Security

Details:

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Labs Ordered:

Medications Prescribed / Dosage / Frequency:

- ☐ Drug Information Sheet for each medication was given to client and family.
- ☐ Benefits/Risks/Possible adverse effects of medication and Alternatives to medication have been discussed.
- ☐ An opportunity was given to ask questions.
- ☐ The client and/or family appear to understand the information on the form.
- ☐ If appropriate, discuss the interaction of psychiatric medication with the following: Pregnancy, Lactation, Alcohol, Nutrition, and Non-Psychiatric Medications
- ☐ An Informed Consent was signed within the past two years.

Client (Family) is able to manage own medication: ☐ Yes ☐ No

If not, explain: _____

Additional Information:

MD/DO/NP Signature: _____ **Date:** _____

PRINT FULL NAME AND TITLE _____

_____
Data Entry Clerk Initials