

Adult Mental Health Standard Diagnostic Assessment

# IDENTIFYING INFORMATION

Name:

Assessment Date & Time:

Address:

DOB:

Gender: Preferred pronouns:

Race: Language: Interpreter needed:

Assessment completed by:

Contributors to the assessment: (review of previous DA, Collateral contacts, etc.)

Reason for referral/Presenting symptoms:

# CURRENT/HISTORICAL INFORMATION

Living Arrangement:

Social History: (Including Family of Origin and Family of Creation)

Developmental History: (Any difficulties meeting developmental milestones?)

# EDUCATION/EMPLOYMENT/MILITARY

Education: (Completion of grade level, Learning difficulty?)

Work History:

Military:

Current legal issues:

# CULTURAL and BELIEF SYSTEM

Cultural and/or Religious Influences:

# STRENGTHS

Strengths:

Hobbies:

Resources:

# BASIC NEEDS STATUS

Current Mental and Physical Health Providers:

Medications:

Physical Health Concerns:

# MENTAL HEALTH

Family History:

Client History:

Client is currently experiencing the following symptoms:

Client identifies his/her most significant Impairments as:

**RISK ASSESSMENT HISTORY AND SUMMARY** (Identify type then severity: mild, moderate, severe)

Suicidal Ideation:

History of Abuse and/or Neglect: Relationship Safety:

Financial:

Other Traumatic Event:

# MENTAL STATUS EXAM

Orientation:

Appearance:

Attitude:

Affect:

Perceptual Disturbances: Motor Activity:

Insight:

Mood:

Thought Process: Thought Content: Rate of Speech: Judgement: Insight:

Fund of Knowledge:

# SUBSTANCE SCREENING AND ADDICTIVE BEHAVIORS

Family History:

Patient History:

Other Addictive Behaviors:

# CAGE-AID

Have you ever felt you could cut down on drinking or drug use? Yes No Have people annoyed you by criticizing your drug use? Yes No

Have you felt bad or guilty about your drinking or drug use? Yes No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? (e.g. eye-opener)? Yes No

TOTAL:

**SUBSTANCE USE** (amount)

Energy Drinks:

Tobacco:

Marijuana:

Alcohol:

Methamphetamine:

Opioids:

Other:

**Chemical Health Treatment History:**

**ASSESSMENT TOOLS and Scores:**

N/A if none used

(Examples: ACE, GAD-7, PHQ-9, CSRS)

**CLINICAL SUMMARY:**

**DIAGNOSIS ICD10 CODE**

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**Client Meets defined Criteria as**:

A condition with a Diagnosis of Mental Illness that meets at Least one of the following Please check at least one:

 The recipient has had two or more episodes of inpatient care for mental illness within the past 24 months.

 The recipient has continuous psychiatric hospitalization or residential treatment exceeding 6 months duration within in the preceding 12 months

 The recipient has a diagnosis of schizophrenia/schizoaffective disorder, bi-polar disorder, major depression or borderline personality disorder and evidences significant impairment in functioning and has a written opinion from a mental health professional stating he/she is likely to have future episodes requiring inpatient or residential treatment unless community support program services are provided.

 The recipient has in the last 3 years been committed by a court as mentally ill person under Minnesota statues or the adult’s commitment as a mentally ill person has been stayed or continued.

 The recipient was eligible under one of the above criteria, but the specified time period has expired.

 The recipient was eligible as a child with severe emotional disturbance and the recipient has a written opinion from a mental health professional in the last 3 years stating that s/he is reasonably likely to have future episodes requiring inpatient or residential treatment of a frequency described in the above criteria unless ongoing case management or community support services are provided.

# SERVICE RECOMMENDATIONS:

ARMHS Services: Yes No Agency:

Outpatient Mental Health Services: Yes No Agency:

|  |  |  |
| --- | --- | --- |
| In Home Community Supports: Yes | No: | Agency & Service: |
| Targeted Case Management Services: services? Agency: | Yes | No Referral made and/or already receiving |
| Other: |  |  |

**SIGNATURES:**

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Printed name of Staff completing DA Credentials Date

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 Signature of Staff completing DA Date

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Staff Credentials Date

 Signature of Mental Health Professional (if different from above)