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

- ☐ Problems with primary support group (Specify):
- ☐ Problems related to the social environment (Specify):
- ☐ Educational problems (Specify):
- ☐ Occupational problems (Specify):
- ☐ Housing problems (Specify):
- ☐ Economic problems (Specify):
- ☐ Problems with access to healthcare services (Specify):
- ☐ Problems related to interaction with the legal system/crime (Specify):
- ☐ Other psychosocial and environmental problems (Specify):

Axis V: Global Assessment of Functioning Scale

Score:	Time Frame:

Admitted to Services: ☐ Yes ☐ 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: *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.*

	1.	
	2.	
	3.	
	4.	
	5.	
	6.	

Interpretive Summary: *Include an integration of potential interrelationships between findings*

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:

Anticipated level and length of care:

Intensity of treatment and expected focus *(goals)* with recommendations:

ASAM Dimensions

Dimension 1:(Acute Intoxication and/or Withdrawal Potential)	☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe
Dimension 2:(Biomedical Conditions and Complications)	☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe
Dimension 3:(Emotional, Behavioral or Cognitive Conditions & Complications)	☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe
Dimension 4: (Readiness to Change)	☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe
Dimension 5: (Relapse, Continued Use or Continued Problem Potential)	☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe
Dimension 6: (Recovery/Living Environment)	☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ 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 *(include visual and motor function)*:

Medications for the past year:

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 *(chronological order)*:
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					

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:

Clinical Assessment (Diagnostic Assessment)

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 #: