

**ALAMEDA COUNTY**  
**Department of Behavioral Health Care Services**  
**- Mental Health Services**

Client Name: \_\_\_\_\_  
 Birthdate: \_\_\_\_\_ Admit Date: \_\_\_\_\_  
 Chart No: \_\_\_\_\_ Reporting Unit: \_\_\_\_\_  
 PSP Client ID No: \_\_\_\_\_

**DSM-IV Multiaxial Diagnostic Evaluation**  
**Initial Assessment Summary/Treatment Plan**

**Diagnosis**

(Please complete all five Axes)

**Axis I: Clinical Disorders**

Other Conditions that may be a Focus of Clinical Attention

Diagnostic Code                      DSM IV Name

_____	_____
_____	_____
_____	_____
_____	_____

(Principal)

**Axis II: Personality Disorders**

**Mental Retardation**

Diagnostic Code                      DSM IV Name

_____	_____
_____	_____
_____	_____
_____	_____

**Axis III: General Medical Conditions**

**Axis IV: Psychological and Environmental Problems (Circle all that apply)**

- A. Problems with primary support group    Specify: \_\_\_\_\_
- B. Problems related to the social environment    Specify: \_\_\_\_\_
- C. Educational problems    Specify: \_\_\_\_\_
- D. Occupational problems    Specify: \_\_\_\_\_
- E. Housing problems    Specify: \_\_\_\_\_
- F. Economic problems    Specify: \_\_\_\_\_
- G. Problems with access to health care services    Specify: \_\_\_\_\_
- H. Problems related to interaction with legal system/crime    Specify: \_\_\_\_\_
- I. Other psychological and environmental problems    Specify: \_\_\_\_\_
- J. Unknown/Unavailable

Principal  
(Check One)

<input type="checkbox"/>

**Axis V: Global Assessment of Functioning Scale**

Current Score: \_\_\_\_\_  
 Highest Past Year Score: \_\_\_\_\_

Diagnosis established by: \_\_\_\_\_  
 Name/Title/Agency

Date: \_\_\_\_\_

<b>2. Signs and Symptoms That Support DSM IV Diagnosis:</b> (List each diagnosis separately.)
<b>3. Risk Assessment/Reduction Plan: (Check and list interventions.)</b> <input type="checkbox"/> Suicidal/Self Harm <input type="checkbox"/> Health <input type="checkbox"/> Violence <input type="checkbox"/> Other(s):
<b>4. Strengths and Resources:</b> (Note client and family strengths and resources and plan to utilize.)
<b>5. Family Goals Participation in Client Plan:</b> (If none, note reason)
<b>6. Special Needs:</b> (Check all that apply. Describe and state plan to address these needs.) <input type="checkbox"/> Cultural <input type="checkbox"/> Linguistic <input type="checkbox"/> Visual/Hearing <input type="checkbox"/> Handicapping Condition Plan:
<b>7. Estimated Duration of Treatment:</b>
<b>8. Prognosis:</b> <input type="checkbox"/> Excellent <input type="checkbox"/> Fair <input type="checkbox"/> Poor
<b>9. Medication Regimen:</b> <input type="checkbox"/> No Prescribed Medication <input type="checkbox"/> See Medication Records <input type="checkbox"/> Prescribed by Outside Medical Doctor (If box checked list medications with dosages and physician's name/telephone number)
<b>10. Tentative Discharge Plan:</b>
<b>11. Professional Disciplines Responsible and Specific Treatment Interventions/Services/Frequency:</b>
<b>12. Client Goals:</b> Long term: Short term:



<b>Area of Need:</b>	
Problem No.:	Statement:
Objective(s):	Date Objectives Achieved:
<b>Area of Need:</b>	
Problem No.:	Statement:
Objective(s):	Date Objectives Achieved:
<b>Area of Need:</b>	
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PSP Client ID No: \_\_\_\_\_

**Treatment Plan**

I understand that I may have a copy of my treatment plan:

Client Signature \_\_\_\_\_ Approval  Yes  No\* Date: \_\_\_\_\_

Clinician Signature \_\_\_\_\_  LPHA/Waivered Date: \_\_\_\_\_

Supervisor Approval \_\_\_\_\_  N/A Date: \_\_\_\_\_

Psychiatrist Approval \_\_\_\_\_  N/A Date: \_\_\_\_\_

\* If client does not approve plan, note reason(s):

**Treatment plan changes:**

Client Signature \_\_\_\_\_  Yes  No\* Date: \_\_\_\_\_

Clinician Signature \_\_\_\_\_  LPHA/Waivered Date: \_\_\_\_\_

Supervisor Approval \_\_\_\_\_  N/A Date: \_\_\_\_\_

Psychiatrist Approval \_\_\_\_\_  N/A Date: \_\_\_\_\_

\* If client does not approve plan, note reason(s):  Yes  No Date

Client Name:	
Birthdate:	Admit Date:
Chart No:	Reporting Unit:
PSP Client ID No:	

Clinician's Service Necessity Rating (Please complete only at the indicated timeframe)  
 6 months     1 year     1.5 years     \_\_\_\_\_

**Please complete the Service Necessity Rating by considering whether the client needs this level of treatment and/or services from this program to maintain community functioning in the following areas:**

<p>A. Client is at risk of not having a permanent living arrangement, including being homeless or at risk of becoming homeless. (For children at risk of out of home placement.)</p>	<p>Low Service Need</p> <p>1 <input type="checkbox"/>    2 <input type="checkbox"/>    3 <input type="checkbox"/>    4 <input type="checkbox"/>    5 <input type="checkbox"/></p> <p>High Service Needs</p>
<p>B. Client has identified need for this level of care to prevent difficulties in education/employment/day/social activities.</p>	<p>Low Service Need</p> <p>1 <input type="checkbox"/>    2 <input type="checkbox"/>    3 <input type="checkbox"/>    4 <input type="checkbox"/>    5 <input type="checkbox"/></p> <p>High Service Needs</p>
<p>C. Client will not have the ability to establish and maintain relationships including social support system.</p>	<p>Low Service Need</p> <p>1 <input type="checkbox"/>    2 <input type="checkbox"/>    3 <input type="checkbox"/>    4 <input type="checkbox"/>    5 <input type="checkbox"/></p> <p>High Service Needs</p>
<p>D. Client will be unable to maintain physical/mental hygiene including management of his/her medication. (Consider age appropriate.)</p>	<p>Low Service Need</p> <p>1 <input type="checkbox"/>    2 <input type="checkbox"/>    3 <input type="checkbox"/>    4 <input type="checkbox"/>    5 <input type="checkbox"/></p> <p>High Service Needs</p>
<p>E. Client will exhibit psychotic symptoms, or suicidal ideation/acts or violent ideations or acts to persons or property.</p>	<p>Low Service Need</p> <p>1 <input type="checkbox"/>    2 <input type="checkbox"/>    3 <input type="checkbox"/>    4 <input type="checkbox"/>    5 <input type="checkbox"/></p> <p>High Service Needs</p>
<p>F. There is a high risk of recurrence to a level of functional impairment.</p>	<p>Low Service Need</p> <p>1 <input type="checkbox"/>    2 <input type="checkbox"/>    3 <input type="checkbox"/>    4 <input type="checkbox"/>    5 <input type="checkbox"/></p> <p>High Service Needs</p>