THERAPIST INITIAL ASSESSMENT

Name _____ Provider

_____

Assessment Date _____ Emergency/Crisis ☐ Yes ☐ No Case # _____

PRESENTING PROBLEM (History of problem, duration, efforts to resolve, symptoms, functional impairment)

_____

_____

_____

_____

_____

_____

_____

_____

_____

RELEVANT SOCIAL HISTORY

Family _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Education_____

Employment_____

Legal_____

Financial_____

Support system_____

_____

Other _____

_____

Name _____

Child/Adolescent History

Any use of drugs or alcohol during pregnancy? _____

Problems during pregnancy or delivery? _____

Congenital defects? (If yes, specify) _____

Age at which child: Sat up _____ Crawled _____ Stood alone _____ Walked _____ First Words _____

Age at which potty trained _____ Length of time to train _____ Soiling or bedwetting? ☐ Yes ☐ No

List any history of seizures, prolonged high fevers, head injuries, poisoning, serious illness or injury_____

_____

List any prolonged separations or traumatic events in childhood_____

_____

_____

School _____ Grade _____ Performance _____

Problems/special services _____

ASSESSMENT OF RISK FOR SUICIDE OR HOMICIDE

Suicidal Ideation (Thoughts of death vs. killing self)_____

_____

Suicidal ideation scale ☐ Yes ☐ No

HX attempts_____

Family History_____

Homicidal/Harming others_____

HX attempts _____

Family History _____

Report made? ☐ Yes ☐ No Party(ies) Contacted _____

HISTORY OF PHYSICAL OR SEXUAL ABUSE (List who was abused, by whom, and approximate time span/age(s) and whether perpetrator still has access to those or other vulnerable parties)

_____

_____

_____

_____

Is a report required? ☐ Yes ☐ No Agency/person contacted & Date _____

Report # _____

ALCOHOL TOBACCO AND SUBSTANCE USE (Assessment for cigarettes, alcohol and prescribed, illicit, and over the counter drugs including frequency and quantity. Effect of use on job, legal, financial, family, and emotional life. SASSI report, if available)

_____

_____

_____

Drug and Alcohol Assessment? ☐ Yes ☐ No SASSI? ☐ Yes ☐ No

Name _____

MENTAL STATUS

Appearance	☐ well groomed	☐ disheveled	☐ bizarre	☐ inappropriate		
Attitude	☐ cooperative	☐ guarded	☐ suspicious	☐ uncooperative		
Motor Activity	☐ calm	☐ hyperactive	☐ agitated	☐ tremors/tics	☐ muscle spasm	
Affect	☐ appropriate	☐ labile	☐ expansive	☐ constricted	☐ blunted	☐ flat
Mood	☐ euthymic	☐ depressed	☐ anxious	☐ euphoric		
Speech	☐ normal ☐ pressured	☐ delayed ☐ perseverating	☐ soft ☐ incoherent	☐ loud	☐ slurred	☐ excessive

Thought Process	☐ Intact	☐ Circumstantial	☐ Loosing of Associations	☐ Tangential	☐ Flight of ideas
Thought Content					
Hallucinations	☐ Not present	☐ Present	☐ Auditory	☐ Visual	☐ olfactory
Delusions	☐ Not present	☐ Present	☐ Persecutory	☐ being controlled	☐ grandiose
			☐ Thought insertion/deletion	☐ bizarre	
Suicidal Ideation	☐ Yes ☐ No	Comments _____			
Homicidal Ideation	☐ Yes ☐ No	Comments _____			
Self-Perception	☐ No impairment	☐ Depersonalization	☐Derealization		
Orientation	☐ fully oriented	disoriented: ☐ always	☐ sometimes	☐ place	☐ person
Memory	☐ intact	impaired: ☐ amnesia: ☐ immediate ☐ partial	☐ recent ☐ global	☐ remote	
Cognitive Function	General Knowledge Intact	☐ Yes	☐ No		
	Simple Calculations intact	☐ Yes	☐ No		
	Serial Sevens intact	☐ Yes	☐ No		
Abstraction	☐ Proverb interpretation intact	Impaired: ☐ concrete	☐ idiosyncratic		
Judgment	☐ intact	impaired: ☐ minimal	☐moderate	☐ severe	
Insight	☐ intact	impaired: ☐ minimal	☐moderate	☐ severe	

CURRENT PHYSICAL HEALTH STATUS	**CHECK BOX THAT APPLIES**
1. Client states he/she has no health problems/concerns at this time; **OR**	☐
2. Client reports he/she has a physical health issue that is stable and does not require evaluation and treatment by a medical provider at this time; **OR**	☐
3. Client reports he/she has a physical health issue and is receiving care from a medical provider at this time; **OR**	☐
4. Client reports he/she has a physical health issue and is not receiving medical care. Referred to PCP for evaluation and treatment of physical health condition.	☐

CENTRAL LIFE ROLE FUNCTION ASSESSMENT: (Document and rate *current* level of severity of functional impairment using specific example(s) to illustrate the nature of your patient's deficits in everyday functioning)

a. Occupation ☐ None ☐ Mild ☐ Moderate ☐ Severe Describe _____
_____

b. School ☐ None ☐ Mild ☐ Moderate ☐ Severe Describe _____
_____

CLINICAL ASSESSMENT:

_____

_____

_____

Name _____

DSM IV DIAGNOSIS

AXIS I _____ _____
AXIS II _____ _____
AXIS III _____ _____
AXIS IV _____
AXIS V GAF _____ Highest last year _____

Psychotropic Medications (include over the counter/herbal, dosage and when first prescribed)

Treatment Plan

Goals

1. _____ _____
   _____ _____
   _____

2. _____ _____
   _____ _____
   _____

3. _____ _____
   _____ _____
   _____

4. _____ _____
   _____ _____
   _____

Treatment Plan discussed with client Yes_____ No_____

Estimated length of treatment and # of sessions _____ Date of next session _____

_____ _____
Therapist Name Therapist Signature Date