INITIAL ASSESSMENT

Your Name, Here
Patient ID: 00300019 | SBH MRN: 00000000

Date of Contact : / / today

Patient Concerns

Prior Mental Health Treatment

Details :

Agencies Providing Other Services

PURPOSE	AGENCY NAME AND CONTACT INFO	START DATE	END DATE

Alcohol / Substance Abuse

Prior Medications

NAME	DAILY DOSE	DURATION	HOW LONG AGO	EFFICACY	SIDE EFFECTS

Current Medications

NAME	DOSAGE
	of or Daily Dose:

		of		or Daily Dose:	
		of		or Daily Dose:	
		of		or Daily Dose:	

Care Plan

Add another problem/goal

Outcome Measures (select which measures should appear in this note)

- [x] SDQ Conduct Subscale
- [ ] Global Appraisal of Individual Needs-Short Screener
- [x] GAD-7 Anxiety Scale
- [ ] Trauma Screen
- [ ] CRAFFT Drug Use Scale
- [ ] ARS
- [ ] SDQ Strengths and Difficulties Questionnaire
- [ ] Short Mood and Feelings Questionnaire - Parent Report
- [ ] Screen for Child Anxiety Related Disorders
- [x] SDQ Hyperactivity Subscale
- [x] PHQ Depression Scale
- [ ] Subset of Vanderbilt
- [ ] CPSS
- [ ] SCS
- [ ] Weight Concerns Scale
- [ ] Short Mood and Feelings Questionnaire - Self Report
- [ ] Pediatric Symptom Checklist-17

PHQ Depression Scale (PHQ-9 Score :)

OVER THE LAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

10. If you checked off any problems on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
0	1	2	3

Significant Medical Problems and History

Personal/Social Information

Family & Cultural History :	(Child, parental, family, developmental history; socioeconomic, spiritual and cultural factors; parenting strategies, parental substance abuse, mental or physical health issues, other family psychiatric history; trauma, witness to violence; custody issues;)
Peer Relationships :	
School Functioning :	
Legal History :	
Current Supports :	(include strengths, activities, interests)
Is living situation adequate? :	Yes No
If no what housing need(s) do you have? :	
What types of housing or shelter have you utilized in the last 3 months? : *	Permanent independent housing (No Code) Street (vehicle/outdoors/camping) 9930306 Shelter 9930311 Supported/Transitional housing 9930313 Staying with other friends/family 9939323 Other 9930319

Suicide Attempts

Past Suicide Attempts :	Yes No
Safety Concerns :	
Flag as Safety Risk? :	

Mental Status Examination

Formulation

Axis 1 Diagnosis

1. 2. 3.

Axis 2-5 Diagnosis

Axis 2 Diagnosis :

Axis 3 Diagnosis :

Axis 4 Diagnosis : Primary Support Group Educational Occupational Housing Economic Access to Health Care Interaction with the Legal System/Crime Social Environment

Axis 5 (CGAS) Diagnosis :

Appointments

DATE & TIME	PERIOD	PROVIDER	VISIT TYPE

Additional Comments

Discuss with Consulting Psychiatrist

Would you like to discuss this patient with the consulting psychiatrist? :

Notes for Psychiatrist :

Task

Flag for Task(s)? :

Notes :

This session was with Jessica Knaster Wasse and took minutes

Add Cancel