Name: ___________________
ID#: _____________________

For Office Use Only:

Clinician Formulation:

Clinical Diagnoses	
Medical Diagnoses	
Psychosocial and Environmental Stressors	

Information/Referrals Provided: (Check those that apply)

☐ Diagnostic Educational Resources____________________
☐ Support Group____________________________________
☐ Community Resources______________________________
☐ Advocacy Training_________________________________
☐ Caregiver Education/Resources______________________
☐ Financial Resources________________________________
☐ Behavioral Health Agency__________________________

☐ Legal Aid_____________________________________
☐ Pastoral Care_________________________________
☐ Medical_______________________________________
☐ Psychiatric____________________________________
☐ Early Intervention_____________________________
☐ Other_________________________________
☐ Patient/Family declined information/resources.

Clinician Signature:_______________________________________ ID#:_______________________

Date Completed:_________________________________

Name: ____________________
ID#: ______________________

Mental Status Evaluation (check all that apply) **Unable to assess due to:** ______________________________

Appearance:	☐Well-groomed ☐Inappropriate	☐Disheveled ☐Adequate	☐Bizarre ☐N/A
Attitude:	☐Cooperative ☐Belligerent	☐Guarded ☐Uncooperative	☐Suspicious ☐N/A
Effort:	☐Good ☐Gives Up Easily	☐Adequate ☐Easily Frustrated	☐Needs Encouragement ☐N/A
Motor Activity:	☐Calm ☐Muscle spasms ☐Restless/Squirmy	☐Hyperactive ☐Hypoactive ☐N/A	☐Agitated ☐Tremors/tics
Impulse Control:	☐Controlled ☐N/A	☐Physically acts out	☐Verbally acts out
Affect:	☐Appropriate ☐Constricted ☐Worrisome ☐Angry	☐Labile ☐Blunted ☐Sad ☐N/A	☐Expansive ☐Flat ☐Apathetic
Mood:	☐Euthymic ☐Euphoric ☐N/A	☐Depressed ☐Irritable	☐Anxious ☐Angry
Speech:	☐Delayed	☐Excessive	☐ ☐Word Find Diff
	☐Artic Difficulty ☐Slurred ☐Incoherent	☐Spontaneous ☐Pressured ☐Perseverating	☐Soft ☐Loud ☐N/A
Thought Process:	☐Intact ☐Flight of Ideas ☐Impulsive ☐Impaired self tracking	☐Circumstantial ☐Cognitive Slowing ☐ ☐ ☐Loose ions	☐Sensory/Percept Impairment ☐N/A
Thought Content:			
Hallucinations:	☐Not present ☐Olfactory	☐Auditory ☐Tactile	☐Visual ☐N/A
Delusions:	☐Not present ☐Grandiose	☐Persecutory ☐ N/A	☐Being Controlled
Risk Assessment:			
Suicidal Intent	☐Not Present ☐No Plan	☐Present ☐Previous	☐Plan ☐N/A
Homicidal Intent	☐Not Present ☐No Plan	☐Present ☐Previous	☐Plan ☐N/A

Current Risk ☐None ☐Mild ☐Moderate ☐Severe ☐N/A

Name: ____________________
ID#: ____________________

Sensorium and Cognition

Orientation	☐Time	☐Place	☐Person☐N/A	
Consciousness	☐Alert	☐Sedated/Lethargic	☐Delirium	☐N/A
Memory:				
Recent	☐Intact	☐Impaired	☐N/A	
Remote	☐Intact	☐Impaired	☐N/A	
Delayed	☐Intact	☐Impaired	☐N/A	
Concentration/Attent Span:	☐Intact	☐Impaired	☐N/A	
Abstract Thinking	☐ Age Approp	☐Inapprop	☐N/A	
Judgement	☐Intact ☐Severe☐N/A	☐Impaired	☐Mild	☐Moderate
Insight	☐Intact ☐Severe☐N/A	☐Impaired	☐Mild	☐Moderate

Global Functioning Summary: ☐N/A

- ☐ 10 Imminent Harm
- ☐ 20 Possible Harm
- ☐ 30 Serious Impairment
- ☐ 40 Major Impairment
- ☐ 50 Serious Symptoms
- ☐ 60 Moderate Symptoms
- ☐ 70 Mild Symptoms
- ☐ 80 Slight Symptoms
- ☐ 90 No Symptoms
- ☐ 100 Superior Functioning

Patient advised of available services? ☐Yes ☐No:
Reason____

Patient advised of assessment and treatment process: ☐Yes ☐No:
Reason____

Clinician's Signature:____ID #___________________________

Date Completed: ___________________________________