Magellan HEALTHCARE℠

Initial Evaluation Template

Demographic Information

(Please complete all questions on this form)

Member Name: _____

Date: _____
Name: _____
Address: _____
Phone (Home): _____ Phone (Work): _____
Date of Birth: _____ Social Security #: _____
Guardianship (for children and adults when applicable): _____

Marital Status (check one):

[] Never Married [] Divorced
[] Married [] Separated
[] Widowed [] Cohabiting

Race (optional):

[] White [] Native American
[] African-American [] Asian
[] Hispanic [] Other

Gender: [] Male [] Female
Age: _____

Family Members:

Name Age Gender Relationship

_____
_____
_____
_____
_____
_____

Employer: _____Occupation: _____
School (for children, and adults when applicable): _____
Referral Source: _____

Insurance Information:

Insurance Company/HMO: _____Phone: _____
Member ID#: _____ Managed Care Company: _____
Claims Address: _____Phone: _____

Emergency Information:

Primary Care Physician: _____ Phone: _____
Name of Emergency Contact: _____ Phone: _____
Relationship to Patient: _____

Source of Information: (patient, family, other): _____

Presenting Problem (include onset, duration, and intensity):

_____
_____
_____

Precipitating Event (why treatment now):_____
_____

Mental Status (circle appropriate items):

Appearance:	Appropriate	Inappropriate	Disheveled	Unclean	Bizarre
Affect:	Appropriate	Inappropriate (describe):_____ (sad, angry, anxious, superficial, restricted, labile, flat)			
Orientation:	Oriented	Disoriented to person, place, time, date, day, situation			
Mood:	Normal	Other_____ (euthymic, depressed, irritable, angry)			
Thought Content:	Appropriate	Inappropriate			
Thought Process:	Logical	Tangential	Illogical		
Speech:	Normal	Slurred	Slow	Pressured	Loud
Motor:	Normal	Excessive	Slow	Other_____	
Intellect:	Average	Above	Below		
Insight:	Present	Partially Present	Absent		
Judgment:	Normal	Impaired			
Impulse Control:	Normal	Impaired			
Memory:	Normal	Impaired:	Immediate	Recent	Remote
Concentration:	Normal	Impaired			
Attention:	Normal	Impaired			
Behavior:	Appropriate	Inappropriate (anxious, agitated, guarded, hostile, drowsy, cooperative, hyperactive, psychomotor retarded)			

Thought Disorder:	No Problem	Grandiosity	Paranoia
	Delusions	Tangential	Loose Associations
	Ideas of reference	Confusion	Thought Blocking
	Perseveration	Flight of Ideas	Hallucinations
	Obsessions	Brain Injury	Phobias

Previous Medical History:

Allergies (adverse reactions to medications/food/etc.): _____
_____
PCP Name and Telephone Number: _____
Date of Last Physical Exam: _____
Findings from Exam: _____
_____

Any relevant medical conditions (diabetes, hypertension, head traumas, cardiac problems, asthma or other breathing problems, cancer, etc.): _____
_____

Family Medical History: _____

Current Medications (Include prescribed dosages, dates of initial prescription and refills, and name of doctor prescribing medication):

_____

_____

Hospitalizations/Surgeries (include dates, complications, adverse reactions to anesthesia, outcomes, etc.):_____

Past Psychiatric History (Mental Health and Chemical Dependency):
Hospitalizations: _____

_____

Family History of Suicide/Homicide: Yes _____ No _____

_____

Prior Outpatient Therapy:

Previous practitioners and dates of treatment: _____

_____

Previous treatment interventions: _____

_____

Response to treatment interventions including medications: _____

_____

Results of recent lab tests and consultation reports: _____

_____

Family Mental Health or Chemical Dependency History: _____

_____

_____

Psychosocial Information:

Support Systems: _____
School/Work Life: _____
Marital History: _____
Legal History: _____
Military History: _____
Spiritual Beliefs: _____

Risk Assessment

Ideations	None Noted	Thoughts Only	Plan (describe)	Intent (describe)	Means (describe)	Attempt (describe)	History (Ideation and/or Attempts)
Suicidal Ideation							
Homicidal Ideation							

Substance Abuse History (complete for all patients age 12 and over)

Substance	Amount	Frequency	Duration	First Use	Last Use
Caffeine					
Tobacco					
Alcohol					
Marijuana					
Opioids/ Narcotics					
Amphetamines					
Cocaine					
Hallucinogens					
Others:					

Children and Adolescents Only:

Developmental History (developmental milestones met early, late, normal):_____
_____
_____

Peri-natal History (details of pregnancy/labor/delivery):_____
_____

Pre-natal History (medical problems during pregnancy, mother's use of medications):_____
_____

Risk Factors to include**:**

____ Non-compliance with treatment
____ AMA/elopement potential
____ Prior behavioral health inpatient admissions
____ History of multiple behavioral diagnosis
____ Suicidal/homicidal ideation
_____ Domestic Violence
_____ Child Abuse
_____ Sexual Abuse
_____ Eating Disorder
_____ Other (describe)

Strengths: _____

Barriers: _____

Diagnostic Impression:

Axis I/ICD-10:
Axis III:

Medication Education (as appropriate): __ Yes __ N/A ___ Patient Verbalizes Understanding
Diagnosis Education (as appropriate): __ Yes __ N/A ___ Patient Verbalizes Understanding

Follow-up Appointment: _____

Clinician Signature: _____ Date: _____