

Hennepin County Diagnostic Assessment Form

Client Name: _____ **DOB:** _____ **SS#:** _____
Referral Source: _____ **Phone:** _____ **FAX:** _____

Date of diagnostic: ____ / ____ / ____

| Current Diagnosis Name | ICD 10 Codes |
|------------------------|--------------|
| | |
| | |
| | |
| | |
| | |

WHODAS Score: _____ (Required)

Minnesota Administrative Rules require a functional assessment (WHODAS) as part of the diagnostic assessment. Providers may use either the 12-item or 36-item WHODAS. The WHODAS is required.

Check and complete **all** that apply:

A. This person has undergone two or more episodes of inpatient care for a mental illness within the preceding twenty-four months at:

| Facility | Admission Date | Discharge Date |
|----------|----------------|----------------|
| | | |
| | | |
| | | |

B. This person has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months duration within the preceding twelve months at:

| Facility | Admission Date | Discharge Date |
|----------|----------------|----------------|
| | | |

C. This person has been treated by a mobile crisis response team two or more times within the preceding 24 months.

D. This person has a diagnosis of schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, and/or borderline personality disorder and is reasonably likely to have future episodes requiring inpatient or residential treatment of a frequency described in A or B (above) **unless** ongoing case management services are provided.

E. In the past three years, this person has been committed by a court as a mentally ill person under Minnesota Statutes, Chapter 253B, or this person's commitment has been stayed or continued for reasons related to this person's mental illness. County: _____ Date committed: _____

F. This person has been eligible for case management services under one of the above items (A, B, C or D) or was eligible as a child for such services **and** is reasonably likely to have future episodes requiring inpatient or residential treatment of a frequency described in item A or B **without** case management services.

This person is seriously mentally ill, has three or more functional impairments, and Adult Rehabilitative Mental Health Services (ARMHS) are medically necessary to maintain stability or improve functioning in the community through skill development in areas of basic living.

SYMPTOMS AND BEHAVIORS THAT IMPACT A CLIENT'S FUNCTIONING

- | | |
|--|---|
| <input type="checkbox"/> Depressed Mood | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Decreased Energy | <input type="checkbox"/> Panic Attacks |
| <input type="checkbox"/> Social Withdrawal | <input type="checkbox"/> Agoraphobia |
| <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> Emotional/Physical/Sexual Trauma (Victim) |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Emotional/Physical/Sexual Trauma (Perpetrator) |
| <input type="checkbox"/> Helplessness | |
| <input type="checkbox"/> Worthlessness | <input type="checkbox"/> Suicidal Ideation |
| <input type="checkbox"/> Grief | <input type="checkbox"/> Homicidal Ideation |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Self-injurious Behavior |
| | |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Property Destruction |
| <input type="checkbox"/> Elevated Mood | <input type="checkbox"/> Fire Setting |
| <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Cruelty to Animals |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Lying/Manipulation |
| <input type="checkbox"/> Obsessions | |
| <input type="checkbox"/> Compulsions | <input type="checkbox"/> Sexual Acting Out |
| <input type="checkbox"/> Somatic Complaints | <input type="checkbox"/> Sexual Promiscuity |
| | |
| <input type="checkbox"/> Disruption of Thought Process | <input type="checkbox"/> Substance Abuse (check one) |
| <input type="checkbox"/> Delusions | <input type="checkbox"/> Active Substance Abuse |
| <input type="checkbox"/> Paranoia | <input type="checkbox"/> Early Full Remission |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Sustained Full Remission |
| <input type="checkbox"/> Auditory | <input type="checkbox"/> Sustained Partial Remission |
| <input type="checkbox"/> Visual | |
| <input type="checkbox"/> Tactile | |
| <input type="checkbox"/> Olfactory | <input type="checkbox"/> Concomitant Medical Condition |
| <input type="checkbox"/> Dissociative States | |

Please elaborate on most significant symptoms identified above and how they interfere with client functioning:

What is the current mental status of this person?

Please provide a history of this person's mental illness:

Please describe the person's medical history and any current medical problems (include current medications):

Please provide a family history of medical issues:

Please provide a history of developmental issues:

Client Strengths, Functional Impairments/Vulnerabilities: (check all applicable)

| | Identified Strength | Functional Impairments/ Vulnerabilities Due to Mental Health Symptoms | Describe the Impairments/Vulnerabilities Due to Mental Health Symptoms |
|---|---------------------|---|--|
| 1. Mental Health Symptom Management | | | |
| 2. Mental Health Service Needs | | | |
| 3. Use of Drugs or Alcohol | | | |
| • Current | | | |
| • History | | | |
| • Family History | | | |
| • Please complete CAGE questions below | | | |
| 4. Vocational Functioning | | | |
| • Employment Status | | | |
| 5. Educational Functioning | | | |
| • Education Level | | | |
| 6. Social Functioning | | | |
| • Leisure Time | | | |
| • Communication Skills | | | |
| • Support Network | | | |
| • Cultural Influences and Impact | | | |
| • Community Resources Utilization and Integration | | | |
| • Belief System | | | |
| 7. Interpersonal Functioning | | | |
| • Relationship with Family | | | |
| • Intellect (problem solving, coping skills) | | | |
| • Judgment | | | |
| 8. Self-Care and Independent Living Capacity | | | |
| • Healthy Lifestyle Skills (grooming, dressing, hygiene, nutrition) | | | |
| • Household Management Skills / Household make-up | | | |
| • Budgeting Skills | | | |
| • Shopping Skills | | | |
| 9. Medical/Dental Health Care Practices | | | |
| • Medical Care Coverage | | | |
| • Mental Health Care Directives | | | |
| • Dental Care | | | |
| • Family Medical History | | | |
| 10.Obtaining and Maintaining Financial Assistance | | | |
| 11.Obtaining and Maintaining Housing | | | |
| 12.Using Transportation | | | |
| 13.Sexuality | | | |
| 14.Safety and Prevention | | | |
| 15. Vulnerabilities:- | | | |
| • Financial Exploitation | | | |
| • Physical Abuse | | | |
| • Sexual Abuse | | | |
| • Passivity | | | |

| | | | |
|--|--|--|--|
| • Presence of suicidal or self-injurious behaviors (note current or history) | | | |
| • Demonstrated Violence Towards Others (note current or history) | | | |
| • Negative Social Behaviors | | | |
| • Other | | | |

CAGE (chemical dependency) questions:

1. Have you ever felt you ought to cut down on your drinking or drug use? yes no
2. Have people annoyed you by criticizing your drinking or drug use? yes no
3. Have you ever felt bad or guilty about your drinking or drug use? yes no
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? yes no

Other Needed Assessments:

| Needed | Not Needed | |
|--------------------------|--------------------------|------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Psychological Testing: |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Neurological Examination: |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Physical Examination: |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Chemical Dependency Assessment: |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. LOCUS: |

What are the client's service needs and what are your recommendations?

Completed By:

Signature of Mental Health Professional

Date of Signature

Print Name of Mental Health Professional

Telephone Number

Qualification(s) as a Mental Health Professional:

- Certified or Certifiable Psychiatrist
- Licensed Psychologist
- Clinical Nurse Specialist
- Licensed Independent Clinical Social Worker
- Licensed Marriage and Family Therapist
- Licensed Professional Clinical Counselor