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

- ☐ Depressed Mood
- ☐ Decreased Energy
- ☐ Social Withdrawal
- ☐ Sleep Disturbances
- ☐ Hopelessness
- ☐ Helplessness
- ☐ Worthlessness
- ☐ Grief
- ☐ Guilt

- ☐ Irritability
- ☐ Elevated Mood
- ☐ Impulsivity
- ☐ Distractibility
- ☐ Hyperactivity
- ☐ Obsessions
- ☐ Compulsions
- ☐ Somatic Complaints

- ☐ Disruption of Thought Process
- ☐ Delusions
- ☐ Paranoia
- ☐ Hallucinations
  - ☐ Auditory
  - ☐ Visual
  - ☐ Tactile
  - ☐ Olfactory
- ☐ Dissociative States

- ☐ Anxiety
- ☐ Panic Attacks
- ☐ Agoraphobia
- ☐ Emotional/Physical/Sexual Trauma (Victim)
- ☐ Emotional/Physical/Sexual Trauma (Perpetrator)

- ☐ Suicidal Ideation
- ☐ Homicidal Ideation
- ☐ Self-injurious Behavior

- ☐ Property Destruction
- ☐ Fire Setting
- ☐ Cruelty to Animals
- ☐ Stealing
- ☐ Lying/Manipulation

- ☐ Sexual Acting Out
- ☐ Sexual Promiscuity

- ☐ Substance Abuse (check one)
  - ☐ Active Substance Abuse
  - ☐ Early Full Remission
  - ☐ Sustained Full Remission
  - ☐ Sustained Partial Remission

- ☐ Concomitant Medical Condition

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	
☐	☐	1. Psychological Testing:
☐	☐	2. Neurological Examination:
☐	☐	3. Physical Examination:
☐	☐	4. Chemical Dependency Assessment:
☐	☐	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