SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

CLIENT NAME _____ **MH ID #** _____

ADULT REASSESSMENT

Agency/Program_____ **Assessment Date** _____

CLIENT NAME _____ **MH ID #** _____

Admission Date _____

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

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

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

Source of Information: ☐ Client interview ☐ICI ☐Previous Records ☐Other_____

Ethnicity _____**Primary Language** _____

If Primary Language is not English, how will language needs be met?_____

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

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

☐Conservator (name): _____Other_____

☐Case Manager (from where_____Other_____

Updates to Presenting Problem, and Current Symptoms (state presenting problem/reason for treatment):

Updates to Psychosocial History
(Include current living situation, family history, legal issues, strengths, cultural and spiritual info)

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Updates to Psychiatric and Medical History (Include changes in the past year, medication changes, current medication, psychiatric treatment, hospitalization)

Overall Concerns / RISK
☐ Yes ☐ None ☐ Undetermined
Suicide/Harm to Self ☐Yes ☐No **Homicide/Harm to Others** ☐Yes ☐No

Changes in Substance Use Status (since last assessment)
☐ Yes ☐ None ☐ Undetermined. If yes, explain:_____

Substance Abuse History ☐ **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					

Other information: ☐ Client supplied a urine specimen for tox screen. Results:_____

Does TRAUMA Impact Functioning or Presenting Problems
☐ Yes ☐ No ☐ Unknown

Overall Summary/Evaluation of current Risk/Trauma/AOD Use

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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

LOCUS

Functional Rating (Sum of all ratings): _____

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)_____ Is client on meds? ☐Yes ☐No

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

Mental Status Exam: *May ONLY be completed by Licensed/Waivered MD/NP, MFT/MFTI, 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
☐ Vis. Hallucinations
☐ Paranoid Ideation
☐ Suicidal Ideation
☐ Flight of Ideas
☐ Poor Insight
☐ Fund of Knowledge

☐ Aud. Hallucinations
☐ Delusions
☐ Bizarre
☐ Homicidal Ideation
☐ Loose Associations
☐ Attention Issues
☐ Other

Speech
☐ Within Normal Limits
☐ Tangential
☐ Slowed
☐ Other

☐ Circumstantial
☐ Pressured
☐ Loud

Cognition
☐ Within Normal Limits
☐ Memory Problems
☐ Poor Concentration
☐ Other

☐ Orientation
☐ Impulse Control
☐ Poor Judgment

MSE Summary:

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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:

Service Strategies: Check any service strategy likely to be used during the course of this plan.

- ☐ Peer/Family Delivered Services (50)
- ☐ Psychoeducation (51)
- ☐ Family Support (52)
- ☐ Supportive Education (53)
- ☐ Delivered in wt LawEnforcement (54)
- ☐ Delivered in Partnership wt. Health Care (55)
- ☐ Delivered in Partnership wt. Social Services (56)
- ☐ Delivered in Partnership wt Substance Tx (57)
- ☐ Integrated Services Mental Health & Aging (58)
- ☐ Integrated Mental Health/Developmental Dis (59)
- ☐ Ethnic-Specific (60)
- ☐ Age-Specific Service (61)
- ☐ Unknown Service Strategy (99)

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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
☐ Ability to Maintain Placement
☐ Social Relationships
☐ Symptom Management
☐ Daily Living Skills

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

Authorized Clinical Staff* involved in assessment interview Signature and Date

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

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.**)