SELF ASSESSMENT MENTAL HEALTH EVALUATION

In order to help you best, we would like to know some things about you. If you have any questions about anything we've asked, please ask for assistance.

Name: _____ _____ _____
(First) **(Middle)** **(Last)**

PRESENTING PROBLEMS

In your own words, please describe your presenting problem.

_____

_____

Please report any of the following symptoms/issues that apply:

Symptom:	How Often?	How long does it last?	How bad does it get?
Anger/Aggression (Verbal and Physical)			
Anxiety/Panic/Phobia			
Attachment Problems			
Bereavement Issues			
Compulsions			
Depressed Mood/ Sad/Withdrawal			
Disturbed Reality Contact/Psychosis (hearing voices, delusions, etc.)			
Enuresis/Encopresis (bedwetting, soiling clothing, etc.)			
Impulsivity/Hyperactivity			
Inattention/Distractibility/ Decreased Concentration			
Mood Swings/Manic Episodes (spending sprees, staying awake for days, etc.)			

Nutritional/Eating Pattern Changes/Disorders			
Obsessions			
Oppositional Behaviors/Lying			
Self-Injurious Behavior			
Sleep Problems			
Stealing/Fire Setting/ Property Damage			
Substance Abuse/Addiction /Other Addictive Behaviors			
Traumatic Stress **(nightmares, flashbacks, etc.)**			
Other			

Choose one or more of the following that apply:

- ☐ None Reported
- ☐ Recent Loss
- ☐ Custody/Placement Issues
- ☐ Physical /Sexual Abuse
- ☐ School/Work Problems
- ☐ Legal Issues
- ☐ Financial Difficulties
- ☐ Separation/Divorce
- ☐ Change in Living Situation

Comments:

Strengths/Needs/Abilities/Preferences

Please list any strengths/needs/abilities/preferences in the space provided below.

Strengths/Capabilities/Natural Supports: **Examples of Strengths: Employed with a Good History, Outgoing/Friendly, High Self-Esteem, Volunteer Activities, Leisure/Recreation, NA, AA, Motivation/Self-Starter, Family/Social Support, Organized, Responsible/Dependable, Actively Involved in Church/Other Positive Community Organization, Good Sense of Humor, has Benefitted From Treatment in the Past, Access to Reliable Transportation, Capacity for Insight.**	
Needs: **Examples of Needs: Services Requested, Financial/Urgent Needs, Resources/Environmental Supports Needed, Educational Needs of Client and Family.**	
Abilities: **Examples of Abilities and/or Interests: Intelligent, Good Verbal Skills, Good Reading Skills, Writing, Sports- specify, Music/Art- describe.**	
Preferences/Advanced Directives/ Religious Preference: **Examples of Preferences: Advanced Directives, Time of Appointments/Services- describe, Gender of Staff- specify, Cultural/Spiritual Considerations.**	

Outpatient/Inpatient Mental Health

Is there a history of Outpatient Mental Health Services provided to client?

☐ None Reported

Name of Agency/Clinician	Dates of Service	Reason for Treatment

Please ensure Authorization for Release of Information is obtained for each agency/clinician.

Is there a history of Inpatient Mental Health Services provided to client?

☐ None Reported

Name of Hospital/Facility	Dates of Service	Reason for Treatment

Please ensure Authorization for Release of Information is obtained for each hospital/facility.

Previous/Current Diagnosis

☐ Not known by client

☐ Yes- please list: _____

Alcohol/Drug Treatment

Has client ever received Alcohol/Drug treatment?

☐ None Reported

Alcohol/Drug Treatment Facility	Dates of Service

Medication History

If you have signed a release of information for all the health care providers you currently are seeing, you need NOT complete this section.

Current Medications:

☐ None Reported

Name of Medication	Do You Take it as Prescribed?	Does it Seem to be Working?

Past Psychotropic Medications Only:

☐ None Reported

Name of Psychotropic Medication	Did the Medication Work?	Reason for Discontinuation?

Medical History/Allergies

Major Medical Conditions/Pain Management Concerns?

☐ None Reported

☐ Diabetes ☐ Hypertension ☐ Asthma ☐ Seizures

☐ Other – please specify: _____

Is the client currently pregnant or nursing?

☐ N/A

☐ Nursing

☐ Pregnant – How far along? _____

Allergies to Medications?

☐ None Reported

Name of Medication	Reaction