The Mandel Center of Arizona, LLC
Alyssa Mandel, LCSW
8120 East Cactus Road • Suite 310
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Office: 480.734.1199
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contact@mandelcenter.com
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Initial Assessment

Client name: ____

Presenting issues per client:

____

____

____

____

Mini-mental status evaluation/current symptoms/functioning:

Vocational/work status: ____

Sleep: ____________________

Concentration: ____________________

Anxiety: ____________________

Appearance: WNL/or: ____________________

Appetite: ____________________

Nutrition:____________________

Mood: ____________________

Attitude: Cooperative, Guarded, Agitated

MMSE Orientation: Person, Place, Time

Memory per client report: WNL/Impaired

Affect: WNL/or: ____________________

Thought Process: Intact, Tangenital, Concrete

Motor Activity: Calm, Hypo, Hyper

Judgement/Insight WNL/or: ____________________

Speech: WNL/or: ____________________

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

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

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:

____

____

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____

____

ALYSSA MANDEL, LCSW ______________________________ *DATE* ______ / ______ / ______