

Date of assessment _____

ASSESSING PRACTITIONER (NAME AND DISCIPLINE): _____

Client/Others Interviewed: _____

I. DEMOGRAPHIC DATA & SPECIAL SERVICE NEEDS:

DOB: _____ GENDER: _____ ETHNICITY: _____ Marital Status: _____

Referral Source: _____

Non-English Speaking, specify language used for this interview: _____

Were Interpretive Services provided for this interview? Yes No

Cultural Considerations, specify: _____

Physically challenged (wheelchair, hearing, visual, etc.) specify: _____

Access issues (transportation, hours), specify: _____

II. Reason for Referral/Chief Complaint

Describe **PRECIPITATING EVENTS(S)/REASON FOR REFERRAL**

CURRENT SYMPTOMS AND BEHAVIORS (INTENSITY, DURATION, ONSET, FREQUENCY) and IMPAIRMENTS IN LIFE FUNCTIONING caused by the symptoms/behaviors (from perspective of client and others):

CLIENT STRENGTHS (to assist in achieving treatment goals)

SUICIDAL THOUGHTS/ATTEMPTS: *“Columbia Suicide Severity Rating Scale Screener (LACDMH Version)”*

Wish to be Dead: *Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.*

1. Within the past 30 days, have you wished you were dead or wished you could go to sleep and not wake up? Yes No

Suicidal Thoughts: *General non-specific thoughts of wanting to end one’s life/commit suicide, “I’ve thought about killing myself” without general thoughts of ways to kill oneself/associated methods, intent, or plan.*

2. Within the past 30 days, have you actually had any thoughts of killing yourself? Yes No

If YES to 2, ask questions 3, 4, 5, and 6

If NO to 2, go directly to question 6

Suicidal Thoughts with Method (without Specific Plan or Intent to Act): *Person endorses thoughts of suicide and has thoughts of at least one method during the assessment period.*

3. Have you been thinking about how you might kill yourself? Yes No

Suicidal Intent (without Specific Plan): *Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts.*

4. Have you had these thoughts and had some intention of acting on them? Yes No

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name:

ID#:

Agency:

Los Angeles County – Division of HIV and STD Programs

Suicide Intent with Specific Plan: *Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.*

5. Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan? Yes No

Suicidal Behavior:

6. Have you done anything, started to do anything, or prepared to do anything to end your life? Yes No

If yes, How long ago did you do any of these?

Additional comments regarding suicidal thoughts/attempts:

Self-Harm (without statement of suicidal intent) Yes No Unable to Assess

If yes, describe

III. MENTAL HEALTH HISTORY/RISKS

History of Problem Prior to Precipitating Event: Include treated & non-treated history.

Impact of treatment and non-treatment history: on the client's level of functioning, e.g., ability to maintain residence, daily living and social activities, health care, and/or employment.

PSYCHIATRIC HOSPITALIZATIONS: Yes No Unable to Assess

If yes, describe **DATES, LOCATIONS, AND REASONS**

OUTPATIENT TREATMENT: Yes No Unable to Assess

If yes, describe **DATES, LOCATIONS, AND REASONS.**

TRAUMA or Exposure to Trauma: Yes No Unable to Assess

Has client ever (1) been physically hurt or threatened by another, (2) been raped or had sex against their will, (3) lived through a disaster, (4) been a combat veteran or experienced an act of terrorism, (5) been in a severe accident, or been close to death from any cause, (6) witnessed death or violence or the threat of violence to someone else, or (7) been the victim of a crime?

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name:

ID#:

Agency:

Los Angeles County – Division of HIV and STD Programs

IV. HIV AND PSYCHOTROPIC MEDICATIONS

Has the client ever taken psychotropic medications? Yes No Unable to Assess

Has the client ever taken HIV medications? Yes No Unable to Assess

List present medications used, prescribed/non-prescribed, by name, dosage, frequency. Indicate from client's perspective what seems to be working and not working.

PSYCHOTROPICS **DOSAGE/FREQUENCY** **PERIOD TAKEN** **EFFECTIVENESS/RESPONSE/SIDE EFFECTS/REACTIONS**

PSYCHOTROPICS	DOSAGE/FREQUENCY	PERIOD TAKEN	EFFECTIVENESS/RESPONSE/SIDE EFFECTS/REACTIONS
HIV MEDICATIONS	DOSAGE/FREQUENCY	PERIOD TAKEN	EFFECTIVENESS/RESPONSE/SIDE EFFECTS/REACTIONS

Medication Comments (include medication adherence issues/history):

V. SUBSTANCE USE/ADDICTION Screening and Assessment

A. Alcohol Screening Questions

1 Drink = 12 Ounces of beer, 5 Ounces of wine, or 1.5 Ounces of liquor

1. In the past year, how often did you have a drink containing alcohol? If "Never", proceed to Drug Screening Questions.	<input type="checkbox"/> Never (0)	<input type="checkbox"/> Monthly or less (1)	<input type="checkbox"/> 2-4 times a month (2)	<input type="checkbox"/> 3 times a week (3)	<input type="checkbox"/> 4+ times a week (4)
1a. In the past year, how many drinks containing alcohol did you have on a typical day when you are drinking?	<input type="checkbox"/> 1 or 2 (0)	<input type="checkbox"/> 3 or 4 (1)	<input type="checkbox"/> 5 or 6 (2)	<input type="checkbox"/> 7 to 9 (3)	<input type="checkbox"/> 10+ (4)
1b. In the past year, how often did you have six or more drinks on one occasion?	<input type="checkbox"/> Never (0)	<input type="checkbox"/> Less than monthly (1)	<input type="checkbox"/> Monthly (2)	<input type="checkbox"/> Weekly (3)	<input type="checkbox"/> Daily or almost daily (4)

Alcohol Screening Score: _____ (For a score of 4 or more, proceed to Assessment. A brief intervention is also indicated)

Was a brief intervention provided? Yes No

B. Drug Screening Questions ("Yes" to any of the questions below indicates a positive screening)

	Ever Used?		Recently Used? (Past 6 Months)	
	Yes	No	Yes	No
1. Have you used nicotine products? (Cigarettes, cigars, electronic cigarettes, smokeless tobacco)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you use products containing caffeine, such as tea, coffee or high-caffeine energy drinks? (Such as AMP, Monster, Red Bull or 5 Hour Energy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you used opioids? (Heroin, opium, non-prescribed pain medications)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you used prescription medications, over the counter medications, and/or non-prescription supplements in a manner other than prescribed? (For example, to get high)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you used stimulants, such as cocaine or methamphetamine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you used drugs intravenously?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you used drugs/alcohol as a means to engage in sexual activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C. Are you interested in changing your substance use patterns? Yes No NA

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name:

ID#:

Agency:

Los Angeles County – Division of HIV and STD Programs

Assessment/Additional Information (answer only if screening is positive)

PAST AND PRESENT USE OF TOBACCO, ALCOHOL, CAFFEINE, CAM (COMPLEMENTARY AND ALTERNATIVE MEDICATIONS) AND OVER-THE-COUNTER, AND ILLICIT DRUGS, if not determined by screener. Be sure to include route of administration, frequency (amount), withdrawals, etc.

VI. MEDICAL HISTORY

HIV Clinic: _____ **PHONE:** _____ **Last Medical Appointment** _____

Major medical problem (treated or untreated) (Indicate problems with check: Y or N for client, Fam for family history.)

Fam	Y	N		Fam	Y	N		Fam	Y	N		Fam	Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizure/neuro disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
	<input type="checkbox"/>	<input type="checkbox"/>	Head trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Renal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/lung disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis
	<input type="checkbox"/>	<input type="checkbox"/>	Weight/appetite chg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Herpes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES (If Yes, specify):												
	<input type="checkbox"/>	<input type="checkbox"/>	Sensory/Motor Impairment (If Yes, specify):												
	<input type="checkbox"/>	<input type="checkbox"/>	Pap smear If yes, date: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mammogram If yes, date: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV Test If yes, date: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant If yes, due date: _____

Comments on above medical problems, co-occurring disorders, recent hospitalizations, etc.

VII. PSYCHOSOCIAL HISTORY

Please state specifically how mental health or HIV status impacts each area below; Be sure to include the client's strengths in each area.

EDUCATION/SCHOOL HISTORY

Special Education: Yes No Unable to Assess Learning Disability: Yes No Unable to Assess
Motivation, education goals, literacy skill level, general knowledge skill level, math skill level, school problems, etc:

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name:

ID#:

Agency:

Los Angeles County – Division of HIV and STD Programs

HIV RISK BEHAVIORS/PARTNER SERVICES:

- | | | |
|---|------------------------------|-----------------------------|
| 1. Have you had unprotected sex with anyone in the past six months? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Have you told all of your present and/or past sexual partners your HIV status? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Have you ever used Partner Services? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Do you want assistance disclosing your HIV status to anyone? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

LEGAL HISTORY AND STATUS

Arrests/DUI, probation, convictions, divorce, conservatorship, parole, child custody, etc:

CURRENT LIVING ARRANGEMENT and Social Support Systems

Type of living setting, problems at setting, community, religious, government agency, or other types of support, etc:

DEPENDENT CARE ISSUES

Number of Dependent Adults: _____ Number of Dependent Children: _____

Ages of children, school attendance/behavior problems of children, special needs of dependents, foster care/group home placement issues, child support, etc:

FAMILY HISTORY/RELATIONSHIPS

History of Mental Illness in Immediate Family: Yes No Unable to Assess

Alcohol/Drug Use in Immediate Family: Yes No Unable to Assess

History of Incarceration in Immediate Family: Yes No Unable to Assess

Family constellation, family of origin, family dynamics, cultural factors, nature of relationships, domestic violence, physical or sexual abuse, home safety issues, family medical history, family legal/criminal issues

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name:

ID#:

Agency:

Los Angeles County – Division of HIV and STD Programs

VIII. MENTAL STATUS EVALUATION

Instructions: Check all descriptions that apply

General Description

Grooming & Hygiene: Well Groomed
 Average Dirty Odorous Disheveled
 Bizarre
Comments:

Eye Contact: Normal for culture
 Little Avoids Erratic
Comments:

Motor Activity: Calm Restless
 Agitated Tremors/Tics Posturing Rigid
 Retarded Akathesis E.P.S.
Comments:

Speech: Unimpaired Soft
 Slowed Mute Pressured Loud
 Excessive Slurred Incoherent
 Poverty of Content
Comments:

Interactional Style: Culturally congruent
 Cooperative Sensitive
 Guarded/Suspicious Overly Dramatic
 Negative Silly
Comments:

Orientation: Oriented
 Disoriented to:
 Time Place Person Situation
Comments:

Intellectual Functioning: Unimpaired
 Impaired
Comments:

Memory: Unimpaired
 Impaired re: Immediate Remote Recent
 Amnesia
Comments:

Fund of Knowledge: Average
 Below Average Above Average
Comments:

Mood and Affect

Mood: Euthymic Dysphoric Tearful
 Irritable Lack of Pleasure
 Hopeless/Worthless Anxious
 Known Stressor Unknown Stressor
Comments:

Affect: Appropriate Labile Expansive
 Constricted Blunted Flat Sad
 Worried
Comments:

Perceptual Disturbance

None Apparent

Hallucinations: Visual Olfactory
 Tactile Auditory: Command
 Persecutory Other
Comments:

Self-Perceptions: Depersonalizations
 Ideas of Reference
Comments:

Thought Process Disturbances

None Apparent

Associations: Unimpaired Loose
 Tangential Circumstantial Confabulous
 Flight of Ideas Word Salad
Comments:

Concentration: Intact Impaired by:
 Rumination Thought Blocking
 Clouding of Consciousness Fragmented
Comments:

Abstractions: Intact Concrete
Comments:

Judgments: Intact
 Impaired re: Minimum Moderate Severe
Comments:

Insight: Adequate
 Impaired re: Minimum Moderate Severe
Comments:

Serial 7's: Intact Poor
Comments:

Thought Content Disturbance

None Apparent

Delusions: Persecutory Paranoid Grandiose
 Somatic Religious Nihilistic
 Being Controlled
Comments:

Ideations: Bizarre Phobic Suspicious
 Obsessive Blames Others Persecutory
 Assaultive Ideas Magical Thinking
 Irrational/Excessive Worry
 Sexual Preoccupation
 Excessive/Inappropriate Religiosity
 Excessive/Inappropriate Guilt
Comments:

Behavioral Disturbance

Behavioral Disturbances: None Aggressive
 Uncooperative Demanding Demeaning
 Belligerent Violent Destructive
 Self-Destructive Poor Impulse Control
 Excessive/Inappropriate Display of Anger
 Manipulative Antisocial
Comments:

Suicidality/Homicidality

Suicidal: Denies Ideation Only
 Threatening Plan
Comments:

Homicidal: Denies Ideation Only
 Threatening Target Plan
Comments:

Other

Passive: Amotivational Apathetic
 Isolated Withdrawn Evasive Dependent
Comments:

Other: Disorganized Bizarre
 Obsessive/compulsive Ritualistic
 Excessive/Inappropriate Crying
Comments:

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name:

ID#:

Agency:

Los Angeles County – Division of HIV and STD Programs

IX. Summary and Diagnosis

1. CLINICAL FORMULATION: (Be sure to include assessment of risk of suicidal/homicidal behaviors, significant strengths/weaknesses, observations/descriptions, symptoms/impairments in life functioning, i.e. Work, School, Home Community, Living Arrangements, etc, and justification for diagnosis)

2. DIAGNOSTIC DESCRIPTOR

ICD DIAGNOSIS CODE (check at least one Primary)

Primary Code _____
 Sec Code _____
Code _____
Code _____
Code _____
Code _____
Code _____
Code _____

3. HIV Medical Care Goals Does client's mental health status interfere with HIV medical care? Yes No

4. Disposition/Recommendations/Plan

5. SIGNATURE

Assessor's Signature & Discipline Date Co-Signature & Discipline Date