the mandel center

The Mandel Center of Arizona. LLC
8120 East Cactus Road | Suite 310
Scottsdale, AZ 85260
Office: 480.734.1199
Fax: 480.551.3363
www.mandelcenter.com

Initial Assessment, Page 1

Client name: _____

Presenting issues per client:

_____

_____

_____

_____

Mini-mental status evaluation/current symptoms/functioning:

Vocational/work status: _____

Sleep: _____ Appetite: _____

Concentration: _____ Nutrition: _____

Anxiety: _____ Mood: _____

Appearance: WNL/or: _____ Attitude: Cooperative, Guarded, Agitated

MMSE Orientation: Person, Place, Time

Motor Activity: Calm, Hypo, Hyper

Memory per client report: WNL/Impaired

Judgement/Insight WNL/or: _____

Affect: WNL/or: _____

Speech: WNL/or: _____

Thought Process: Intact, Tangenital, Concrete

Content: WNL/or: _____

Risk Assessment:

Abuse, violence present in the home: No / Yes

Have you ever been arrested? No / Yes

Are you currently on probation or parole? No / Yes

Have you ever considered suicide? No / Yes

Have you ever attempted suicide? No / Yes

Have you ever physically harmed another? No / Yes

Comments: _____

_____

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Initial Assessment, Page 2

Client name: _____

Family History:

	NAME	*AGE*	*LOCATION*	*IN HOME*	*QUALITY OF RELATIONSHIP*
Mother:					
Father:					
Sibling:					
Sibling:					
Sibling:					
Sibling:					
Partner/Spouse					
Child:					
Child:					
Child:					

Other family history/cultural: _____

_____

Substance use/abuse history: ***C****UTDOWN* ***A****NNOYED* ***G****UILTY* ***E****YE-OPENER*

Statement on use/abuse: _____

SUBSTANCE	*AGE BEGAN*	*LAST USE*	*PATTERN AND QUALITY*
Alcohol			
Cannabis			
Coc/Crack/Meth		Route:	
Other illegal drugs		Route:	
R/X		Other:	
Tobacco		Caffeine	

Statement on eating disorder: _____

_____

Restriction _____

Bingeing _____

Compulsive over-eating _____

Purging _____

Exercising _____

Another _____

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Initial Assessment, Page 3

Client name: _____

Mental Health Treatment History: No / Yes

_____

_____

Lifetime Hospitalization History: No / Yes

_____

_____

Medical Conditions:

_____

_____

Allergies: _____

Medication/dose/purpose: _____

_____

Recent stressors: **Strengths/Managing Techniques:** **Supports:**

_____

_____

_____

Provisional Diagnosis:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V current GAF: _____

Additional comments:

_____

_____

_____

_____

_____

CLINICIAN NAME (print) _____

CLINICIAN SIGNATURE _____ *DATE* _____ / _____ / _____