

BAYOU HEALTH BEHAVIORAL HEALTH ASSESSMENT - ADULT

DEMOGRAPHIC INFORMATION

Assessment Date:		Provider/Agency Name:		Provider NPI:		Provider TIN:	
Recipient Name: (first, middle, last)						Medicaid Number:	
Age:	DOB:	Ethnicity:	Gender:	Gender Expression:	Marital Status:	SSN:	
LOCUS:			PRIMARY DIAGNOSIS:				

BEHAVIORAL HEALTH HISTORY

I. CHIEF COMPLAINT (Major symptoms, difficulties, and/or Issues as they relate to behavioral health –in recipient’s own words/quoted.)						
II. PRESENTING PROBLEM/HISTORY OF PRESENT ILLNESS (Including recipient’s reason for seeking services, precipitating factors, symptoms, behavioral and functioning impacts, onset/course of issues, current behavioral health providers, services sought and recipient expectation.)						
CURRENT BEHAVIORAL HEALTH PROVIDER NAME:				PHONE NUMBER:		
III. PAST PSYCHIATRIC HISTORY (First onset of illness, past diagnostic and treatment history, medications, hospitalizations):						
Prior Outpatient Mental Health Treatment: <input type="checkbox"/> No; <input type="checkbox"/> Yes; Detail:			Psychiatric Hospitalizations: <input type="checkbox"/> No; <input type="checkbox"/> Yes; Detail:			
Additional History/Comments:						
IV. SUBSTANCE ABUSE/DEPENDENCE (Past use of primary, secondary & tertiary current substance, incl. type, freq, method & age of 1st use.)						
Check any/all that apply in past 12 months:						
<input type="checkbox"/> Alcohol Use; <input type="checkbox"/> Illegal Drug Use; <input type="checkbox"/> Injected Drug Use ; <input type="checkbox"/> Tobacco Product Use; <input type="checkbox"/> Prescription Drugs Abuse; <input type="checkbox"/> Non-Prescription (OTC) abuse; <input type="checkbox"/> Alcohol and/or Drug Overdose; <input type="checkbox"/> Alcohol and/or Drug Withdrawal; <input type="checkbox"/> Problems caused by gambling; <input type="checkbox"/> Trouble stopping any substance; <input type="checkbox"/> Caffeine Use; <input type="checkbox"/> Other/Describe:						
Substance Abuse Treatment History: <input type="checkbox"/> None; <input type="checkbox"/> Outpatient; <input type="checkbox"/> Intensive Outpatient; <input type="checkbox"/> Residential/Inpatient;; <input type="checkbox"/> Detox; <input type="checkbox"/> Other/Describe:						
SUBSTANCE TYPE Include all use in last 30 days.	AGE OF 1ST USE	YEARS IN LIFETIME	DAYS IN PAST 30	DAYS SINCE LAST USE	AMOUNT	ROUTE OF ADMINISTRATION
						<input type="checkbox"/> Oral; <input type="checkbox"/> Nasal; <input type="checkbox"/> Smoking; <input type="checkbox"/> Non-IV Injxn; <input type="checkbox"/> IV
						<input type="checkbox"/> Oral; <input type="checkbox"/> Nasal; <input type="checkbox"/> Smoking; <input type="checkbox"/> Non-IV Injxn; <input type="checkbox"/> IV
						<input type="checkbox"/> Oral; <input type="checkbox"/> Nasal; <input type="checkbox"/> Smoking; <input type="checkbox"/> Non-IV Injxn; <input type="checkbox"/> IV
						<input type="checkbox"/> Oral; <input type="checkbox"/> Nasal; <input type="checkbox"/> Smoking; <input type="checkbox"/> Non-IV Injxn; <input type="checkbox"/> IV
						<input type="checkbox"/> Oral; <input type="checkbox"/> Nasal; <input type="checkbox"/> Smoking; <input type="checkbox"/> Non-IV Injxn; <input type="checkbox"/> IV

PHYSICAL

V. CURRENT MEDICAL CONDITIONS (Check all that apply)						
<input type="checkbox"/> Pregnant	Due date:	Prenatal care:		<input type="checkbox"/> Cancer	<input type="checkbox"/> Underweight	
<input type="checkbox"/> None Reported	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Seizure	<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Overweight	
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Sexually Transmitted Dz.	
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Digestive Problems	<input type="checkbox"/> Other/Describe:		
VI. CURRENT & PAST MEDICATIONS (Including non-psychotropic medications)						
Medication Name	Dose	Freq.	Route	Current	COMMENTS (Reason Prescribed/Response, etc.)	
				<input type="checkbox"/> Yes; <input type="checkbox"/> No		
				<input type="checkbox"/> Yes; <input type="checkbox"/> No		
				<input type="checkbox"/> Yes; <input type="checkbox"/> No		

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				<input type="checkbox"/> Yes; <input type="checkbox"/> No	
				<input type="checkbox"/> Yes; <input type="checkbox"/> No	
				<input type="checkbox"/> Yes; <input type="checkbox"/> No	
				<input type="checkbox"/> Yes; <input type="checkbox"/> No	
				<input type="checkbox"/> Yes; <input type="checkbox"/> No	
				<input type="checkbox"/> Yes; <input type="checkbox"/> No	
				<input type="checkbox"/> Yes; <input type="checkbox"/> No	

VII. ALLERGIES No Reported Drug or Food Allergies; Other/Describe:

VIII. PRIMARY CARE PHYSICIAN	NAME	PHONE	FAX
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IX. ADDITIONAL MEDICAL HISTORY (Diagnosis, Hospitalizations, Surgery, labs values, status of conditions, etc.)

SOCIAL

X. LEGAL STATUS

Current Legal Status: <input type="checkbox"/> None; <input type="checkbox"/> Parole; <input type="checkbox"/> Probation; <input type="checkbox"/> Charges Pending; <input type="checkbox"/> Court-Ordered Outpatient Treatment; <input type="checkbox"/> AOT; <input type="checkbox"/> Judicial; <input type="checkbox"/> Other; Comment/Detail:	Past Legal Status: <input type="checkbox"/> None; <input type="checkbox"/> DWI; <input type="checkbox"/> Prior Arrests; <input type="checkbox"/> Prior Incarcerations; <input type="checkbox"/> Other; Comment/Detail:
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XI. FAMILY HISTORY (relationship status with relatives, family involvement in treatment, and living status of significant relatives):

Custodial Status: <input type="checkbox"/> Independent Adult; <input type="checkbox"/> Biologic Father; <input type="checkbox"/> Biologic Mother; <input type="checkbox"/> Joint Biologic Parents; <input type="checkbox"/> Gov't/Judicial; <input type="checkbox"/> Other:	Contact Info: Name:	Relation	Phone #
Adverse Circumstances in Family of Origin: <input type="checkbox"/> N/A; <input type="checkbox"/> Poverty; <input type="checkbox"/> Criminal Behavioral; <input type="checkbox"/> Mental Illness; <input type="checkbox"/> Substance Use; <input type="checkbox"/> Abuse; <input type="checkbox"/> Neglect; <input type="checkbox"/> Domestic Violence; <input type="checkbox"/> Violence; <input type="checkbox"/> Trauma; <input type="checkbox"/> Divorce <input type="checkbox"/> Other/Describe:			
Family Stress: <input type="checkbox"/> Low Stress; <input type="checkbox"/> Mildly Stressful; <input type="checkbox"/> Moderately Stressful; <input type="checkbox"/> Highly Stressful; <input type="checkbox"/> Extremely Stressful <input type="checkbox"/> Other/Describe:			
Family Supports: <input type="checkbox"/> Highly Supportive; <input type="checkbox"/> Supportive; <input type="checkbox"/> Limited Support; <input type="checkbox"/> Minimal Support; <input type="checkbox"/> No Support <input type="checkbox"/> Other/Describe:			
Additional Comments:			

XII. TRAUMA HISTORY

History of Trauma: None; Experienced; Witnessed; Abuse; Neglect; Violence; Sexual Assault;
 Other/Describe:

XIII. LIVING SITUATION (Current status and functioning)

a. Primary Residence: Own Home; Apartment; Relative's Home; Group Home; Homeless; Living with friend/acquaintance
 Other/Describe:
How long at current residence?
Level of time in community of residence?
Family/Household Composition:
Source of meals/food: **Means of transportation:**
Additional Comments: (Include psychological and social adjustments made to disabilities and/or disorders.)

b. Needs -List what is needed to improve/maintain daily living situation (Ex. Transportation, ability to cook independently, housing subsidy, money in savings, care-giver resource assessment, etc.)

c. Preferences - Include things recipient feels will enhance his/her living situation.

d. Strengths -List assets, service options, and resources the person has to meet needs, including available housing options. (Ex. Knows area, applied for housing subsidy, can live with family member, unpaid care-giver resource available, etc.)

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e. **Abilities/Interests** –Include recipient reported skills, aptitudes, capabilities, talents & competencies that might assist in maintaining or improving living situation.

XIV. LEARNING/WORKING AND FUNCTIONAL STATUS

a. **Employment/Education/Rehabilitation Status:**

Current source of income:

Highest Grade or Completed/Degree:

Difficulties with Reading/Writing: No; Yes;

Current Employment Status:

Assistive Devices utilized/required: No; Yes;

Additional Comments: (Include psychological and social adjustments made to disabilities and/or disorders.)

Estimated Monthly Income Amount:

Military Status:

Military Trauma: No; Yes;

Estimated Literacy Level:

Prior Employment Status:

b. **Current Status & Functioning** (Assess ability to fulfill responsibilities, interact with others, capacity self-care, missed activities, work or school due to health, etc.)

Functional Status Impairment Rating: (From LOCUS Functional Status Evaluation Parameters.) Minimal; Mild; Moderate; Serious; Extreme.

As Evidenced By:

c. **Needs** - List what is needed to improve/maintain income, employment, education, vocational skills, etc. (Ex. Financial support, new skills, training, education, etc.)

Problems with Basic Needs: Food; Shelter; Clothing; Funds; Healthcare; ADL's

Other/Describe:

d. **Preferences** –Include things recipient feels will enhance functional status with regard to income, employment, learning, literacy, etc.

e. **Strengths** –List assets, service options, skills & resources recipient has to meet needs. (Ex. Intelligent, motivated, supportive family, education, job experience, interest in furthering education or vocational status, etc.)

f. **Abilities/Interests** - Include recipient reported skills, aptitudes, capabilities, talents & competencies that might assist in maintaining or improving functional status.

XV. SOCIAL HISTORY AND COMMUNITY INTEGRATION

a. **Current status and functioning** (Involvement in the community, social supports and activities, social barriers)

Does Recipient feel supported by friends or family? Yes; No;

Recreational Activities:

Self-Help Activities:

Additional Comments: (Include psychological and social adjustments made to disabilities and/or disorders.)

b. **Needs** - List what is needed to improve/maintain recreation, social functioning & community integration. (Ex. Meet new people, painting supplies, sports team, improve family relationships etc.)

c. **Preferences** –Include things recipient feels will enhance or stimulate recreational interests, social functioning & community integration.

d. **Strengths** -List assets, service options & skills that may enhance socialization & community integration. (Ex. Friendly, athletic, independent, friend plays, paints, past history of compliance in treatment, signs of resilience despite past adversity, etc.)

e. **Abilities/Interests** - Include recipient reported skills, aptitudes, talents & competencies that may help maintain or improve socialization & community functioning.

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CURRENT STATUS

XVI. MENTAL STATUS EXAMINATION <i>(Circle or Check all that apply.)</i>	
a. GENERAL APPEARANCE	<input type="checkbox"/> Healthy; <input type="checkbox"/> As stated Age; <input type="checkbox"/> Older Than Stated Age; <input type="checkbox"/> Young-looking; <input type="checkbox"/> Tattoos; <input type="checkbox"/> Disheveled; <input type="checkbox"/> Unkempt; <input type="checkbox"/> Malodorous; <input type="checkbox"/> Thin; <input type="checkbox"/> Overweight; <input type="checkbox"/> Obese; <input type="checkbox"/> Other/Describe:
b. BEHAVIOR & PSYCHOMOTOR ACTIVITY	<input type="checkbox"/> Normal; <input type="checkbox"/> Overactive; <input type="checkbox"/> Hypoactive; <input type="checkbox"/> Catatonia; <input type="checkbox"/> Tremor; <input type="checkbox"/> Tics; <input type="checkbox"/> Combative; <input type="checkbox"/> Abnormal Gait ; <input type="checkbox"/> Other/Describe:
c. ATTITUDE	<input type="checkbox"/> Optimal; <input type="checkbox"/> Constructive; <input type="checkbox"/> Motivated; <input type="checkbox"/> Obstructive; <input type="checkbox"/> Adversarial; <input type="checkbox"/> Inaccessible; <input type="checkbox"/> Cooperative; <input type="checkbox"/> Seductive; <input type="checkbox"/> Defensive; <input type="checkbox"/> Hostile; <input type="checkbox"/> Guarded; <input type="checkbox"/> Apathetic; <input type="checkbox"/> Evasive; <input type="checkbox"/> Other/Explain:
d. SPEECH	<input type="checkbox"/> Normal; <input type="checkbox"/> Spontaneous; <input type="checkbox"/> Slow; <input type="checkbox"/> Impoverished; <input type="checkbox"/> Hesitant; <input type="checkbox"/> Monotonous; <input type="checkbox"/> Soft/Whispered; <input type="checkbox"/> Mumbled; <input type="checkbox"/> Rapid; <input type="checkbox"/> Pressured; <input type="checkbox"/> Verbose; <input type="checkbox"/> Loud; <input type="checkbox"/> Slurred; <input type="checkbox"/> Impediment; <input type="checkbox"/> Other/Describe:
e. MOOD:	<input type="checkbox"/> Dysphoric; <input type="checkbox"/> Euthymic; <input type="checkbox"/> Expansive; <input type="checkbox"/> Irritable; <input type="checkbox"/> Labile; <input type="checkbox"/> Elevated; <input type="checkbox"/> Euphoric; <input type="checkbox"/> Ecstatic; <input type="checkbox"/> Depressed; <input type="checkbox"/> Grief/mourning; <input type="checkbox"/> Alexithymic; <input type="checkbox"/> Elated; <input type="checkbox"/> Hypomanic; <input type="checkbox"/> Manic; <input type="checkbox"/> Anxious; <input type="checkbox"/> Tense; <input type="checkbox"/> Other/Describe:
f. AFFECT	<input type="checkbox"/> Appropriate; <input type="checkbox"/> Inappropriate; <input type="checkbox"/> Blunted; <input type="checkbox"/> Restricted; <input type="checkbox"/> Flat; <input type="checkbox"/> Labile; <input type="checkbox"/> Tearful; <input type="checkbox"/> Intense; <input type="checkbox"/> Other/Describe:
g. PERCEPTUAL DISTURBANCES	<input type="checkbox"/> None; <u>Hallucinations:</u> <input type="checkbox"/> Auditory; <input type="checkbox"/> Visual; <input type="checkbox"/> Olfactory; <input type="checkbox"/> Tactile; <input type="checkbox"/> Other/Describe:
h. THOUGHT PROCESS	<input type="checkbox"/> Logical/Coherent; <input type="checkbox"/> Incomprehensible; <input type="checkbox"/> Incoherent; <input type="checkbox"/> Flight of Ideas; <input type="checkbox"/> Loose Associations; <input type="checkbox"/> Tangential; <input type="checkbox"/> Circumstantial; <input type="checkbox"/> Rambling; <input type="checkbox"/> Evasive; <input type="checkbox"/> Racing Thoughts; <input type="checkbox"/> Perseveration; <input type="checkbox"/> Thought Blocking; <input type="checkbox"/> Concrete; <input type="checkbox"/> Other/Describe:
i. THOUGHT CONTENT	<input type="checkbox"/> Preoccupations; <input type="checkbox"/> Obsessions; <input type="checkbox"/> Compulsions; <input type="checkbox"/> Phobias; <input type="checkbox"/> Delusions; <input type="checkbox"/> Thought Broadcasting; <input type="checkbox"/> Thought Insertion; <input type="checkbox"/> Thought Withdrawal; <input type="checkbox"/> Ideas of Reference; <input type="checkbox"/> Ideas of Influence; <input type="checkbox"/> Delusions; <input type="checkbox"/> Other/Describe:
j. SUICIDAL/HOMICIDAL IDEATION	<input type="checkbox"/> Suicidal Thoughts; <input type="checkbox"/> Suicidal Attempts; <input type="checkbox"/> Suicidal Intent; <input type="checkbox"/> Suicidal Plans; <input type="checkbox"/> History of Self-Injurious Behavior <input type="checkbox"/> Homicidal Thoughts; <input type="checkbox"/> Homicidal Attempts; <input type="checkbox"/> Homicidal Intent; <input type="checkbox"/> Homicidal Plans; <input type="checkbox"/> Other/Describe:
k. SENSORIUM/COGNITION	<input type="checkbox"/> Alert; <input type="checkbox"/> Lethargic; <input type="checkbox"/> Somnolent; <input type="checkbox"/> Stuporous; Oriented to: <input type="checkbox"/> Person; <input type="checkbox"/> Place; <input type="checkbox"/> Time; <input type="checkbox"/> Situation; <input type="checkbox"/> Normal Concentration; <input type="checkbox"/> Impaired Concentration; <input type="checkbox"/> Other/Describe:
l. MEMORY	<u>Remote Memory:</u> <input type="checkbox"/> Normal; <input type="checkbox"/> Impaired; <u>Recent Memory:</u> <input type="checkbox"/> Normal; <input type="checkbox"/> Impaired; <u>Immediate Recall:</u> <input type="checkbox"/> Normal; <input type="checkbox"/> Impaired <input type="checkbox"/> Other/Describe:
m. INTELLECTUAL FUNCTIONING (Estimate)	<input type="checkbox"/> Above Avg.; <input type="checkbox"/> Normal/Avg.; <input type="checkbox"/> Borderline; <u>Intellectual Disability</u> <input type="checkbox"/> Mild; <input type="checkbox"/> Moderate; <input type="checkbox"/> Severe <input type="checkbox"/> Other/Describe:
n. JUDGEMENT	<input type="checkbox"/> Critical Judgment Intact; <input type="checkbox"/> Impaired Judgment; <input type="checkbox"/> Other/Describe:
o. INSIGHT	<input type="checkbox"/> True Emotional Insight; <input type="checkbox"/> Intellectual Insight; <input type="checkbox"/> Some Awareness of Illness/symptoms; <input type="checkbox"/> Impaired Insight; <input type="checkbox"/> Denial; <input type="checkbox"/> Other/Describe:
p. IMPULSE CONTROL	<input type="checkbox"/> Able to Resist Impulses; <input type="checkbox"/> Recent Impulsive Behavior; <input type="checkbox"/> Impaired Impulse Control; <input type="checkbox"/> Compulsions; <input type="checkbox"/> Other/Describe:
XVII. RISK ASSESSMENT: Assess potential risk of harm to self or others, including patterns of risk behavior and/or risk due to personality factors, substance use, criminogenic factors, exposure to elements, exploitation, abuse, neglect, suicidal or homicidal history, self-injury, psychosis, impulsiveness, etc.	
a. Risk of Harm to Self:	<input type="checkbox"/> Prior Suicide Attempt; <input type="checkbox"/> Stated Plan/Intent; <input type="checkbox"/> Access to means (weapons, pills, etc.); <input type="checkbox"/> Recent Loss; <input type="checkbox"/> Presence of Behavioral Cues (isolation, giving away possessions, rapid mood swings, etc.); <input type="checkbox"/> Family History of Suicide; <input type="checkbox"/> Terminal Illness; <input type="checkbox"/> Substance Abuse; <input type="checkbox"/> Marked lack of support; <input type="checkbox"/> Psychosis; <input type="checkbox"/> Suicide of friend/acquaintance; <input type="checkbox"/> Other/Describe:
b. Risk of Harm to Others:	<input type="checkbox"/> Prior acts of violence; If yes, when was most recent violent act? ____; <input type="checkbox"/> Destruction of property; <input type="checkbox"/> Arrests for violence; <input type="checkbox"/> Access to means (weapons); <input type="checkbox"/> Substance use; <input type="checkbox"/> Physically abused as child; <input type="checkbox"/> Was physically abusive as a child; <input type="checkbox"/> Harms animals; <input type="checkbox"/> Fire setting; <input type="checkbox"/> Angry mood/agitation; <input type="checkbox"/> Prior hospitalizations for danger to others; <input type="checkbox"/> Psychosis/command hallucinations; If yes, is there a history of acting on any commands to harm others? <input type="checkbox"/> Yes <input type="checkbox"/> No; <input type="checkbox"/> Other/Describe:
c. Risk of Harm to Self or Others Rating: <i>(From LOCUS Risk of Harm Evaluation Parameters.)</i>	<input type="checkbox"/> Minimal; <input type="checkbox"/> Low; <input type="checkbox"/> Moderate; <input type="checkbox"/> Serious; <input type="checkbox"/> Extreme. As Evidenced By:
d. Recipient Safety & Other Risk Factors:	<input type="checkbox"/> Feels unsafe in current living environment; <input type="checkbox"/> Feels currently being harmed/hurt/abused/threatened by someone; <input type="checkbox"/> Engages in dangerous sexual behavior; <input type="checkbox"/> Past involvement with Child or Adult Protective Services; <input type="checkbox"/> Relapse/decompensation triggers; <input type="checkbox"/> Other/Describe:
e.	Describe recipient's preferences and desires for addressing risk factors, including any Mental Health Advance Directives or plan of response to periods of decompensation/relapse (Ex. Resources recipient feels comfortable reaching out to for assistance in a crisis.):
XVIII. CULTURAL AND LANGUAGE PREFERENCES <i>(Language, Customs/Values/Preferences)</i>	
a.	Spiritual Beliefs/Preferences:
b.	Cultural Beliefs/Preferences:

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XIX. PRINCIPAL DIAGNOSES (Provide principle behavioral and medical diagnoses)

XX. INTERPRETATIVE SUMMARY Describe recipient's global preferences/hopes for recovery, recommended treatments/assessments, level of care, duration. Include clinical/central theme, co-occurring disabilities, environmental and personal supports/needs.

IDENTIFIED NEEDS

1.
2.
3.
4.
5.

RECOMMENDED SERVICES

MH Services: <input type="checkbox"/> ACT	<input type="checkbox"/> CPST	<input type="checkbox"/> PSR-Individual	<input type="checkbox"/> PSR-Group	<input type="checkbox"/> PSH
<input type="checkbox"/> Med Mgt	<input type="checkbox"/> Outpt Therapy (Ind)	<input type="checkbox"/> Outpt Therapy (Fam)	<input type="checkbox"/> Outpt Therapy (Group)	
SA Services: <input type="checkbox"/> Residential Tx	<input type="checkbox"/> Halfway House	<input type="checkbox"/> IOP	<input type="checkbox"/> Ambulatory Detox	
<input type="checkbox"/> Outpt Therapy (Ind) <input type="checkbox"/> Outpt Therapy (Fam) <input type="checkbox"/> Outpt Therapy (Group)				
Other (with explanation):				

SIGNATURE

PRINTED NAME OF ASSESSOR	SIGNATURE	LMHP STATUS	DATE