

Name:

Date/Time Begin:

Date/Time End:

Address  
Insurance:

City:  
Policy #  
Policy #  
Policy #

DOB: Age: Sex: Race:  
Phone: Cell Phone:  
**Exam by Psychiatrist: Time:**

# of Contacts:  
Referral Source:

Collateral Calls:  
Location of Screening:

D/C w/30 days Date: Hospital:  
Holding Bed: **No**

Diagnosis:

Disposition:

Presenting Problem:

**1. Family Composition:**

Who does client live with (names, ages, relationship):

Biological Parents:  Married  Divorced  Separated  Never Married  Widowed

Custody status/visitation:

Does client have siblings:  No  Yes If yes, ages:

**2. Academic Functioning:**

School: Grade: CST Classified?  No  Yes Classification:

Recent grades: Have grades recently:  Improved  Declined  No Change

Sports, activities, jobs, etc.:

Behavioral problems in school:  No  Yes If yes, Specify:

**3. Peer Relationships:**

Does patient have friends?  Yes  No Explain:

Does patient have difficulty getting along with peers?  No  Yes Explain

**Clinician:**

**Name:**

Parental concerns with patient's friends:

**4. Sexual Abuse:**  No  Yes Explain:

If yes, was patient the:  Victim or  Perpetrator Treatment:

Date:

**5. Physical Abuse or Neglect:**  No  Yes Explain:

If yes, was patient the:  Victim or  Perpetrator Treatment:

Date:

**6. Self Injurious Behavior:**  No  Yes Explain:

**7. Bed Wetting:**  No  Yes until what age?

Current:  No  Yes

**8. Cruelty to Animals:**  No  Yes Describe:

**9. Fire Setting**  No  Yes Explain:

**10. Juvenile Justice Involvement:**  None  Arrest  Incarceration  Probation

**11. Family History of Mental Illness/Substance Abuse:**

**12. Current Medical Concerns:**

**13. Current Psychotropic Medication:**  None  Yes (describe below)

Medication

Dosage

Route

Frequency

Last Taken

**Medication Prescribed by:**

Specialty:

**14. Past Psychotropic Medications:**  None  Yes List:

**15. Substance Abuse/Use:**  No  Yes **Family Hx:**  No  Yes

**16. Medical Hospitalization/Surgeries:**  No  Yes

**17. History of Seizures or Neurological Symptoms:**  No  Yes

**18. Allergies:**  No  Yes Type/Reaction:

**19. Developmental Milestones:** Normal pregnancy  No  Yes If no, Explain:

**20. Sleeping patterns:**  Normal/No problems  Difficulty Falling Asleep  Difficulty staying asleep

Frequent Awakening  Difficulty awakening in A.M.  Nightmares

**21. Eating Patterns:**  Normal/ No problems  recent weight gain \_\_\_\_\_  recent weight loss \_\_\_\_\_

Binging/Purging  Change in Appetite

**Clinician:**

**Name:**

**PHYSICAL STATUS:**

**Appearance/Dress:**  unremarkable  neat  bizarre  casual  disheveled  body odor

**Other:**

**Body Behavior:**  bent  rigid  relaxed  tremors  erect  folded arms

High motor activity  motor retardation  restless

**Other:**

**Facial Expression:**  appropriate  pained  remote  eye contact  sad  stern  flat  angry  blinking  downcast  eyes  grimacing  smiling  happy  fixed stare  animated

**Other:**

**Speech:**  unremarkable  rambling  repetitive  verbose  mute  obscene  slurred  inaudible  slow

deliberate  labored  concise  hesitant  infantile  pressured  monotone

loud  mumbled

**Other:**

**EMOTIONAL STATUS:**

**Mood:**  euthymic  depressed  irritable  euphoric  cheerful  tearful  uncooperative  pessimistic  defensive  remote  angry  crying  optimistic  anxious  complaining  hostile  sarcastic

**Other:**

**Affect:**  appropriate  inappropriate  flat  blunted  labile  withdrawn  incongruent  dull  broad  aloof  explosive  hostile  constricted

**Other:**

**Attitude:**  cooperative  tense  apprehensive  uneasy  worried  stressed  realistic  passive  regressed  critical  infantile  dependent  hostile  resistant  suspicious  guarded  attentive

**Other:**

**COGNITIVE STATUS:**

**Concentration:**  normal  deficit  language barrier

**Other:**

**Thought Process:**  logical  organized  delusional  confused  racing  loose association  disorganized  preoccupied  tangential  grandiose  compulsive  depersonalization  fantasies  obsessions  Phobias  somatic  hallucinations (audio, visual, tactile, command)

**Other:**

**Orientation:**  person  place  time  self  circumstances

**Memory:** Recall of:  Immediate (seconds)  Recent: (minutes/months)  Remote (yrs exp.)

**Judgment:**

**Insight:**  intact  partial  none:

**Clinician:**

Name:

### **SUICIDE LETHALITY ASSESSMENT**

#### **Presence of Risk Factors**

- Thoughts regarding death and dying
- Command hallucinations to kill or be killed
- Family history of suicide
- Depression or hopelessness
- Previous suicide attempts
- Excessive alcohol or drug use
- Rational thinking loss (psych or organic)
- Separated, widowed, divorced
- Organized or serious attempt
- No social support
- Stated future attempt (determined to repeat or ambivalent)
- Legal problems
- Physical / sexual abuse
- History of assault, aggression, impulsive
- Financial stress
- Guilt / shame
- Recent loss / anniversary of loss
- Poor sleep
- Chronic illness (Chronic pain, COPD, Dialysis) or caregiver of such
- History of traumatic event

#### **Presence of Protective Factors**

- Positive experience with professional help
- Ability to use coping skills
- Strong support system
- Future goals
- Religious prohibition / spirituality
- Willing and able to participate in treatment
- Responsibility to children / pets
- Ability to channel stressors

#### **Suicide Inquiry (Specific questioning about thoughts, plans, behaviors, intent)**

**Ideation:** Frequency, Intensity, Duration – last 48 hours, past month and worst ever (Behavioral Incident)

**Plan:** Timing, Location, Lethality, Availability, Preparatory Acts

**Behaviors:** Past or aborted attempts, rehearsals (*tying noose, loading gun, versus non-suicidal self injurious actions*)

**Intent:** Extent to which the patient (1) expects to carry out the plan & (2) believes the plan / act to be lethal vs. self injurious (*explore ambivalence: reason to die vs. reason to live*)

#### **Assessment of Dangerousness other than Suicide**

- History of self-mutilation
- History of aggressive or assaultive behavior
- History of arrest or incarceration due to violence

**Clinician:**

Name:

**Family Stressors**

Report any recent family stressors or ongoing family conflicts:

Report any traumatic losses (note any attempted or completed suicides known to the client plus any other recent deaths):

**CURRENT & PAST MENTAL HEALTH TREATMENT**

**1. Current treatment:**

GET "RELEASE OF INFORMATION" SIGNED BY GUARDIAN

Please list:

Most recent appointment:

Next scheduled appointment:

**2. Past treatment:**

How long ago?

Duration of treatment:

**3. Has client been psychiatrically hospitalized:**  No  Yes (see below)

**Hospital**

**Date**

**Duration**

**Reason for Admission**

**PAST/ CURRENT AGENCY INVOLVEMENT**

(Include DYFS, Probation, Schools, DDD and Other Mental Health Systems)

GET "RELEASE OF INFORMATION" SIGNED BY GUARDIAN

**Agency**

**Contact Person**

**Telephone  
Number**

**Problem/Reason**

**Date**

**Collateral Contacts:**

**Least Restrictive Alternative:**

**Disposition:**

**Clinician:**