

Clinical Assessment

Client Name (Last, First, MI)			ID #	Medicaid #	DOB:	Age:
Sex:	Ethnic Group:	Marital Status:	Occupation:	Education:		
Multiaxial Diagnosis						
Axis I: Clinical Disorders / Other Conditions That May Be a Focus of Clinical Attention						
Diagnostic Code			DSM-IV Name			
Axis II: Personality Disorders / Mental Retardation						
Diagnostic Code			DSM-IV Name			
Axis III: General Medical Conditions						
ICD-9-CM Code			ICD-9-CM Name			
Axis IV: Psychosocial and Environmental Problems						
	<input type="checkbox"/> Problems with primary support group (Specify):					
	<input type="checkbox"/> Problems related to the social environment (Specify):					
	<input type="checkbox"/> Educational problems (Specify):					
	<input type="checkbox"/> Occupational problems (Specify):					
	<input type="checkbox"/> Housing problems (Specify):					
	<input type="checkbox"/> Economic problems (Specify):					
	<input type="checkbox"/> Problems with access to healthcare services (Specify):					
	<input type="checkbox"/> Problems related to interaction with the legal system/crime (Specify):					
	<input type="checkbox"/> Other psychosocial and environmental problems (Specify):					
Axis V: Global Assessment of Functioning Scale						
	Score:			Time Frame:		
Admitted to Services: <input type="checkbox"/> Yes <input type="checkbox"/> No, Reason for Non-admission:						
Statement of Medical Necessity: I recommend that the above-named Medicaid beneficiary receive Rehabilitation Services for the maximum reduction of emotional, behavioral, and functional developmental delays, and for restoration of the beneficiary to his or her best possible functioning level. This beneficiary meets the medical-necessity criteria for Rehabilitative Services evidenced by a Psychiatric/Substance Abuse Disorder diagnosis from the current edition of the DSM or the ICD.						
Licensed Professional of Healing Arts Signature and Credentials:				Date:		
Master Problem List: <i>In concise statements, list the most immediate problems the client is presenting. Indicate whether each problem will be addressed on the Treatment Plan (T); whether it will be referred (R) for services elsewhere; or whether it will be monitored (M). Place the letter that corresponds to the appropriate disposition in the space provided to the left of each problem statement.</i>						
	1.					
	2.					
	3.					
	4.					
	5.					
	6.					
Interpretive Summary: <i>Include an integration of potential interrelationships between findings</i>						
Interpretation of all Pertinent Assessment Information:						
Identification of any Disabilities/Co-Existing Disorders:						
Central Themes:						
Client's perception of his/her needs, strengths, limitations, or problems:						
Positive and negative factors likely to affect client's course of treatment and clinical outcomes following discharge (e.g., recovery):						
Recommended treatments:						

Clinical Assessment (Diagnostic Assessment)

Anticipated level and length of care:	
Intensity of treatment and expected focus (<i>goals</i>) with recommendations:	
ASAM Dimensions	
Dimension 1:(Acute Intoxication and/or Withdrawal Potential)	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Very Severe
Dimension 2:(Biomedical Conditions and Complications)	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Very Severe
Dimension 3:(Emotional, Behavioral or Cognitive Conditions & Complications)	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Very Severe
Dimension 4: (Readiness to Change)	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Very Severe
Dimension 5: (Relapse, Continued Use or Continued Problem Potential)	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Very Severe
Dimension 6: (Recovery/Living Environment)	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Very Severe
Clinician Signature and Title:	Date:
Clinical Assessment Outline:	
Presenting Problems	
Reason for Entry:	
Source of Referral:	
Legal Involvement:	
Self-Identified Problems:	
Recent Stressor:	
Health/Medical/Development History	
Regular physician's name and telephone number:	
General health:	
Medical problems (<i>include visual and motor function</i>):	
Medications for the past year:	

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Nutrition:					
Vision / Hearing:					
Prenatal exposure to ATOD:					
Developmental delays:					
Allergies:					
Hospitalizations:					
Disabilities:					
Tuberculosis screening:					
Need for assistive technology:					
HIV/AIDS test HIV risk behaviors:					
Child birth(s) previous history and, if currently pregnant, identify due date and prenatal care referrals:					
Family/Social Interaction					
Family of origin and present family, including relationships with all family members (<i>chronological order</i>):					
History as a survivor, perpetrator, and/or witness of an psychosocial, emotional, physical, sexual abuse, and/or neglect:					
Family history of substance use/abuse, current family use, and family psychiatric history:					
Other intimate and social relationships:					
Needed and available social supports:					
Peer group functioning:					
Pertinent current / historical life situation information on sexual orientation, gender expression:					
Cultural, ethnic & spiritual background:					
Psychoactive Substance Use History					
Drug	Age at First Use	Frequency (past 12 months)	Quantity (specify time frame)	Last Use	How Used
Alcohol					
Amphetamines					

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Caffeine					
Cannabis					
Cocaine					
Hallucinogen					
Inhalant					
Nicotine					
Opioid					
PCP					
Sedative Hypnotic					
Synthetic					
Other					

Psychoactive Substance Use: *Include other relevant substance use factors such as loss of control, tolerance, treatment history, patterns of use, and problems related to use. Include data to differentiate between use, abuse, and dependence.*

Psychological: *Complete "Special Populations" section as appropriate.*

Mental Status and Cognitive Functioning:

Current Emotional State; Emotional Functioning Issues; Ability to Manage Emotions:

Risk Taking behaviors; History of Violence/Risk to Others:

Personal Safety Concerns; Suicide Attempts Thoughts:

Psychiatric History to include Presence of Past or Current Hallucinations; Eating Disorder Behaviors:

Special Populations: *Client is a member of the following special population group:*

- Child/Adolescent
 Senior
 Dual Diagnosis
 Other Coexisting Disabilities/Disorders
 None of the Above (*Go to next section*)

Gambling:

History of Gambling: Yes No

If yes:

Age at which Gambling Began:

Describe Preoccupation with Gambling, Loss of Control, Tolerance:

Treatment History:

Gambling Patterns (including patterns impacted by substance use/abuse):

Problems Related to Gambling:

Educational/Vocational:

Years of Education/Education History:

Apparent Educational Deficiencies:

Literacy Level:

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Military Service (Self, Other Family Members, Significant Other):				
Job/Employment History:				
Abilities, Strengths, Needs and Preferences:				
Client and Clinician Perceptions of Abilities, Strengths, Needs, and Preferences:				
Unique Factors Affecting the Course of Treatment and Client Expectations of Treatment Outcomes:				
Financial Status:				
Leisure Skills/Activities/Interests:				
Recovery Environment:				
Other:				
Sources of Information Other than Client:				
Name:			Relationship:	
Name:			Relationship:	
Clinician Signature and Title:			Date:	
Agency Name:	NPI:	Medicaid Provider ID:	Phone #:	Fax #:

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