SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

CLIENT NAME _____ **MH ID #** _____

ADULT ADMISSION ASSESSMENT

Agency/Program_____

Client _____ **MH ID #** _____ **Admission Date** _____

Address _____ **Birth Date** _____ **Age** _____

Phone Number (Home) _____ **Cell #** _____ **Work #** _____

Current Insurance (check all that apply) ☐ Medicare ☐ Medi-Cal ☐ Private Ins (name) _____

Emergency Contact: Name _____ **Phone Number**_____

Source of Information ☐ **Client interview** ☐ **ICI** ☐ **Previous Records** ☐ **Other**_____

Ethnicity _____ **Primary Language** _____

Is Client able to communicate in English? ☐ Yes ☐ No **Interpreter** (name if needed) _____

Other persons or agencies actively involved in the client's care:

☐ Conservator (name): _____

☐ Case Manager (from where): _____

☐ Other: _____

Sexual Orientation and Gender Identify: **What is your preferred name?** _____

What is your sexual orientation?

☐ Straight or heterosexual ☐ Lesbian or Gay ☐ Bisexual ☐ Queer ☐ Asexual ☐ Don't Know/Declined to answer ☐ Did not ask ☐ Another _____

What is your current gender identity? ☐ Male ☐ Female ☐ Female to Male/Transgender Male ☐ Male to Female/Transgender Female ☐ Genderqueer not exclusive male/female ☐ Declined to answer ☐ Did not ask ☐ Another_____

What are your pronouns?

☐ He/Him ☐ She/Her ☐ They/Them ☐ Declined to Answer ☐ Did not ask ☐ Another_____

What sex were you assigned at birth on your original birth certificate?

☐ Male ☐ Female ☐ Declined to answer ☐ Did not ask ☐ Another_____

Have you been diagnosed by a Doctor with an intersex condition?

☐ Yes ☐ No ☐ Declined to answer ☐ Did not ask

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Presenting Problem and current symptoms (*as stated by client or others, precipitants and current stressors - Discuss symptoms consistent with diagnostic formulation):*

Functional problems: (Discuss functioning problems consistent with diagnostic formulation).

Do symptoms & behaviors affect:	**Describe**	**Rating scale 0 – 4 (minimal – severe)**
Activities of daily living		
Work		
Parenting/relationships		
Social life		

Risk Factors ☐ **Harm to Self** ☐ **Harm to Others** ☐ **None**

Overall degree of risk to self or others: ☐ **None** ☐ **Low** ☐ **Moderate** ☐ **High**

Current ideation (describe using client statements) jenab
Expressed intent (describe using client statements) jenab
Specific Plan (describe using client statements. How detailed is the plan? Is client making preparations like giving away belongings or preparing a will?)
Ease & means of availability jenab
Access to firearms/ weapons in the home jenab
Degree of perceived Hopeless-/ helplessness
Reliability of impulse control and judgement
Amount of & ability to use, supportive resources

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LETHALITY OF PRIOR SUICIDE/ SELF HARM ATTEMPTS Description Date	Seriousness of Previous Suicide Attempts 0 – 4 (minimal – severe)
1.	
2.	
3.	

Sexual History/HIV Risk Assessment/Other:

Psychiatric History (Include dates)

☐ Hospitalizations:

☐ Outpatient MH treatment:

☐ Substance abuse treatment:

☐ Victim of violence (including domestic violence and childhood abuse):

☐ Perpetrator of violence:

Other information:

Medications and Medical History

Current RX Med.	Amount	Frequency	Prescribed By	Purpose of Med.
OTC/Herbs				

Previous Medications (list previous psychiatric medications and whether or not they were helpful):

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Allergic to any medications? ☐ no ☐ yes (name) :

Medical History

- ☐ Surgery (when & for what):
- ☐ Chronic illness (include seizures, thyroid disorder, cancer, anemia):
- ☐ Hospitalizations:
- ☐ Head trauma:
- ☐ Major accidents:
- ☐ Allergies:

Other significant medical history:

Primary Care Physician _____ **Phone Number** _____

Date of last physical exam _____

Psych/Social History

Current Living Situation and Social Support System:

Family & Relationship History & Issues, and Developmental History:

Vocational & Educational History:

Cultural and Spiritual Issues:

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Legal History:

Strengths as stated by client:

Substance Abuse History (See psychiatric hx for substance abuse treatment) ☐ **None/Not Relevant**

Substance	Age of 1st Use	Highest Usage Amount and Frequency dur. Time Period	Current Usage with Amount/Frequency/Route	Date of Last Use	Rating of current abuse 0 – 4 minimal- severe
Alcohol					
Amphetamines					
Cocaine					
Opiates					
Sedatives					
PCP					
Hallucinogens					
Inhalants					
Marijuana					
Cigarettes					
RX Drugs					

☐ **Client supplied a urine specimen for tox screen. Results:**

Other information:

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Mental Status Exam: *May ONLY be completed by Licensed/Registered/Waivered MD/OD/NP, MFT/AMFT, LPCC, LCSW/ASW, PhD/PsyD, RN with Psych MS or training or Trainee with co-signature.*

General Appearance
☐ Appropriate ☐ Disheveled ☐ Bizarre
☐ Inappropriate ☐ Other

Affect
☐ Within Normal Limits ☐ Constricted
☐ Blunted ☐ Flat
☐ Angry ☐ Sad
☐ Anxious ☐ Labile
☐ Inappropriate ☐ Other

Physical and Motor
☐ Within Normal Limits ☐ Hyperactive
☐ Agitated ☐ Motor Retardation
☐ Tremors/Tics ☐ Unusual Gait
☐ Muscle Tone Issues ☐ Other

Mood
☐ Within Normal Limits ☐ Depressed
☐ Anxious ☐ Expansive
☐ Irritable ☐ Other

Thought Content and Process
☐ Within Normal Limits ☐ Aud. Hallucinations
☐ Vis. Hallucinations ☐ Delusions
☐ Paranoid Ideation ☐ Bizarre
☐ Suicidal Ideation ☐ Homicidal Ideation
☐ Flight of Ideas ☐ Loose Associations
☐ Poor Insight ☐ Attention Issues
☐ Fund of Knowledge ☐ Other

Speech
☐ Within Normal Limits ☐ Circumstantial
☐ Tangential ☐ Pressured
☐ Slowed ☐ Loud
☐ Other

Cognition
☐ Within Normal Limits ☐ Orientation
☐ Memory Problems ☐ Impulse Control
☐ Poor Concentration ☐ Poor Judgment
☐ Other

MSE Summary:

LOCUS

Functional Rating (Sum of all ratings): _____
Is client on meds? ☐ Yes ☐ No

Risk of Harm: Rate (1-5)_____ Functional Status: Rate (1-5)_____
Co-Morbidity: Rate (1-5)_____ Recovery Environment (Stress): Rate (1-5)_____
Recovery Environment (Support): Rate (1-5)_____Treatment & Recovery History: Rate (1-5)_____
Engagement: Rate (1-5)_____

Rate (0-5)_____the extent to which total rating above is influenced by substance abuse, unresolved medical condition, developmental disability, situational issues: (Describe)

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Diagnosis:

Does the client have a substance abuse/dependence issue? ☐ **Yes** ☐ **No** ☐ **Unknown**

Has client experienced traumatic events? ☐ **Yes** ☐ **No** ☐ **Unknown**

Check one entry in √ P column to specify the Primary diagnosis. (You may report additional diagnoses)

Place a check in the √ AOD column if the diagnosis is substance abuse/dependence related.

DSM5 DIAGNOSIS	ICD-10	√ AOD	√ P
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

General Medical Conditions

17 = Allergies	☐	12 = Diabetes	☐	29 = Muscular Dystrophy	☐
16 = Anemia	☐	09 = Digest-Reflux,Irrit'lBowel	☐	15 = Obesity	☐
01 = Arterial Sclerotic Disease	☐	34 = Ear Infections	☐	21 = Osteoporosis	☐
19 = Arthritis	☐	26 = Epilepsy/Seizures	☐	30 = Parkinson's Disease	☐
35 = Asthma	☐	02 = Heart Disease	☐	31 = Physical Disability	☐
06 = Birth defects	☐	18 = Hepatitis	☐	08 = Psoriasis	☐
23 = Blind/Visually Impaired	☐	03 = Hypercholesterolemia	☐	36 = Sexually TransmittedD.	☐
22 = Cancer	☐	04 = Hyperlipidemia	☐	32 = Stroke	☐
20 = Carpal Tunnel Syndrome	☐	05 = Hypertension	☐	33 = Tinnitus	☐
24 = Chronic Pain	☐	14 = Hyperthyroid	☐	10 = Ulcers	☐
11 = Cirrhosis	☐	13 = Infertility	☐		
07 = Cystic Fibrosis	☐	27 = Migraines	☐	00 = No Gen. Medical Cond'n	☐
25 = Deaf/Hearing Impaired	☐	28 = Multiple Sclerosis	☐	99 = Unk/Not Report'd. GMC	☐
37 = Other: (Please list)					

Number of children under the age of 18 the client cares for or is responsible for at least 50% of the time _____

Number of dependent adults age 18 or older the client cares for or is responsible for at least 50% of the time _____

DIAGNOSTIC COMMENTS:

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Clinical Formulation

May ONLY be completed by Licensed/Registered/Waivered MD/OD/NP, MFT, LCSW, LPCC, PhD/PsyD, RN with Psych MS or Trainee with co-signature.

As a result of the Primary Diagnosis, the client has the following functional impairments:
Treatment is being provided to address, or prevent, significant deterioration in an important area of life functioning.

☐ School/Work Functioning ☐ Social Relationships ☐ Daily Living Skills
☐ Ability to Maintain Placement ☐ Symptom Management

Clinical Formulation: (Include current presenting issues, course of treatment, impairments, diagnostic criteria, strengths, and treatment recommendations)

Additional Factors or Comments:

Authorized Clinical Staff* involved in assessment interview Signature and Date

Assessor's Name/Discipline – Printed **Date**
Conducted the Mental Status Exam and provided Diagnosis.

Authorized Clinical Staff* involved in assessment interview Signature and Date

Assessor's Signature and Discipline **Date**

Assessor must be a *Licensed/Registered/Waivered MD/OD/NP, MFT, LCSW, LPCC, PhD/PsyD, RN with Psych MS or Trainee with co-signature.*(At minimum the assessor is responsible for reviewing the completed assessment, conducting the mental status exam, providing a clinical formulation and providing the diagnosis. **Assessor signs here to co-sign for assessments provided by trainees.**)