# QI CORNER


*Best Practices Series*

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- Assessment

**To help ensure your success with following County, State, and Federal guidelines, we highlight some best practices for assessment documentation.**

The purpose of an assessment is to identify presenting problems, gather information for treatment planning and address biopsychosocial needs. The main components address psychological, biological and social factors. The assessment must be completed within thirty (30) days from date of service.

**For Optum's assessment template please click HERE**

## Have Questions?

Email us at: SDQI@Optum.com

## A thorough assessment should include:

**Reasons for Referral & Presenting Problem:** Why is the client seeking services now?

**History of Mental Health Treatment:** Dates of previous treatment, providers of previous treatment, and therapeutic interventions and responses

**Risk Assessment:** History of previous or current suicidal, homicidal and/or self-injurious behaviors, including date, methods or lethality (as applicable).

**Family History**: Medical and/or mental health

**Social History:** Legal concerns, trauma history, relationships, work history

**Substance Abuse Screening:** Current or past substance use including amount and frequency of use and impact on functioning

**Cultural Issues:** Spirituality, race, and religion

**Strengths:** Client and family strengths

**For children and Adolescents**: A complete developmental history (physical, psychological, social, intellectual and academic) is documented

**Medical History:** Including any current medical conditions (allergies, current medications, prescriber contact information, primary care physician, family medical history)

**Mental Status Exam**: Documenting the client's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory, and impulse control

**Resources:** There is documentation that the client was asked about community resources (support groups, social services, school-based services, other social supports) they are currently utilizing

**Clinical Formulation:** Summary of information received, diagnostic impressions and next steps