



Colorado Health Partnerships, LLC
Pikes Peak ♦ SyCare ♦ West Slope Casa ♦ ValueOptions

INITIAL ASSESSMENT FORM

CLIENT NAME: _____ CLIENT MEIDCAID #: _____

1. Presenting problem in emotional/behavioral terms as described by the client/guardian (What do they want?):

Four horizontal lines for writing the presenting problem.

2. Current precipitant leading to treatment now as described by the client/guardian (Why now?):

Three horizontal lines for writing the current precipitant.

3. Risk Factors: [] SI [] HI [] Gravely Disabled [] Other: _____

4. Mental Status: select all that apply

- a. Appearance: [] age-appropriate [] younger than age [] older than age
b. Eye contact: [] good [] fair [] poor
c. Grooming: [] good [] fair [] poor
d. Attentiveness: [] attentive [] distracted [] resistant [] preoccupied [] disinterested
e. Alertness: [] alert [] drowsy [] stupor
f. Motor: [] normal [] slowed [] agitated [] abnormal (tremors, tics, grimaces, other: _____)
g. Speech: [] normal [] slowed [] pressured [] loud [] quiet [] inarticulate
f. Affect: [] stable/appropriate [] labile [] constricted [] inappropriate to content & circumstance [] flat [] blunted [] other: _____
g. Mood: [] neutral [] pleasant [] happy [] sad [] euphoric [] irritable [] anxious [] fearful [] angry [] apathetic [] other: _____



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h. Thought Content: normal worthless/hopeless self-deprecating threatening
 obsessions ruminating phobias ideas of reference paranoia magical
ideation delusions grandiose other: _____

i. Thought Process: normal associations illogical incoherent tangential
 flight of ideas word salad other: _____

j. Perception: normal auditory hallucinations visual hallucinations tactile
hallucinations depersonalization derealization other: _____

k. Intelligence: average below average above average

l. Insight (for age): good fair poor

m. Judgment (for age): good fair poor

5. **Psychosocial History** (family issues, abuse, significant events, etc):

6. **Client Strengths:**



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7. **Prior Psychiatric treatment:** select if not applicable

8. **Developmental History for clients < 18 y/o:** select if not applicable

9. **Substance Abuse (past/present):** select if not applicable

10. **Mental Retardation/Developmental Disabilities/organic conditions that may impact clinical presentation or functioning in treatment:** select if not applicable

11. **Medical conditions that may impact clinical presentation or functioning in treatment:** select if not applicable



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12. **Current Medications** (doses, frequency): select if not applicable

13. **Medication referral as necessary:** select if not applicable

14. **Initial DSM-IV Diagnosis**

- a. Axis I: _____
- b. Axis II: _____
- c. Axis III: _____
- d. Axis IV: _____
- e. Axis V: _____

Comments/Notes:

Provider Signature (include credentials): _____

Date of Assessment: _____