

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

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**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?

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## 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**

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

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

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**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"/>	<b>ALLERGIES</b> (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:

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**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

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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:

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**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