Initial Assessment

Client Information	
Client Name: Last, First	**Date of Assessment:** 7/17/21
Date of Birth: 2/19/76	**Referral Source:** Primary Care Physician
CPT Code/Time Spent: 90791- 50 mins	**Other Agencies Involved:** SMART recovery
Source of Information: Client	**Preferred Language of Treatment:** English

Beneficiary Rights

Beneficiary Rights Provided:

☒ Explanation of the State Guide to Medi-Cal Mental Health Services

☒ Grievance/Appeal Process

☒ Notice of Privacy Practices

☐ Not provided, Explain:

Domain 1: Presenting Problem/Chief Complaint (Presenting problem, current mental status exam, impairments in functioning):

Client is a 46-year-old, Caucasian, divorced, heterosexual male with depressive symptoms. Client recently finalized divorce with his wife of 9 years, which he reports has increased depressive symptoms of irritability, anger, hopelessness, insomnia, and loss of appetite. Client reports he has been having an increase of these symptoms for the past 2 years. Client states his depression has impacted his relationships with family and friends. During assessment, client presented with casual dress and disheveled appearance. Attitude was calm and cooperative. Poor eye contact, no abnormal movements or psychomotor agitation. Slow speech with low volume. Depressed and irritable mood. Linear thought process, no AH/VH/delusions reported. Passive SI with no intent. No HI. Client presented as drowsy, oriented x4, difficulty concentrating and was a fair historian. Fair insight and judgement.

Domain 2: Experience of Trauma (Trauma exposures, trauma reactions, trauma screening, systems involvement):

Client's parents divorced when client was in high school. Client reported that, prior to the divorce, his parents would often fight and at times become physical. Client recalls having to hide in the closet with his brother during the parental discord. Client reported no CWS involvement.

Domain 3: Behavioral Health History (Mental health history, substance abuse/use, including past and/or present nicotine use, previous services, interventions that have been utilized):

Client's diagnostic history began at 19 years old, to include Anxiety and Depression. Client has received therapeutic services intermittently since then. Client reports better outcomes with male clinicians, as he feels more comfortable with them. Client had one hospitalization in college for SA in which he intentionally overdosed on 36 OTC medications. Client reports he experimented with various substances in college and drank alcohol 5-6 days a week to the point of becoming inebriated. While intoxicated, client engaged in verbal and physical altercations with strangers, which resulted in two arrests in the past (no current charges) and minor injuries. Alcohol abuse also impacts client's timeliness, productivity, and relationships with coworkers at work, resulting in many warnings and potential for losing his job. No tobacco/nicotine use reported. Client states he used to attend SMART recovery but has since relapsed and disengaged from services.

Domain 4: Medical History and Medications (Physical health conditions, medications, developmental history):

Client currently taking HCTZ, ZOCOR, and Effexor 75 mg BID. Client reports hypertension and high cholesterol. Both managed with medication.

Allergies: No food or drug allergies reported

Primary Care Physician: Dr. Primary 888-555-4567

Domain 5: Psychosocial Factors (Family history, current family involvement, significant life events within family, social and life circumstances, social supports, legal/justice involvement, community engagement, cultural considerations):

Client has a history of arrest due to assault while under the influence. He reported minor offense as a juvenile for shoplifting. No current legal involvement. Client works part time on a food truck. Client denies any support from community resources, however likes to play basketball at the local recreation center. Client identifies one or two friends that he is close with. Client identifies as heterosexual and has not been in a relationship or dated since divorce from wife. Client reports that his grandfather suffered from depression and an aunt that was diagnosed with anxiety. No cultural consideration identified that would impact treatment. Client does not report any religious affiliation.

Domain 6: Strengths, Risk and Protective Factors (Strengths and protective factors, risk factors and behaviors, safety planning. Include past and present danger to self and danger to others. Detail intent, plan, access to means, previous attempts, relevant risk factors – such as co-occurring disorders, loss, abuse, access to firearms, etc.):

Client reports that his sister and mother live nearby and offer support. Client is motivated for treatment and getting back to activities he used to enjoy. Client endorses passive SI, reports no plan or intent. Client denies access to any firearms. Client has history of one SA attempt in college. Client states that he has been drinking more and has recently blacked out. Client and therapist developed safety plan.

Domain 7: Clinical Summary, Treatment Recommendations, Level of Care Determination (Clinical impression, summary of clinical symptoms and functional impairments, diagnostic impression, and treatment recommendations)

Client with a diagnostic impression of Major Depressive Disorder and Alcohol Abuse.
Individual therapy will focus on finding effective and healthy coping strategies to reduce substance use and depressive symptoms. SI will be closely monitored. Client agreed to reengage SMART recovery to target alcohol abuse. Provider will coordinate care with PCP and new psychiatrist (ROIs obtained) and refer to community resources as needed. Client will be seen on a weekly basis.

Clinician Information

Clinician Signature:
Caring Provider, LCSW

Clinician Printed Name:	Date:7/17/21
Caring Provider, LCSW	