

Client Name: _____

Client Strengths/Resources:

Risk Assessment:

- Current Substance Use Yes No
Suicide Risk Yes No
Homicide Risk Yes No
Previous Psychiatric Hospitalization Yes No

If risk areas have been checked as YES, please describe areas of risk:

Prior Treatment History:

Does the client have a prior treatment history? Yes No

If yes:

- Treatment was for Substance Abuse Mental health Both S/A and M/H
- Provider name: _____
- Dates of Service: _____
- Program Type: Inpatient Outpatient Day Treatment Hospital Detox Other
- Focus of treatment: _____

- Outcome of Treatment: _____

Provider Name (Printed): _____

Provider Signature: _____