BRIEF ASSESSMENT

Client Name:	**Date of Assessment:**
Date of Birth:	**Social Security #:**
Tribe/Ethnicity:	**Employer:**
Home Phone #:	**Work Phone #:**
Other Phone #:	
Current Address:	
Parent/Guardian (for Child/Adolescent)**:**	
Other family members in the home:	
Primary language of Client:	**Family/Significant Others:**
Emergency Contact Name:	**Phone #:**
Referred by:	
Medical Provider:	**Insurance**
Client's/Family's Presentation of the Problem:	
Client's/Family's Expected Outcome:	

Problem Areas (enter score if present) **1 = mild, 2 = moderate, 3 = severe**

Family Conflict/Crisis		Interpersonal Relationships		Psychological/Emotional	
Child/Adolescent Behavior		Work Performance		Learning Disabilities	
Legal/Financial		School Performance		Crisis Adjustment	
Abuse victim		Trauma Victim		Anger Management	
Grief/Bereavement		Cultural Conflict		Other Adjustment Issues	
Other (please explain):					
For Child/Adolescent Only:		Risk-taking Behaviors		Fire-setting	

Comments:

History of Suicidal and/or Homicidal Behavior (list):

Prior Mental Health Treatment (list):

Current Health Status:	**Current Medications (list):**
Hx of Head Injury:	**Allergies (Medication & Other):**

Drug/Alcohol Assessment

	Substance(s)	**Frequency & Amount of Use**	**Treatment**
Family History			
Personal Use			

Is Substance Use the ☐ Primary focus of treatment; ☐ Contributing to current problems; ☐ Not relevant; or ☐ Needs further assessment

Mental Status Exam

Category	**Selections**			
GENERAL OBSERVATIONS				
Appearance	☐ Well groomed	☐ Unkempt	☐ Disheveled	☐ Malodorous
Build	☐ Average	☐ Thin	☐ Overweight	☐ Obese
Demeanor	☐ Cooperative	☐ Hostile	☐ Guarded	☐ Withdrawn
	☐ Preoccupied	☐ Demanding	☐ Seductive	
Eye Contact	☐ Average	☐ Decreased	☐ Increased	
Activity	☐ Average	☐ Decreased	☐ Increased	
Speech	☐ Clear	☐ Slurred	☐ Rapid	☐ Slow
	☐ Pressured	☐ Soft	☐ Loud	☐ Monotone
	Describe:			
THOUGHT CONTENT				
Delusions	☐ None Reported	☐ Grandiose	☐ Persecutory	☐ Somatic
	☐ Bizarre	☐ Nihilist	☐ Religious	
	Describe:			

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Other	☐ None Reported	☐ Poverty of Content	☐ Obsessions	☐ Compulsions
	☐ Phobias	☐ Guilt	☐ Anhedonia	☐ Thought Insertion
	☐ Ideas of Reference		☐ Thought Broadcasting	
	Describe:			
Self Abuse	☐ None Reported		☐ Self Mutilization	
	☐ Suicidal (assess lethality if present)		☐ Intent	☐ Plan
Aggressive	☐ None Reported	☐ Aggressive (assess lethality of present)		
	☐ Intent		☐ Plan	
PERCEPTION				
Hallucinations	☐ None Reported	☐ Auditory	☐ Visual	
	☐ Olfactory	☐ Gustatory	☐ Tactile	
	Describe:			
Other	☐ None Reported	☐ Illusions	☐ Depersonalization	☐ Derealization

THOUGHT PROCESS			
☐ Logical	☐ Goal Oriented	☐ Circumstantial	☐ Tangential
☐ Loose	☐ Rapid Thoughts	☐ Incoherent	☐ Concrete
☐ Blocked	☐ Flight of Ideas	☐ Perserverative	☐ Derailment
Describe:			
MOOD			
☐ Euthymic	☐ Depressed	☐ Anxious	
☐ Angry	☐ Euphoric	☐ Irritable	
AFFECT			
☐ Flat	☐ Inappropriate	☐ Labile	☐ Blunted
☐ Congruent with Mood	☐ Full	☐ Constricted	
BEHAVIOR			
☐ No behavior issues	☐ Assaultive	☐ Resistant	
☐ Aggressive	☐ Agitated	☐ Hyperactive	
☐ Restless	☐ Sleepy	☐ Intrusive	
MOVEMENT			
☐ Akasthisia	☐ Dystonia	☐ Tardive Dyskinesia	☐ Tics
Describe:			
COGNITION			

Impairment of:	☐ None Reported		☐ Orientation	☐ Memory
	☐ Attention/Concentration		☐ Ability to Abstract	
	Describe:			
Intelligence Estimate	☐ Mental Retardation	☐ Borderline	☐ Average	☐ Above Average
IMPULSE CONTROL		☐ Good	☐ Poor	☐ Absent
INSIGHT		☐ Good	☐ Poor	☐ Absent
JUDGMENT		☐ Good	☐ Poor	☐ Absent
RISK ASSESSMENT				
Risk to Self	☐ Low	☐ Medium	☐ High	☐ Chronic
Risk to Others	☐ Low	☐ Medium	☐ High	☐ Chronic
ELABORATION OF POSITIVE MENTAL STATUS FINDINGS				

Strengths/Resources (enter score if present) **1 = Adequate, 2 = Above Average, 3 = Exceptional**

Family Support		Social Support Systems		Relationship Stability	
Intellectual/Cognitive Skills		Coping Skills & Resiliency		Insight & Sensitivity	
Socio-Economic Stability		Communication Skills		Maturity & Judgment Skills	
Parenting Skills		Motivation for Help		Other	
Comments:					

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Biopsychosocial Formulation

Serious current risk of any of the following: (Immediate response needed)	
Abuse or Family Violence ☐ Yes ☐ No	**Harm to Self/Others** ☐ Yes ☐ No
Psychotic or Severely Psychologically Disabled ☐ Yes ☐ No	
Is there a handgun in the home? ☐ Yes ☐ No	**Any other weapons? ?** ☐ Yes ☐ No
Plan:	
Safety Plan Reviewed ☐ Yes ☐ No	

Provisional Diagnoses

Axis I:
Axis II:
Axis III:
Axis IV:
Axis V:

Provisional Treatment Plan

Goals/Objectives	
Medication Prescribed	
Treatment Plan Reviewed ☐ Yes ☐ No	

Referrals
Include Date & Time, if known

Psychiatrist	**Psychologist**	**Medical Provider**	**Counselor (list type)**
Social Worker	**Nutritionist**	**Rehabilitation**	**School Counselor**
Community Agency	**Inpatient Facility**	**Benefits Coordinator**	
Other:			