MOORE INSTITUTE

Mental Health Assessment Form

Client Name:			
Date of Birth:		**Medicaid Number:**	
Address:			
City, State, Zip			
Parent/Guardian (if applicable):			
Phone Number:			

Date of Service:		**Time of Service:**	
Duration of Service:			

Presenting Concern/Chief Complaint (include symptoms, intensity and duration):

Cultural Assessment/Strengths:

MOORE INSTITUTE

Mental Health Assessment Form

Client Name: _____

Mini Mental Status Exam:	
Presentation (include appearance, psychomotor activity, manner/attitude):	
Speech (include quality/quantity):	
Emotions (include mood, affect, impulse control):	
Thought Process (include productivity, continuity, orientation, memory, attention /concentration, judgment, insight):	
Thought Content (include preoccupations, perceptions, delusions):	
Somatic (include sleep, appetite, weight, energy):	

MOORE INSTITUTE

Mental Health Assessment Form

Client Name: _____

Alcohol/Drug Assessment	
Tobacco Use (current and historical to include amount and frequency, age first used, current frequency of use, frequency in past 6 months, method of use):	
Alcohol Use (current and historical to include amount and frequency, age first used, current frequency of use, frequency in past 6 months, method of use):	
Other Drug Use (current and historical to include amount and frequency, age first used, current frequency of use, frequency in past 6 months, method of use):	Primary:
	Secondary:
	Tertiary:
Previous/Current Abuse Treatments:	

MOORE INSTITUTE

Mental Health Assessment Form

Client Name: _____

Prior Treatment History (including high levels of treatment, such as residential, day treatment):
Current Medications (type, frequency, dosage):

MOORE INSTITUTE

Mental Health Assessment Form

Client Name: _____

<table>
<tr><td colspan="4">Risk Assessment:</td></tr>
<tr><td>History of violence toward self or others:</td><td colspan="3"></td></tr>
<tr><td>History of hospitalizations:</td><td colspan="3"></td></tr>
<tr><td>Medical Concerns:</td><td colspan="3"></td></tr>
<tr><td>Cause of dangerousness:</td><td>Suicidal Ideation</td><td>Homicidal Ideation</td><td>Grave Disability</td></tr>
<tr><td rowspan="6">If Suicidal Ideation:</td><td colspan="3">Suicidal behavior:</td></tr>
<tr><td>Ideation: yes/no</td><td>Plan: yes/no</td><td>Intent: yes/no</td></tr>
<tr><td colspan="3">Precipitants/stressors/interpersonal triggers:</td></tr>
<tr><td colspan="3">Change in current treatment</td></tr>
<tr><td colspan="3">Access to weapons</td></tr>
<tr><td colspan="3">Protective Factors:</td></tr>
<tr><td colspan="2">Internal (ability to cope, frustration tolerance):</td><td>External (responsibility to children/pets, social supports):</td></tr>
</table>

MOORE INSTITUTE

Mental Health Assessment Form

Client Name: _____

Risk Assessment Continued:			
If Homicidal Ideation:	Identified target?	Notified/Duty to Warn?	
	Past assault history/legal history:		
	Access to weapons/plan/intent:		
	Psychotic disorder?		
	TBI		
	Cluster B traits/ conduct		
	Substances		
If Grave Disability:	Medical concerns directly related to GD:		
	Level of support needed to complete ADLs:		
	Able to have this level at home through supports:		
Overall Risk Level:	High	Medium	Low

MOORE INSTITUTE

Mental Health Assessment Form

Client Name: _____

Crisis Plan (if applicable):	
Social History	
Early Childhood Development:	
Current Psychosocial Situation:	

MOORE INSTITUTE

Mental Health Assessment Form

Client Name: _____

Social History Continued:	
Abuse History:	
Crime Victimization:	
Family History of Mental Illness/Drug Use:	
Education:	
Current Occupational Assessment:	
Military History:	
Legal Status:	

MOORE INSTITUTE

Mental Health Assessment Form

Client Name: _____

Diagnosis		
Primary	Code	
	Description	
	Rationale/DSM Criteria	
Secondary	Code	
	Description	
	Rationale/DSM Criteria	
Tertiary	Code	
	Description	
	Rationale/DSM Criteria	
Other	Code	
	Description	
	Rationale/DSM Criteria	

Disposition Plan:	
Clinical Impressions:	
Referred to / Recommendations:	
Additional Referrals/Recommendations:	

Signatures		**Date**
Clinician Name and Credentials (printed):		
Clinician Signature:		