


Name: _____	NHI: _____	 BAY OF PLENTY DISTRICT HEALTH BOARD H A U O R A A T O I MH&AS COMPREHENSIVE ASSESSMENT FORM - ADULT
Address: _____	_____	
DOB: _____	Ethnicity: _____	


Attach patient label

INTERVIEWER/S		Date of Interview:
		Time of Interview
Others present		
Referrer:		
G.P		
Legal Status:	Responsible Clinician:	
Enduring Power of Attorney:	EPoA on file: <input type="checkbox"/> yes <input type="checkbox"/> no	

INTRODUCTION	
<i>Reason for referral</i>	
<i>Consumer's reaction to referral</i>	

PRESENTING PROBLEMS AND HISTORY	
<i>Consumer's belief of what is wrong.</i>	
<i>Why Now?</i>	

SYMPTOM ENQUIRY	
<i>Any of the following not detailed above</i>	
<i>Depression</i>	
<i>Elation</i>	
<i>Anxiety</i>	
<i>Panic</i>	
<i>Phobia</i>	
<i>Obsessions</i>	
<i>Compulsions</i>	


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<i>Delusions Hallucinations Passivity experiences</i>	
<i>Suicidal/homicidal ideas & plans</i>	
<i>Physical symptoms related to mental disorder</i>	

SUBSTANCE USE	Are you Smokefree?	Yes	No	NRT offered?	Accepted	Declined	(see treatment plan)
Primary Substance of Concern: <i>(Current or most recent use, first use.)</i>							


Drugs used (specify type)	Age first used	Years of heaviest use	Approx. date last used	Frequency of use	Quantity	Method le. Inject, smoke, snort
Alcohol						
Cannabis						
Synthetic Cannabis						
Amphetamines (speed)						
Methamphetamine ('P')						
Party Pills						
Ecstasy						
Cocaine						
Benzodiazepine						
Heroin						
Methadone - non-prescribed						
Methadone – prescribed						
Other opioids						
Hallucinogens (LSD, mushrooms)						
Solvents / Inhalants						
Other						
Caffeine						
Gambling: Do you gamble?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, is this a problem for you?			

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FAMILY PSYCH HISTORY	
SOCIAL SITUATION	
<i>Marital Status Family Support Friends Accommodation Forensic Status activities of daily living function/work/vocational programme and strengths?</i>	
FAMILY STRUCTURE	
<i>Parents Siblings Offspring Deaths Quality of relationships</i>	

CHILDREN	Number of dependent children: _____			
<i>No. of dependent children?</i>	Names and ages of dependents: _____			
<i>Effect of illness On dependent children, Who cares for children when unwell? Family support for parenting?</i>				
Care Planning	Care Plan Required Yes <input type="checkbox"/> No <input type="checkbox"/>		Information Provided Yes <input type="checkbox"/> No <input type="checkbox"/>	
<u>Family violence screening (FVS).</u> <i>The staff in this DHB are concerned about FV and its impact on women and children, therefore we ask all women about any violence in their home.</i>	FV Screen Yes No If no, please indicate why below.	CYFS referral indicated Yes No	Safety plan discussed completed Yes No	Referral to other support agencies i.e. Police, women's refugee, local lwi services, please indicate FV resources provided Yes NO
	Framing questions For FV:-			

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<i>Have you ever been subject to violence (physical, sexual or emotional) in the last 12 months? Do you feel safe in your home and in your relationships Any concerns for safety or welfare of your children?</i>	
Premorbid Personality	
CULTURE & SPIRITUAL NEEDS	
<i>Ethnic & religious affiliations</i> <i>Include hapu/iwi if Maori</i>	
MENTAL STATUS EXAMINATION	
<i>Behaviour</i>	
<i>Appearance & Movement &</i>	
<i>Affect & Mood</i>	
<i>Thought process & content, Perception Cognition, Speech</i>	
<i>Orientation</i>	
<i>Memory, Recall Concentration Motivation</i>	
<i>Insight & Intellectual functioning Knowledge Concrete thinking</i>	



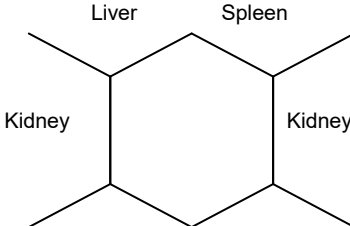
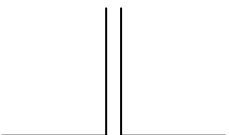
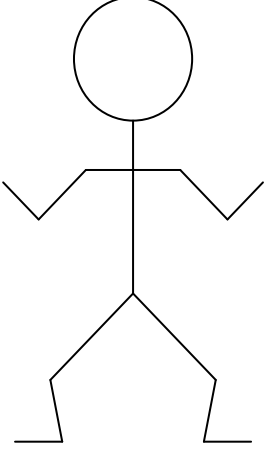
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<i>Rapport</i>			
RISK FORMULATION			
<i>e.g. 5 P's model</i>			
■ <i>Problem:</i>			
■ <i>Predisposing factors:</i>			
■ <i>Precipitating factors:</i>			
■ <i>Perpetuating factors:</i>			
■ <i>Protective factors:</i>			
<i>(Can include interventions in place.)</i>			
DIAGNOSIS/ IMPRESSION			
INITIAL MANAGEMENT PLAN	Plan	Rationale	Evaluation
<i>Risk</i>			
<i>Psycho-social needs</i>			
<i>Medication</i>			
<i>Crisis plan</i>			

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PHYSICAL EXAMINATION

General:	
Physi	
al description:	
Height :	Weight:
Eyes: (colour/glasses)	Hair:
Teeth:	
Distinguishing features:	
Urinalysis:	
Temperature:	Skin:
Rash:	
Jaundice:	Cyanosis:
Clubbing:	Lymphadenopathy:
Pallor:	Anaemia:
VS:	
Pulse:	BP:  / 
JVP:	
Apex:	ABDO:
HS:	
Oedema:	
Peripheral Pulses:	
Resp:  Trachea: Percussion: Breath Sounds: Added:	
NEURO: GCS /15	PERIPHERIES REFLEXES
Orientated time/place/person	
CN II Visual Acuity	
Fundi	
CN III Pupils	
CN III, IV, VI Eye movements	
Nystagmus	
CN V Sensation	
Musculature	
Corneal Reflex	
CN VII Power	
CN VIII Hearing	
CN IX, X Soft Palate	
CAG	
CN XI Musculature	
CN XII Tongue	
MEDICAL DIAGNOSIS:	
INVESTIGATIONS: FBC U&E Cm Gluc LFTS TFT ECG Chest X-ray	
Other:	