FAMILY CONNECTIONS, LLC
Supporting Opportunities for Growth & Development

Initial Clinical Assessment

Patient Name	Street Address	City, State, Zip	Telephone

Date Of Birth	Insurance Policy	Marital Status/Relationship
School	Employer	Guardianship Status

Emergency Contacts
Name: Address: Phone: Relationship:
Name: Address: Phone: Relationship:

Your Household Make Up?

Name	Age	Relationship

1643 Warwick Avenue, #200, Warwick RI 02889 Phone: 401-952-8188 Fax: 401-385-9410
email: familyconnections@familyconnectionsri.com website: familyconnectionsri.com

Social History:

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Presenting Problem:

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Symptoms Currently Experiencing:

__Sleep Disturbance	__Poor Concentration	__Delusions	__Anorexia
__Mood Lability	__Paranoid Ideation	__Abusing	__Episodic Crying
__Loose associations	__Alcohol	__Low Energy	__Anxiety
__Laxative	__Depressed Mood	__Panic Attacks	__Tangential
__Psychomotor Retardation	__Phobias	__Oppositional/Defiant	__Rx Meds
__Psychomotor Retardation	__Aggressive Behavior	__Illicit Drugs	__Obsessions/Compulsions
__Appetite Disturbance	__Irritability	__Hallucinations	__Sexual Dysfunction

Mental Status Exam (Circle as appropriate)

Attention **Affect** **Mood** **Appearance** **Motor Activity** **Thought Process** **Hallucinations** **Delusions** **Memory** **Judgment/Insight** **Orientation** **Suicidal** **Homicidal** **Speech** **Impulse Control**	Good (on task 90%) Fair (on task 75%) Easily Distracted Highly Distractible Appropriate Labile Expansive Constricted Blunted Normal Depressed Anxious Euphoric Other: ______________ Well-groomed Disheveled Bizarre Inappropriate Other: ______________ Calm Hyperactive Agitated Tremors Tics Muscle Spasms Intact Circumstantial Tangential Flight of Ideas Loose Associations None Auditory Visual Olfactory Command None Persecutory Grandiose Religious Other:______________ Intact Impaired: (circle) **Immediate** **Recent** **Remote** Intact Impaired: (circle) **Mild** **Moderate** **Severe** All Spheres Impaired: (circle) **Person** **Place** **Time** **Purpose** None Ideation Plan Intent Means None Ideation Plan Intent Means Normal Slow Slurred Pressured Rapid Appropriate Limited Poor Other: ______________________________________

Functional Impairments:

Family	None	Mild	Moderate	Severe	__________________________
Relationship with S/O or Primary Relationships	None	Mild	Moderate	Severe	__________________________
Physical Health	None	Mild	Moderate	Severe	__________________________
Work	None	Mild	Moderate	Severe	__________________________
School	None	Mild	Moderate	Severe	__________________________
Spiritual	None	Mild	Moderate	Severe	__________________________
Social/Activity Level	None	Mild	Moderate	Severe	__________________________

Addiction/Chemical Use & Dependency Assessment (Clients 12 years and older)

Tobacco	Frequency	__Currently	__By History	__N/A
Alcohol	Frequency	__Currently	__By History	__N/A
Cannabis	Frequency	__Currently	__By History	__N/A
Nicotine	Frequency	__Currently	__By History	_-N/A
Prescribed/OTC Medicines	Frequency	__Currently	__By History	__N/A

Interventions Needed: ____

Developmental History (children/adolescents): ____

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Historical/Current ADD/ADHD symptoms:____

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Historical/Current Depressive symptoms: ____

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Historical/Current Anxiety symptoms: ____

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Historical/Current Sexual/Physical Abuse: ____

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Family History of Addiction/Chemical Abuse: ____

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Behavioral Health Treatment History

Current Treatment & Providers:

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Family History of Mental Health Treatment/Diagnosis: ______________________________________

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Prior or Current psychotropic medication: ____

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History of Psychiatric Hospitalization:____

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Functional Impairments: ____

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Medical History
Medical Conditions: ____ ____ ____ Current PCP:____ Allergies: ____ ____ ____ Current prescriptions: ____ ____ ____ Family Medical History: ____ ____ ____ ____

Cultural Variables:

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Environmental Factors:

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Current/Hx of Legal Concerns:

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Additional Providers

1. ____
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2. ____
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3. ____
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4. ____
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5. ____
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Client meets criteria for the following DSM V diagnosis/diagnoses:
(Primary Diagnosis): ____ ____ ____ ____ **TREATMENT RECOMMENDATIONS:** ____ ____ ____ ____ ____ ____

CLINICIAN: ____ DATE: ___________________________________

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