

ASSESSMENT INITIAL CLINICAL

Last Name _____ First _____ Date _____

Medical Problems _____

Medications Used __Depression __Bipolar __Sleep __HBP __Pain __Anxiety
__allergies __other _____

Alcohol/drugs __None __yes Substances _____
__12 step __quit on own Frequency _____ Amount _____ Duration _____

Risk for harm __None __Ideation __Plans __Means

Prior Admissions __None _____

Multiple Codes __None _____

Presenting Problems: __relationship __marital __co-worker __grief __anxiety
__adjustment __divorce __depression __bipolar __attention __substance abuse
__sleep __acute stress __ptsd __work stress __school stress __behavioral
__other _____

Psychiatric History: __previous problems _____
__hospitalization for emotional disorders _____ when _____
__current counselor/psychiatrist _____

Support System: __Friends/Family _____
__Marital _____
__Spiritual _____
__Hobbies _____

Mental Status: appearance, affect, orientation, mood, thought content, thought process,
intellect, insight, judgement, impulse control, memory, concentration, attention, behavior,
speech, mood, __normal __any present _____

Thought Disorders: delusions, paranoia, ideas of reference, obsessions, confusion, flight
of ideas __normal __any present _____

Axis I(clinical) _____ Axis II(per) _____
Axis III _____ Axis IV _____

GAF __81-90 Absent __71-80 Transient/Expected __61-70 Mild __51-60 Moderate
__Serious – no friends, unable to keep job, impairment in reality, delusions, danger to
self or others

Signature _____ Date _____