

INTEGRATED BIOPSYCHOSOCIAL ASSESSMENT

Date: _____ Time: _____

IDENTIFYING/DEMOGRAPHIC INFORMATION

Legal Name: _____ **Age:** _____ **Date of Birth:** _____
SSN: _____ **Gender:** _____ **Lives with:** _____
Race/Ethnicity:
 Caucasian African American Native American Asian Hispanic/Latino Other
Address: _____ **City:** _____ **Zip:** _____
Phone Numbers:
Home: _____ **Work:** _____ **Cell:** _____ **Pager:** _____
Referral Source: _____

Name
Agency
Telephone Number

CUSTODY INFORMATION

Legal Guardian(s): _____ **Relationship:** _____
Custody Status: DHS OJA DHS Involvement OJA Involvement Power of Attorney
 Self Tribal Custodial Parent: **Mother:** _____ **Father:** _____ Other: _____
For OJA & DHS Custody (worker contact information):
Primary Worker: _____ **E-Mail:** _____
Office Phone: _____ **Fax:** _____ **Cell:** _____ **Pager:** _____
County: _____ **Supervisor:** _____ **Office Phone:** _____
Secondary Worker: _____ **E-Mail:** _____
Office Phone: _____ **Fax:** _____ **Cell:** _____ **Pager:** _____
County: _____ **Supervisor:** _____ **Office Phone:** _____
DHS ARC: _____ **Phone #:** _____ **Fax #:** _____
Emergency contact if other than legal guardian: _____

INSURANCE INFORMATION

Primary Insurance:	Group #: _____	ID #: _____
Contact: _____	Phone #: _____	
Subscriber: _____	Relationship: _____	
Subscriber Employer: _____	Phone #: _____	
Social Security #: _____	Date of Birth: _____	
PCP: _____	Phone #: _____	Fax: _____
Secondary Insurance:	Group #: _____	ID #: _____
Contact: _____	Phone #: _____	
Subscriber: _____	Relationship: _____	
Subscriber Employer: _____	Phone #: _____	
Social Security #: _____	Date of Birth: _____	
<input type="checkbox"/> DDSD Waiver <input type="checkbox"/> Soonercare TEFRA <input type="checkbox"/> Workers Compensation		

CURRENT OUTPATIENT AND CASE MANAGEMENT PROVIDERS

Current Outpatient Provider:		
Phone #:	Fax #:	
Date of last visit:	Frequency Scheduled:	How often attended:
Current Psychiatrist:		
Phone #:	Fax #:	

Patient Name: _____ Date: _____

PHP/IOP/Substance Abuse Tx: _____

Upon discharge, do you plan to return to current O/P provider? Yes No

If not, does client have preference for new provider? Yes No Name of Preference: _____

Medical release forms signed to obtain outpatient treatment information? Yes No

Case Management Services:

Does client have current case management services? Yes No

Name of current provider for case management services: _____

If not, does client wish to enroll for case management services? Yes No

Systems of Care: Yes No

Provider: _____

REASON FOR ADMISSION

Describe specific emotional/behavioral problems that led to your coming here today:

When did the symptoms start? _____

Recent changes in sleep/appetite? _____

Is the client experiencing any health problems? Yes No

If yes, explain:

Emotional/Behavioral History (History of current issues, beginning with the past 24-48 hours):

CONTRIBUTING STRESSORS

Please indicate any current contributing stressors (i.e. significant loss; recent move; deaths; incarceration; any interactions with police, law enforcement, or security officers; pending legal charges):

If pending legal charges, court date is: _____

Has this person had any charges or referrals regarding sexual offenses? Yes No

If yes, (1) please explain: _____

(2) Sexual Offense Risk assessment administered: Yes No

Possible identifiers: _____

History of Abuse: Sexual Physical Mental Neglect Witness to Domestic Abuse

Perpetrator _____ Reported to authorities: Yes No

When Reported _____ By Whom was it Reported _____

Patient Name: _____ Date: _____

HISTORY OF TREATMENT

(Include agency, city and phone #; dates and duration)

Previous Inpatient: _____

Previous Outpatient/IOP/Substance Abuse: _____

Previous history of family members treated for mental health (Include family history of suicide):

Maternal Family Hx: _____

Paternal Family Hx: _____

TREATMENT EXPECTATIONS

What changes in the client are expected after inpatient treatment?

CLIENT STRENGTHS

What are the client's strengths [based on a time when not in crisis]?

What are the client's interests [based when not in crisis]?

What abilities does this client possess that will help them while in treatment?

Patient/family needs

EARLY DEVELOPMENTAL PROBLEMS

Did the client experience any developmental difficulties from birth to age 5 (problems at birth, delayed milestones, head injuries, serious illnesses)? Yes No

If "Yes," describe:

Patient Name: _____ Date: _____

SELF REPORT/OBSERVATIONS

	No Risk		Low Risk			Moderate			High Risk		
	0	1	2	3	4	5	6	7	8	9	10
Anxiety (circle one) Comments	<hr/>										

Depression (circle one) Comments	<hr/>										
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Hopelessness (circle one) Comments	<hr/>										
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Grief/Losses Comments	<input type="checkbox"/> Years ago	<input type="checkbox"/> Months ago	<input type="checkbox"/> Past week	<input type="checkbox"/> Today	<hr/>						
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Self Abusive Behaviors Types of Behavior Comments	<input type="checkbox"/> History of <input type="checkbox"/> Cutting	<input type="checkbox"/> Monthly <input type="checkbox"/> Burning	<input type="checkbox"/> Weekly <input type="checkbox"/> Head banging	<input type="checkbox"/> Daily <input type="checkbox"/> Other	<hr/>						
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Suicidal Thoughts	<input type="checkbox"/> None	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily	<hr/>						
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Current suicidal intent _____
History of suicidal thoughts: _____

Suicidal Plan Access to means Comments	<input type="checkbox"/> No plan	<input type="checkbox"/> Unclear	<input type="checkbox"/> Some plan	<input type="checkbox"/> Well thought out	<hr/>						
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Previous Suicide Attempts Client's expectation of being discovered: Comments	<input type="checkbox"/> None	<input type="checkbox"/> Low lethality <input type="checkbox"/> Low expectation	<input type="checkbox"/> Moderate lethality <input type="checkbox"/> High expectation	<input type="checkbox"/> High lethality	<hr/>						
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Homicidal/Violent Thoughts Comments	<input type="checkbox"/> None reported	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily	<input type="checkbox"/> Currently	<hr/>						
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Homicidal/Violent Plan Comments	<input type="checkbox"/> No plan	<input type="checkbox"/> Unclear	<input type="checkbox"/> Some plan	<input type="checkbox"/> Well thought out	<hr/>						
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Hostility/Aggressiveness Comments	<input type="checkbox"/> Verbal	<input type="checkbox"/> Against property	<input type="checkbox"/> Auto-aggression	<input type="checkbox"/> Physical	<hr/>						
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History of Violence Comments	<input type="checkbox"/> None reported	<input type="checkbox"/> Little	<input type="checkbox"/> Some	<input type="checkbox"/> Marked	<hr/>						
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Sexual Aggression

- None
- Touching own private parts in front of others or to the point of causing harm
- Showing others your private parts
- Touching other's private parts without permission
- Forcing others who are younger or compromised to do sexual things

Delusions Types of Delusions: Describe	<input type="checkbox"/> None reported <input type="checkbox"/> Persecutory	<input type="checkbox"/> History of <input type="checkbox"/> Grandiose	<input type="checkbox"/> Monthly <input type="checkbox"/> Bizarre	<input type="checkbox"/> Weekly <input type="checkbox"/> Idea of reference	<input type="checkbox"/> Daily	<hr/>					
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Hallucinations Types of Hallucinations: Describe	<input type="checkbox"/> None reported <input type="checkbox"/> Visual	<input type="checkbox"/> History of <input type="checkbox"/> Auditory	<input type="checkbox"/> Monthly <input type="checkbox"/> Command	<input type="checkbox"/> Weekly <input type="checkbox"/> Tactile	<input type="checkbox"/> Daily <input type="checkbox"/> Olfactory	<hr/>					
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Patient Name: _____ Date: _____

BEHAVIORAL INFORMATION

Check if the behavior was/is exhibited by the client:

BEHAVIORS	Description	Age Behavior Began	None Reported	History of	Monthly	Weekly	Daily
Cries easily							
Withdrawn or sad							
Nightmares							
Loss of interest in usual activities							
Worried							
Afraid							
Sets fires							
Preoccupation with fire							
Cruel to animals							
Steals							
Lies							
Problems getting along with peers							
Runs away from home							
Refuses requests							
Difficulty following rules							
Behaves impulsively							
Trouble sitting still							
Trouble paying attention							
Can't delay wants							
Separation Anxiety							
Soils the bed [encopresis]							
Wets the bed/enuresis							
Obsessive/compulsive behaviors							
Special fears or phobias							
Physical complaints							
Self-induced vomiting							

Patient Name: _____ Date: _____

BEHAVIORS	Description	Age Behavior Began	None Reported	History of	Monthly	Weekly	Daily
Refuses to eat							
Over-eats							
Hides food / Hoarding							
Over-responds to events							
Under-responds to events							
Panic Attacks							
Problems functioning in groups							
Physically fights with siblings							

SCHOOL INFORMATION

Current school and grade level _____				
Grades are overall: <input type="checkbox"/> Failing <input type="checkbox"/> Passing		Best subject: _____		Worst subject: _____
Ever been home schooled? _____				
How does current academic progress compare to last semesters? <input type="checkbox"/> Better <input type="checkbox"/> Same <input type="checkbox"/> Worse				
Please list significant changes: _____				
Any specific learning disabilities?: <input type="checkbox"/> Yes <input type="checkbox"/> No List: _____				
Have or had an IEP: <input type="checkbox"/> Yes <input type="checkbox"/> No Retained in which grades? _____				
Dates of suspensions and reasons: _____				
Dates of expulsion and reasons: _____				
Current Full Scale IQ: _____ Functioning Level: _____				
Psychological/Intellectual Testing completed: _____				
Any difficulties with the following?				
Daydreams in school: Describe: _____	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently	<input type="checkbox"/> Always
Argues with teacher: Describe: _____	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently	<input type="checkbox"/> Always
Skips after arriving: Describe: _____	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently	<input type="checkbox"/> Always
Refuses to attend: Describe: _____	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently	<input type="checkbox"/> Always

EMPLOYMENT INFORMATION

<input type="checkbox"/> N/A	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part time	<input type="checkbox"/> Employed by: _____
<input type="checkbox"/> Disabled	<input type="checkbox"/> Workers Comp	<input type="checkbox"/> Other: _____	
Active Military Service: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what branch?: _____		
Type of discharge: <input type="checkbox"/> Honorable <input type="checkbox"/> Dishonorable			

Patient Name: _____ Date: _____

SUBSTANCE ABUSE HISTORY AND CURRENT USE

DRUGS USED	History of	Age of 1 st Use	Monthly	Weekly	Daily	Last Use	Comments
NONE							
Tobacco							
Alcohol							
Inhalants							
Amphetamines							
THC							
Prescription Pills							
Opiates/Benzodiazepines							
LSD or other Hallucinogens							

Age of 1st Use: _____
 Have you been using more drugs or alcohol to get high or drunk? Yes No
 Have you ever experienced blackouts? Yes No
 Have you ever lost a job, been expelled from school, had problems with family, social or recreational activities due to the use of a substance? Yes No If yes, explain: _____

Have you ever used drugs/alcohol knowing that it would cause you problems? Yes No
 Do you spend a great deal of time in activities necessary to obtain the substance (visiting multiple doctors, ordering on-line, and looking for ways to find or pay for drugs)? Yes No
 Have you ever had a persistent desire or unsuccessful effort to cut down/control your drug/alcohol use? Yes No
 Do you feel you have an alcohol or drug problem? Yes No
 Does anyone else believe you have an alcohol or drug problem? Yes No
 Is there a history of chemical dependency in the family? Yes No If yes, who? _____

PRENATAL AND DEVELOPMENTAL INFORMATION

Was the pregnancy planned? <input type="checkbox"/> Yes <input type="checkbox"/> No	Mother's age at time of child's birth:
Marital status of birth parents: <input type="checkbox"/> Married <input type="checkbox"/> Single/Not Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Prenatal care received: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did the mother drink, use drugs, or smoke during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes," identify substance(s) and amount of use?	
Did the mother take any medications during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes," identify medications and reason for use:	
Was the mother sick or have any complications during the pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes," describe:	
Were there any significant stressors during the pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes," describe:	
How long was the labor?	Type of delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section
Birth weight:	
Was the pregnancy planned? <input type="checkbox"/> Yes <input type="checkbox"/> No	Mother's age at time of child's birth:
Did the child experience any difficulties at birth (birth defects, injuries, or breathing problems)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes," describe:	
History of Postpartum Depression?:	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", indicate duration:

Patient Name: _____ Date: _____

EARLY SENSORY ISSUES

ISSUES WITH	Y	N	IF 'YES' BRIEFLY EXPLAIN
Touch			
Food			
Clothing tags			
Loud noises			
Texture			

DEVELOPMENTAL INFORMATION

MILESTONE	AGE	COMMENTS/CONCERNS
Crawled		
Walked unattended		
Said single words		
Talked in short sentences		
Toilet trained		

BEHAVIORS OBSERVED BY CAREGIVER(S) DURING THE FIRST YEARS OF LIFE

(special emphasis on those occurring regularly/most of the time):

BEHAVIOR	Y	N	IF 'YES' BRIEFLY EXPLAIN
Did not enjoy cuddling			
Difficulty with transitions & change			
Poor response to new things (places, people, foods.)			
Feelings always expressed very strongly			
Very unpredictable patterns of sleep, appetite			
Was not calmed by being held or stroked			
Frequent head banging			
Difficult to comfort			
Excessively irritable			
Extremely active			
Excessively restless			
Difficult to feed			
Very lethargic			

Patient Name: _____ Date: _____

TRAUMA HISTORY INFORMATION

LIFE EVENT	Y	N	AGE	DURATION	IF 'YES' BRIEFLY EXPLAIN
Multiple school moves					
Parent absent from the home					
Family member under medical care for a significant or life threatening illness					
Family member hospitalized for a significant of life threatening illness					
Family member required a major medical procedure					
Death of a family member					
Death of a friend					
Seen a dead body					
Responsible for death of another person					
Injured in a motor vehicle accident					
Experienced life threatening injury or illness					
Experienced and/or injured in a natural disaster					
Witness of school violence					
Victim of school violence					
Witnessed community violence					
Victim of community violence					
Victim of war/terrorism/political violence					
Witnessed family violence					
Victim of family violence					
Victim of physical or verbal threats of harm/violence toward child/child's loved one					
Exposed to drug/alcohol use					
Required visit to ER for a non-accidental injury					
Referred to DHS for physical abuse					
Victim of kidnapping					
Witnessed sexual behavior					
Exposed to pornography					
Participated in sexual acts					
Victim of rape					

Patient Name: _____ Date: _____

LIFE EVENT	Y	N	AGE	DURATION	IF 'YES' BRIEFLY EXPLAIN
Referred to DHS for sexual abuse					
Victim of deprivation of adequate basic needs as an infant or in early childhood					
Lives or lived in extreme poverty					
Chronic transient living environment					
Diagnosed as a failure to thrive					
Victim of abandonment					
Caregiver was mentally ill					
Caregivers failed to supervise adequately to avert preventable accidents					
Caregiver had difficulty meeting basic needs of food and shelter					
Caregiver failed to provide adequate emotional/psychological attention or care					
Victim of public humiliation					
Caregiver shamed child for "normal" behaviors such as crying, exhibiting affection, etc.					
Singled out for criticism, most of the chores or to receive fewer rewards					
Placed in recognizable dangerous or unpredictable situations					
Victim of verbal belittling or degradation					
Victim of unrealistic or impossible expectations being set with threat of harm/ danger if not met					
Caregiver detached or only interacts when necessary					
Caregiver failed to express any affection, caring or love for child					
Isolated child for extended & unreasonable periods					
Has appeared or testified in court					
Has been charged with a crime					
Has been convicted of a crime					
Placed out of home					
Placed in foster care					
Adopted					

Patient Name: _____ Date: _____

RELATIONSHIP(S) INFORMATION

Single
 Never married
 Married
 Divorced
 Widowed
 Boyfriend/Girlfriend

Describe the quality of current relationship:	
Describe how others perceive the quality of current relationship:	

SEXUAL HISTORY INFORMATION

First sexually active at what age?	Age of partner?
Is sexual behavior and/or orientation causing emotional, spiritual, or physical problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, describe:	

FAMILY CONSTELLATION INFORMATION

Biological Parents:

Mother:	City of residence:	Quality of relationship:
Father:	City of residence:	Quality of relationship:

Step-parent(s) (if applicable):

Step-mother:	Quality of Relationship:
Step-father:	Quality of Relationship:

Guardian(s) (if applicable):

	Quality of Relationship:
	Quality of Relationship:

Contact with non-custodial parent? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please explain:
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Siblings	Brother	Sister	Age	Bio	Half	Step	Lives in Home	Lives out of Home
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CURRENT LIVING ARRANGEMENT

Single parent family
 2 Parent family
 Alone
 Spouse
 Community Based Placement
 Homeless/Shelter

Individuals currently living in the home:

Name:	Relationship:	Quality of relationship:
Name:	Relationship:	Quality of relationship:
Name:	Relationship:	Quality of relationship:
Name:	Relationship:	Quality of relationship:
Name:	Relationship:	Quality of relationship:

RELATIONSHIP INFORMATION

Best relationship with?	
Most difficult relationship with?	
Most important relationship?	

SPIRITUAL/RELIGIOUS/CULTURAL INFORMATION

Religious affiliation of patient:	<input type="checkbox"/> None
Religious affiliation of family:	<input type="checkbox"/> None
Belief in God/Higher Power? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does pt feel supported by his/her faith? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is family active in religious activities? <input type="checkbox"/> Yes <input type="checkbox"/> No	if yes, describe:
Explain any spiritual/religious issues/needs that may affect treatment:	
Please explain any cultural background or orientation issues/needs that may affect treatment:	

Patient Name: _____ Date: _____

TREATMENT BARRIERS

- Communication Language Sensory Physical Religious Spiritual Cultural
- Transportation Family resistance to treatment Family resistance to medication
- Limited community resources other: _____

Briefly describe how these may negatively affect the client's ability to benefit from treatment:

DISCHARGE PLANNING

Any problems anticipated in accessing follow-up care? Yes No

If 'Yes,' describe:

Any problems anticipated with living arrangements after discharge (i.e. living conditions, people with whom you will live, etc.)?

Yes No

If 'Yes,' describe:

INTEGRATED CLINICAL SUMMARY

1. Significant findings from the Biopsychosocial Assessment including previous successes and/or failures in treatment:

2. Significant findings from Nurse Biophysical Assessment (Include Axis III and how it impacts treatment):

3. Significant findings from Therapeutic Recreation Assessment:

4. Family members participating in treatment:

5. Issues to be addressed in Treatment:

LMHP Signature

Date/Time

Patient Name: _____ Date: _____

MENTAL STATUS EXAM

Behavior during interview:

- Cooperative Uncooperative Other _____

Physical appearance:

- Looks stated age Looks older than stated age Looks younger than stated age

Emotional presentation:

- Consistent with age Older than age Younger than age

Facial expression:

- Congruent to affect/topic Not congruent to affect/topic

Manner of dress:

- Appropriate Inappropriate Disheveled Provocative

Gait:

- Normal Unsteady Disturbed Unobserved

Posture:

- Relaxed Erect Slouched

Level of distress:

- Calm Tearful Mildly irritable Severely agitated/aggressive

Eye contact:

- Direct Downcast With Prompting Avoidant Culturally appropriate.

Separated from a caretaker:

- N/A Easily With difficulty Required physical assistance

Oriented:

- Person Place Time Situation

Disorientation/Disorganization:

- None Little Some Marked

Speech pattern:

- Normal Pressured Hesitant Rapid Mumbled Slow
 Loud Emotional Slurred Monotonous Soft Impaired

Affect:

- WNL Blunted Fearful Anxious Euphoric Flat
 Depressed Irritable Angry Cheerful Labile

Thought process:

- Normal Disjointed Incoherent Distracted Flight of ideas
 Tangential Blocking Confabulations/neologisms

Memory:

- Short-term memory appears intact: Yes No
Long-term memory appears intact: Yes No

Patient Name: _____ Date: _____

PRELIMINARY DIAGNOSIS

Information obtained from (check all that apply):

Client Mother Father DHS OJA Guardian Other: _____

Axis I: _____

Axis II: _____
 Full Scale IQ _____

Axis III: _____

Axis IV:

<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Problems with primary support group <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Educational problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Housing problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Problems with access to health care services <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Problems related to interaction with the legal system/crime <small>Mild Mod Severe</small>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Problems related to the social environment <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Occupational problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Economic problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other psychosocial and environmental problems <small>Mild Mod Severe</small>
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Axis V: Current GAF _____ Highest Past Year _____

Disposition: Admit to Acute level of care **Unit:** _____ **Physician:** _____
 Admit to RTC level of care **Unit:** _____ **Physician:** _____
 Referred IOP/outpatient to: _____

Admission Status: Voluntary Emergency Detention (ED)

Physician Signature		Date/Time
LBHP Signature		Date/Time
RN Signature		Date/Time
Intake/Assessment Signature		Date/Time
Other Signature		Date/Time

Patient Name: _____ **Date:** _____

Biophysical/Nursing

Eye Color: _____ **Hair Color:** _____ **Complexion:** _____

Personal hygiene: _____

Vital Signs: Blood Pressure: _____ Temperature: _____ Pulse: _____ Respiration: _____

Assistive Devices:

Eyeglasses: Yes No Contact Lenses: Yes No
Dentures: Yes No Hearing Aid: Yes No
Cochlear implant: Yes No If Yes, describe: _____
Other: _____

Exams:

Date of last physical exam: _____ **Where:** _____

Last eye exam: _____ Last dental exam: _____ Last hearing test: _____

Vision Problems Yes No If Yes, describe: _____
Hearing Problems: Yes No If Yes, describe: _____
Dental issues: Yes No If Yes, describe: _____
Speech problems: Yes No If Yes, describe: _____
Speech therapy: Yes No If Yes, describe: _____
Prosthesis: Yes No If Yes, describe: _____
Physical restrictions: Yes No If Yes, describe: _____
Piercing: Yes No If Yes, describe: _____
Tattoos: Yes No If Yes, describe: _____
Injuries: Yes No If Yes, describe: _____
Physical Therapy: Yes No If Yes, describe: _____
Occupational Therapy: Yes No If Yes, describe: _____

List any major illnesses or accidents you may have had in the past: _____

Biophysical:

Headaches Yes No Trouble with decisions Yes No
Seizures Yes No Vertigo Yes No
Mood changes Yes No Syncope Yes No
Crying spells Yes No Tremor Yes No
Fatigue Yes No Loss/increase of appetite Yes No
Constipation Yes No Current/history of heart problems Yes No
Pain/burning during urination Yes No Anemia/sickle cell Yes No
Urinary retention Yes No History of head trauma Yes No
Urinary urgency Yes No Pica (eating or mouthing nonfood items) Yes No
Urinary frequency Yes No History of high blood pressure Yes No
Diarrhea Yes No Surgery Yes No
Open sores/wounds Yes No Nausea/Vomiting over the past 3 days Yes No
Diabetes Yes No Sleep disturbances (nightmares, sleepwalking) Yes No
Respiratory conditions Yes No Difficulty chewing/swallowing Yes No
Frequent ear infections Yes No GI Problems Yes No
Falls frequently Yes No Reoccurring earaches/ear drainage Yes No
Tics Yes No Seizures Yes No
Loss of consciousness Yes No Sexually transmitted disease Yes No
Color blind Yes No Received treatment Yes No
Medical hospitalization Yes No Other long-term medical complaint/problem Yes No
Appears malnourished Yes No Recent weight changes Yes No
Appears Obese Yes No If 'Yes,' how much: _____

Patient Name: _____ **Date:** _____

Presently being treated for a medical/surgical problem: Yes No

Explain all 'Yes' responses: _____

List any previous medication(s) and reasons for discontinuation:

Medication	Reason for Discontinuation	When taken	Taken regularly	Dosage

History of medication non-compliance? Yes No If yes, explain _____

Activities of Daily Living:

Feeds self Dresses self Ambulatory Uses a wheelchair
 Assistance with dressing Assistance with feeding Assistance with ambulation
 Impact/limitations on day-to-day function: _____

Sleep Pattern:

Amount (hours/noc): _____ Recent change? Yes No
Insomnia: Yes No If 'Yes,' indicate Initial: _____ Middle: _____ Terminal: _____
Sleep Routine (medications, toys, nightlight, etc.): _____

Nutrition:

Height: _____ %tile **Weight:** _____ %
Growth chart less than 5th percentile in weight or height Yes No Explain _____
Underweight: growth chart with Weight more than 2%tile rankings (heavy lines, z scores) below height %tile
 Yes No Explain _____
General/Regular Diet Yes No
Special Diet Requirements: Yes No (include medical/ethnic/cultural issues affecting food intake) If 'Yes,' describe: _____

History of or current behavior: Anorexia nervosa, bulimia nervosa, over-eating Yes No Explain _____

Obstetric/Gynecological:

Date of last menstrual period: _____ Menstrual difficulties: Yes No If 'Yes,' describe: _____
Sexually active: Yes No Possibility of pregnancy: Yes No Currently pregnant? Yes No #months _____
Birth control use: Yes No Type: _____
Have you ever been pregnant: Yes No If 'Yes,' number of pregnancies: _____ Number of live births: _____

Patient Name: _____ Date: _____

Allergies:

Any sensitivity to skin or other negative reactions/illness following oral administration or injection of:

Medications: Yes No If Yes, describe: _____

Food: Yes No If Yes, describe: _____

Other: Yes No If Yes, describe: _____

Immunization Record obtained: Yes No

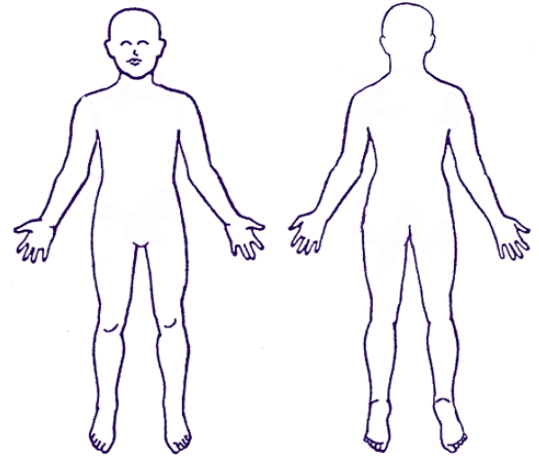
If no, parents informed they must bring a copy? Yes No

List any missing immunizations: _____

Head lice present: Yes No **Date and type of last treatment:** _____

Indicate on diagram all body marks such as old or recent scars, bruises or discoloration (regardless of how slight), lacerations, ulceration, deformities, tattoos, piercings or questionable markings. Indicate surgeries.

General Physical Appearance:



Additional Information:

Does patient have a medical advance directive? Yes No Copy provided? Yes No

Does patient have a psychiatric advance directive? Yes No Copy provided? Yes No

Signature of RN completing the Medical section: _____

Patient Name: _____ **Date:** _____

ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS)

	None, Normal	Minimal (extreme normal)	Mild	Moderate	Severe
Facial and Oral Movements					
1. Muscles of Facial Expression: e.g., movement of forehead, eyebrows, periorbital area, cheeks; including frowning, blinking, smiling, grimacing	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
2. Lips and Perioral Area e.g. puckering, pouting, smacking	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
3. Jaw: e.g., biting, clenching, chewing, mouth opening, lateral movement	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4. Tongue Rate only increases in movement both in and out of mouth, Not inability to sustain movement	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
Extremity Movements					
5. Upper (arms, wrists, hands, fingers) Include choreic movements (i.e. rapid, objectively purposeless, irregular spontaneous); athetoid movements (i.e. slow, irregular complex, serpentine). DO NOT include tremor (i.e. repetitive, regular, rhythmic).	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
6. Lower (Legs, knees, ankles, toes) e.g., lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
Trunk Movements					
7. Neck, shoulders, hips e.g., rocking, twisting, squirming, pelvic gyrations	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

SCORING:

- Score the highest amplitude or frequency in a movement on the 0-4 scale, not the average;
- Score Activated Movements the same way; do not lower those numbers as was proposed at one time;
- A POSITIVE AIMS EXAMINATION IS A SCORE OF 2 IN TWO OR MORE MOVEMENTS or a SCORE OF 3 OR 4 IN A SINGLE MOVEMENT.
- Do not sum the scores: e.g. a patient who has a scored 1 in four movements DOES NOT have a positive AIMS score of 4.

Overall Severity

8. Severity of abnormal movements	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
9. Incapacitation due to abnormal movements	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
10. Patient's awareness of abnormal movements (rate only patient's report)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

Dental Status

	Yes	No
11. Current problems with teeth and/or dentures?	<input type="checkbox"/>	<input type="checkbox"/>
12. Does patient usually wear dentures?	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

Examiners Signature _____ Next Exam Date _____

Patient Name: _____ Date: _____

RISK FACTORS

History of (check all that apply):

RISK BEHAVIORS	Y	N	DATE IDENTIFIED	IF 'YES' BRIEFLY DESCRIBE	DATE RESOLVED
Losing control					
Assault					
Violence					
Medical conditions/physical disability					
Feeling unsafe					
History of trauma					
Physical/sexual abuse					
Restraint or seclusion					
Self injurious behavior					
Other					

Triggers contributing to escalation (things that make it more difficult for client to calm down when already upset.):

TRIGGERS	Y	N	DATE IDENTIFIED	IF "YES", WHAT WILL STAFF OBSERVE?	DATE RESOLVED
Being touched					
People in uniform					
Time of day (when?)					
Loud noise					
Not having control/input					
Not having personal space					
Being isolated					
Time of year (when?)					
Yelling					
Being around men					
Being around women					
Other					

Coping skills/techniques the client uses to regain behavioral control (things which help the client feel better when he/she has a hard time and thinks she/he may lose control):

COPING STRATEGIES	School	Comm	Home	DATE IDENTIFIED	COPING STRATEGIES	School	Comm	Home	DATE IDENTIFIED
Voluntary time-out in quiet room					Reading				
Sitting by the nurses station					Watching TV				
Talking with a peer					Pacing the halls				
Talking with a male staff					Listening to music				
Talking with a female staff					Exercise				
Calling a friend					Drawing/Art				
Deep breathing/relaxation					Writing in a journal				
Lying down with cold face cloth					Taking a shower/bath				
Wrapping in a blanket					Talking with parent				

When a client becomes upset, which interventions have been effective (indicate a preference in the event this would become necessary):

Quiet room: Yes No Voluntary time-out: Yes No Open door separation from milieu: Yes No

Other: Yes No Describe: _____

What do you need from staff when upset? _____

LMHP Signature

Date/Time

Patient Name: _____ Date: _____

Therapeutic Recreational Assessment

1. Why have you been admitted to the hospital? _____

2. How do you spend you leisure time? Alone With others Both

3. List leisure activities that you enjoy: _____ How often do you participate in these activities?
_____ Daily Weekly Monthly Yearly Never
_____ Daily Weekly Monthly Yearly Never
_____ Daily Weekly Monthly Yearly Never
_____ Daily Weekly Monthly Yearly Never

4. Are there any activities you would like to learn more about while you are here? Yes No
If yes, describe: _____

5. Are you interested in learning about?

Exercise/Physical Activity:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Communications Skills	<input type="checkbox"/> Yes <input type="checkbox"/> No
Leisure Skills/Awareness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Community Resources	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stress Management	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anger Management	<input type="checkbox"/> Yes <input type="checkbox"/> No
Relaxation	<input type="checkbox"/> Yes <input type="checkbox"/> No		

6. Are you affiliated with any groups or organizations? Yes No
If yes, describe: _____

7. List any barriers to leisure participation (e.g. problems with learning/hearing/vision/physical limitations):

8. Are there any medical concerns that might limit your participation in leisure activities (e.g. asthma, allergies)?

9. Are there any cultural or religious beliefs that will influence your recreational therapy treatment?

Recreational Therapist Observations and Recommendations:

Recreational Therapist Signature

Date

Patient Name: _____ Date: _____