

Mental Health Assessment Form

Patient Information				
First Name	Last Name	Patient ID	Ethnicity	
Patient Skills/Strengths				
Presenting Problems				
Presenting Mental Health Problem(s)				
History of Presenting Problem(s)				
Current Symptoms				
Goals for Treatment				
Medical History				
<u>Current Medications</u>				
Medication Name	Dose	Frequency	Indication	Note
<u>Medical History</u>				

Patient Information			
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Medical History (Continued)			
Family History			
Developmental History (If Applicable)			
Psychological History			
Personal History			
Family History			
Psychosocial History			
Education/Vocation			
Social Relationships			
Living Situation			
Developmental History			
Childhood/Adolescence			
Cultural Factors			

Patient Information						
First Name	Last Name	Patient ID	Ethnicity			
Substance Abuse History						
Substance	Age of First Use	Frequency	Date of Last Use	Note		
Risk Screening						
Select all that applies						
<input type="checkbox"/> Suicide/Self-harm	<input type="checkbox"/> Neglect/Abuse	<input type="checkbox"/> Substance abuse				
<input type="checkbox"/> Cognitive Impairment	<input type="checkbox"/> Absconding risk (if inpatient)	<input type="checkbox"/> Substance use				
<input type="checkbox"/> Risk to dependent children (if applicable)	<input type="checkbox"/> Forensic and legal history	<input type="checkbox"/> Cultural isolation				
<input type="checkbox"/> Homelessness	<input type="checkbox"/> Other:					
If any of the above is selected, please elaborate						
Mental Status Examination						
Observations						
Appearance	<input type="checkbox"/> Neat	<input type="checkbox"/> Disheveled	<input type="checkbox"/> Inappropriate	<input type="checkbox"/> Bizarre	<input type="checkbox"/> Other:	
Speech	<input type="checkbox"/> Normal	<input type="checkbox"/> Tangential	<input type="checkbox"/> Pressured	<input type="checkbox"/> Impoverished	<input type="checkbox"/> Other:	
Eye Contact	<input type="checkbox"/> Normal	<input type="checkbox"/> Intense	<input type="checkbox"/> Avoidant	<input type="checkbox"/> Other:		
Motor Activity	<input type="checkbox"/> Normal	<input type="checkbox"/> Restless	<input type="checkbox"/> Tics	<input type="checkbox"/> Slowed	<input type="checkbox"/> Other:	
Affect	<input type="checkbox"/> Full	<input type="checkbox"/> Constricted	<input type="checkbox"/> Flat	<input type="checkbox"/> Labile	<input type="checkbox"/> Other:	
Comments:						
Mood						
<input type="checkbox"/> Euthymic	<input type="checkbox"/> Anxious	<input type="checkbox"/> Angry	<input type="checkbox"/> Depressed	<input type="checkbox"/> Euphoric	<input type="checkbox"/> Irritable	<input type="checkbox"/> Other:
Comments:						
Cognition						
Orientation Impairment	<input type="checkbox"/> None	<input type="checkbox"/> Place	<input type="checkbox"/> Object	<input type="checkbox"/> Person	<input type="checkbox"/> Time	
Memory Impairment	<input type="checkbox"/> None	<input type="checkbox"/> Short-term	<input type="checkbox"/> Long-term	<input type="checkbox"/> Other:		
Attention	<input type="checkbox"/> Normal	<input type="checkbox"/> Distracted	<input type="checkbox"/> Other:			
Comments:						

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Mental Status Examination (Continued)			
Perception			
Hallucinations	<input type="checkbox"/> None	<input type="checkbox"/> Auditory	<input type="checkbox"/> Visual <input type="checkbox"/> Other:
Other	<input type="checkbox"/> None	<input type="checkbox"/> Derealization	<input type="checkbox"/> Depersonalization
Comments:			
Thoughts			
Suicidality	<input type="checkbox"/> None	<input type="checkbox"/> Ideation	<input type="checkbox"/> Plan <input type="checkbox"/> Intent <input type="checkbox"/> Self-harm
Homicidality	<input type="checkbox"/> None	<input type="checkbox"/> Aggressive	<input type="checkbox"/> Intent <input type="checkbox"/> Plan
Delusions	<input type="checkbox"/> None	<input type="checkbox"/> Grandiose	<input type="checkbox"/> Paranoid <input type="checkbox"/> Religious <input type="checkbox"/> Other:
Comments:			
Behavior			
<input type="checkbox"/> Cooperative <input type="checkbox"/> Guarded <input type="checkbox"/> Hyperactive <input type="checkbox"/> Agitated <input type="checkbox"/> Paranoid <input type="checkbox"/> Stereotyped <input type="checkbox"/> Aggressive <input type="checkbox"/> Bizarre <input type="checkbox"/> Withdrawn <input type="checkbox"/> Other:			
Comments:			
Insight	Comments:		
<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor			
Judgment	Comments:		
<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor			
Physical Examination Results			

Patient Information

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Assessment Summary

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Plan/Notes

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Clinician Name	Clinician Designation	Clinician Signature	Date
			