

MENTAL HEALTH ASSESSMENT

Patient name		Date of Birth	
Address			
Post Code		Phone	
		Gender	
Aboriginal or Torres Strait Islander origin	No <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/> Unknown <input type="checkbox"/>		
GP		Practice postcode	
Date of Assessment		Outcome Tool	
		Result	

Problem	Diagnosis
1.	
2.	
3.	

Mental Health History / Treatment

Allied Health Referral Data	Has the person ever received specialist mental health care: Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Language spoken at home: English <input type="checkbox"/> Italian <input type="checkbox"/> Greek <input type="checkbox"/> Cantonese <input type="checkbox"/> Mandarin <input type="checkbox"/> Arabic <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other <input type="checkbox"/> Please specify:..... How well does the person speak English: Very well <input type="checkbox"/> Well <input type="checkbox"/> Not well <input type="checkbox"/> Not at all <input type="checkbox"/>
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Medications	Allergies

Family History of Mental Illness

Medical Conditions

Social History

Allied Health Referral Data	Does the person live alone: Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Is the person a low income earner (A judgment by GP) Yes <input type="checkbox"/> No <input type="checkbox"/>
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Abuse history - substance / sexual / physical		
Alcohol use:	Tobacco:	BMI:

Personal History (eg childhood, education, relationship history, coping with previous stressors)	
Allied Health Referral Data	Highest education level completed: Primary or below <input type="checkbox"/> Secondary Year 10 or equivalent <input type="checkbox"/> Secondary Year 11 or equivalent <input type="checkbox"/> Secondary Year 12 or equivalent <input type="checkbox"/> Tertiary <input type="checkbox"/>
Relevant Physical and Mental Examination	Investigations
Mental Status Examination	
Appearance and General Behaviour	Mood (Depressed / Labile)
Thinking (Content / Rate / Disturbances)	Affect (Flat / Blunted)
Perception (Hallucinations etc)	Sleep (Initial Insomnia / Early Morning Wakening)
Cognition (Level of Consciousness / Delirium / Intelligence)	Appetite (Disturbed Eating Patterns)
Attention / Concentration	Motivation / Energy
Memory (Short & Long term)	Judgement (Ability to make rational decisions)
Insight	Anxiety Symptoms (Physical & Emotional)
Orientation (Time / Place / Person)	Speech (Volume / Rate / Content)
Risk Assessment	
Suicidal ideation	Suicidal intent
Current plan	Risk to Others
Key Family/ Support Contact	
FORMULATION - Main problem / diagnosis (risk / protective factors)	ICD - 10 Provisional Diagnosis
	F1 Alcohol & Drug Use disorder <input type="checkbox"/>
	F2 Psychotic Disorder <input type="checkbox"/>
	F3 Depression <input type="checkbox"/>
	F4 Anxiety Disorder <input type="checkbox"/>
	F5 Unexplained Somatic Disorder <input type="checkbox"/>
	Other / Unknown:
Patient Education Yes <input type="checkbox"/> No <input type="checkbox"/>	Date for Mental Health Plan
Eligibility for the Better Outcomes in Mental Health Care initiative Yes <input type="checkbox"/> No <input type="checkbox"/>	
Notes	

