THE CENTER FOR DRUG-FREE LIVING, INC.
Brief Behavioral Health Status Exam (1091)

CLIENT NAME: **NUMBER:**

Start Time: **End Time:**

Purpose of Exam: ☐ Evaluate Clinical Necessity ☐ Evaluate Service Needs

Setting: ☐ Residential ☐ Outpatient ☐ Detox ☐ Other:

APPEARANCE: ☐ Clean ☐ Neat ☐ Unkempt ☐ Disheveled ☐ Other:
Looks Stated Age: ☐ Yes ☐ No ☐ Younger ☐ Older

EYE CONTACT: ☐ Appropriate ☐ Inappropriate

ORIENTATION: **X 4:** ☐ Time ☐ Place ☐ Person ☐ Situation

MEMORY: ☐ Normal Limits ☐ Deficient: ☐ Immediate ☐ Recent ☐ Remote
☐ Other:

ATTENTION: ☐ Adequate ☐ Inadequate

PERCEPTION: ☐ Adequate ☐ Inadequate

MOTOR ACTIVITY: ☐ Normal ☐ Slowed ☐ Restless ☐ Agitated

COGNITIVE PERFORMANCE: ☐ Normal Limits ☐ Poor memory ☐ Low self-awareness
☐ Short attention ☐ Developmental disability
☐ Poor concentration ☐ Impaired judgement
☐ Slow processing

THOUGHT PROCESS: ☐ Normal limits ☐ Illogical ☐ Delusional
☐ Hallucinating (visual, auditory, tactile)
☐ Paranoid ☐ Ruminative ☐ Intact ☐ Derailed thinking
☐ Loose association ☐ Anti-psychotic medication

DANGER TO OTHERS: ☐ Does not appear dangerous to others ☐ Violent temper
☐ Threatens others ☐ Physical abuser ☐ Hostile ☐ Assaultive
☐ Homicidal ideation ☐ Homicidal threats ☐ Homicide attempt

DANGER TO SELF: ☐ Does not appear dangerous to self ☐ Suicidal ideation
☐ Current plan/means ☐ Recent attempt ☐ Past attempt
☐ Self-injury ☐ Self-mutilation

SENSORY DEFICITS: ☐ None or ☐ Speech ☐ Hearing ☐ Vision

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Brief Behavioral Health Status Exam (1091) Continued

CLIENT NAME: **NUMBER:**

SPEECH: ☐ Clear ☐ Slurring ☐ Slowed ☐ Loud ☐ Soft ☐ Pressured ☐ Excessive ☐ Minimal ☐ Incoherent ☐ Other:

MOOD: ☐ Euthymic ☐ Unremarkable ☐ Depressed ☐ Tearful ☐ Anxious ☐ Manic ☐ Labile ☐ Other:

AFFECT: ☐ Full range ☐ Constricted range ☐ Flat

INSIGHT INTO PROBLEM: ☐ Takes responsibility ☐ Intellectual insight ☐ Emotional insight ☐ Slight awareness ☐ Blames others ☐ Complete denial

BEHAVIOR DURING INTERVIEW: ☐ Cooperative ☐ Guarded ☐ Withdrawn ☐ Acting Out ☐ Oppositional ☐ Hostile ☐ Passive ☐ Other:

ADDITIONAL OBSERVATIONS:

CLIENT STRENGTHS:

SERVICE NEEDS:

PROVISIONAL IMPRESSION/DIAGNOSIS: 303.90 Alcohol Dependence
-
311.00 Depressive Disorder NOS

PLAN OF TREATMENT: ☐ **Individual Therapy** ☐ **Group Therapy** ☐ **Family Therapy** ☐ **Psychiatric Referral**

DISCHARGE CRITERIA:

Clinician Signature: _____ Date: _____

If Medicaid client: LPHA, M. CAP Signature: _____Date: _____

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