Initial Clinical Assessment

Family Guidance Centers

Patient Name: _____

DOB: ____/_____/_____ Current Age: _____

Gender: ☐ Male ☐ Female Therapist: _____

Date of Completion: _____

Reason for Referral:

Current Behaviors, Problems, Symptoms, and Situational Needs (check all that apply):

☐ Angry	☐ Hallucinations	☐ Mood Swings	☐ Sexual Acting Out
☐ Anxious	☐ Hyperactivity	☐ Obsessive/Compulsive	☐ Stealing
☐ Defiant	☐ Hypersomnia	☐ Oppositional	☐ Substance Use
☐ Disassociation	☐ Impulsivity	☐ Panic Attacks	☐ Suicidal Ideation
☐ Distractible	☐ Inattentive	☐ Phobia	☐ Tearful
☐ Eating Disorder	☐ Insomnia	☐ Physically Abusive	☐ Thought Disturbance
☐ Encopretic/Enuretic	☐ Irritability	☐ Poor Concentration	☐ Verbally Abusive
☐ Fearful	☐ Labile Mood	☐ Poor Self Care	☐ Weight Gain
☐ Feelings of guilt/worthless	☐ Lying	☐ Poor Social Skills	☐ Weight Loss
☐ Fidgety	☐ Manic/Hypomanic	☐ Sad/Depressed Mood	
☐ Fire Setting			

Comments/Additional Information:

Developmental History

Prenatal History (include prenatal medical problems, medications use by mother, prenatal alcohol/drug/cigarette use, complications of pregnancy, and delivery difficulties)

☐ Within normal limits ☐ Unknown

Developmental Milestones (did child reach important developmental milestones in age-appropriate time frames?)

☐ Within normal limits ☐ Unknown

History of Abuse/Trauma (include history of emotional, physical, or sexual abuse, significant losses or separation and it's impact on client's current functioning)

☐ Within normal limits ☐ Unknown

Previous Service History/Results of Previous Examinations (may include: previous outpatient, psychiatric, acute inpatient, residential, substance abuse, or other services. Indicate type of service, dates, reason for services, and outcome)

Family/Social History

Current Legal Guardian: _____

Current Living Situation (include any type of residence - private home, group home, foster home, etc; all people living within the home; and custodial arrangements if any)

Family Relationships/Roles (describe quality of client's relationship with important family figures - parents, siblings, extended family and the roles they play within the family system. List significant support systems available to family)

Family History of Mental Illness, Substance Abuse, and Trauma

Family History of Domestic Violence

Culture, Ethnicity, & Spirituality (describe aspects of these dimensions relevant to client's history and service delivery)

Psychosexual History (include relevant information about sexual activity, sexual orientation, and personal values about sexuality)

Peer Relationships (Check all that apply)

☐ Relates well to peers	☐ Has significant friendships	☐ Belongs to clubs/team
☐ Has boyfriend/girlfriend	☐ Visits at friend's home	☐ Solves problems effectively
☐ Shares well	☐ Age-appropriate hobbies	☐ Has leadership skills
☐ Few friends	☐ Aggressive/fights	☐ Isolates self
☐ Rejected/teased by peers	☐ Bullies others	☐ Solitary interests
☐ Gang affiliation/behavior	☐ Easily led by peers	☐ Seeks negative attention
☐ Impulsivity problems	☐ Manipulative with peers	

Other information:

Educational/Vocational History

Current School: _____ Grade: _____ Contact Person: _____

Special Education: ☐ None ☐ ED ☐ LD ☐ OHI ☐ MIMD ☐ MOMD ☐ Other

Education Information (describe history of school placements, disciplinary history, attendance patterns, results of any specific testing, and estimate overall intellectual capacity and learning ability)

Vocational Experience, History, & Needs (experiences with work, need for vocational assessment, vocational skills, etc)

Medical History (non-psychiatric)

	YES	NO
Serious or Chronic Conditions of Parents:		
Serious or Chronic Conditions of Siblings:		
Handicaps/Disabilities/Functional Limitations:		
Communications Needs (Speech, Language, and Hearing):		
Vision Problems:		
Allergies (include allergies to medications):		
Recent Physical Complaints/Current Illnesses:		
Past Serious Illnesses/Injuries:		
Chronic Conditions/Infectious Diseases:		
Hospitalizations:		

Client's immunizations are currently up to date? ☐ Yes ☐ No
Verified by: ☐ Public school requires current immunizations ☐ Immunization record provided/sought

Primary Care Physician: _____ Meets regularly? ☐ Yes ☐ No
If client is not connected with PCP, was referral made? ☐ N/A ☐ Yes ☐ No

Medication

Current Medications

Name of Medication	Prescribing Doctor	When Taken (Beginning/End Date)	Dosage, Frequency & Effectiveness:

Psychotropic Medication History (List any past medications that have ever caused allergies, adverse or unusual reactions and indicate effectiveness of previously used medications)

Criminal Justice History ☐ None

Criminal Behavior? ☐ Yes ☐ No Court Involvement? ☐ Yes ☐ No Contact Person: _____

Describe Criminal Justice Involvement (Include current legal charges, upcoming court dates, time spent in detention, previous commitment, probation status)

Substance Use History ☐ None

Ever Used?	Substance	Amount + Frequency Most Recent Use	Age of 1st Use	Negative Consequences	Signs of Dependency
☐	Alcohol				
☐	Marijuana				
☐	Amphetamines				
☐	Barbiturates				
☐	Other Sedatives				
☐	Tranquilizers				
☐	Cocaine				
☐	Heroin				
☐	Other Opiates				
☐	Hallucinogens				
☐	Inhalants				
☐	PCP				
☐	Over-the-Counter				
☐	Tobacco/Nicotine				
☐	Gambling				
☐	Other (list)				

Client needs referral for additional substance abuse evaluation and/or treatment? ☐ Yes ☐ No

Additional Substance Abuse Information (patterns of use, illegal activity, dealing, consequences of use, stage of change)

_____

Risk Assessment

Current Suicide Risk	Self-injurious Behavior	History of Abuse/Neglect	Physical/Domestic	Sexually Risky Behavior
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Additional Information (family history of suicide, additional risk-taking behaviors, suicide plan and lethality)

Mental Status Exam

Appearance/ General Behavior Dress Face Eye Contact	☐ Meticulous ☐ Neat ☐ Disheveled ☐ Bizarre ☐ Age-appropriate ☐ Animated ☐ Fixed ☐ Sad ☐ Angry ☐ Direct ☐ Avoidant ☐ Stares
Attitude	☐ Cooperative ☐ Seductive ☐ Suspicious ☐ Hostile ☐ Negative ☐ Uncooperative ☐ Indifferent ☐ Evasive ☐ Demanding ☐ Passive
Psychomotor	☐ Underactive ☐ Relaxed ☐ Rigid ☐ Agitated ☐ Retarded ☐ Hyperactive
Speech: Quantity	☐ Spontaneous ☐ Slurred ☐ Mute ☐ Verbose
Speech: Quality	☐ Coherent ☐ Incoherent ☐ Loud ☐ Soft ☐ Stuttering ☐ Pressured
Perception/ Hallucinations	☐ Yes ☐ No Type:
Affect	☐ Broad ☐ Full ☐ Blunted ☐ Anxious ☐ Restricted ☐ Flat ☐ Inappropriate
Mood	☐ Appropriate ☐ Angry ☐ Labile ☐ Depressed ☐ Euphoric
Thought	☐ Goal directed ☐ Blocked ☐ Flight of ideas ☐ Circumstantial ☐ Pre-occupied ☐ Loose assoc. ☐ Obsessive ☐ Tangential ☐ Short attention span
Consciousness	☐ Alert ☐ Hyper-alert ☐ Lethargic ☐ Stuporous ☐ Confused ☐ Distracted
Orientation	☐ Person ☐ Place ☐ Time

Strengths, Abilities, & Interests

☐ Creative	☐ Honest	☐ Artistic	☐ Musical
☐ Independent	☐ Compliant with Meds	☐ Self-aware	☐ Insight
☐ Social	☐ Physically healthy	☐ Sense of humor	☐ Problem solving
☐ Supportive family	☐ Academic Success	☐ Physically Active	☐ Friendly
☐ Polite	☐ Has financial resources	☐ Logical	☐ Goal oriented
☐ Reliable Transp.	☐ Family conn. to school	☐ Advocates for self	☐ Kind
☐ Dependable	☐ Trustworthy	☐ Helpful	☐ Adaptable

Other

Clinical Summary & Diagnosis

Primary Diagnosis:

Secondary Diagnosis:

Summary of Clinical Findings:

Treatment Plan

Goals of Treatment:

Estimated Number of Treatment Sessions to Achieve Goals: _____

_____

Provider/Credentials