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|  |  | | | |  | |  |
| PROVIDER | ADDRESS | | | | PHONE | | FAX |
|  |  | | | |  | |  |
| CLIENT LAST NAME | CLIENT FIRST NAME | | | | MIDDLE NAME | | SUFFIX( Sr.,Jr.) |
|  | | |  | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| PREFERRED LAST NAME | | | PREFERRED FIRST NAME | | | | D.O.B. |
|  | | *MM/DD/YY* | | **---** | | *MM/DD/YY* | *Circle Preferred Pronoun: He/Him, She/Her, They/Them, Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| EPISODE OPENING DATE | | INDICATE 12 MO. AUTHORIZATION CYCLE | | | | |  |

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| Sex Assigned at Birth: Male | | | Female | | | Intersex | | Other: | | |
| Gender Identity: Male | | Female | | Intersex | € Gender Queer | | Gender Non-Conforming | | Male to Female | Female to Male |
| Other: |  | | | | | | | | | |

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| Emergency Contact | Relationship | Contact address ( Street, City, State, Zip) | | | | Contact Phone number |
| Release for Emergency Contact obtained for this time period: | | | | | | |
| **Assessment Sources of Information(**Check All that Apply): | | | **Client** | **Family Guardian** | **School** | **Other:** |

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| **REFERRAL Source/ RESON FOR REFERRAL/ CLIENT COMPLAINT** |
| Describe precipitating event(s) for Referral: |
| Narrative continued in Addendum |
| Current Symptoms and Behaviors (intensity, duration, onset, frequency): |
| Narrative continued in Addendum |
| Impairments in Life Functioning caused by the MH symptoms/Behaviors (from perspective of client and/or others): |
| Narrative continued in Addendum |
| **MENTAL HEALTH HISTORY** |
| **Psychiatric Hospitalizations: € Yes € No € Unable to Assess** |
| If Yes, describe dates, locations, reasons, response to, and satisfaction with treatment: |
| Narrative continued in Addendum |
| **Outpatient Treatment: € Yes € No € Unable to Assess** |
| If Yes, describe dates, locations, reasons, response to, and satisfaction of treatment: |
| Narrative continued in Addendum |
| **Prior Mental Health Records Requested:** **Yes**  **No (See InSyst Face Sheet for current and history of past services)** |
| Prior Mental Health Records Requested from: |
| Narrative continued in Addendum |
| **History of Trauma or Exposure to Trauma:** **Yes**  **No**  **Unable to Assess** |
| Has client ever: (1) been physically hurt or threatened by another, (2) been raped or had sex against their will, (3) lived through a disaster, (4) been a combat veteran or experienced an act of terrorism, (5) been in severe accident, or been close to death from any cause, (6) witnessed death or violence or the threat of violence to someone else, or (7) been the victim of crime? **Describe:** |
| Narrative continued in Addendum |
| **Risk factors:**  *Aggressive/violent behavior/danger to self/others, and include level of impairments (i.e., school suspension, law enforcement/incarceration, crisis services, and hospitalization)*  *Please check if occurred within the last 30 days. Date of onset*  **Client:** |
| **Family:** |
| Narrative continued in Addendum |
| **Safety plan completed or MH objective in Tx Plan** |

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| **Additional Risk Assessment (**Elaboration of ALL risk factors, note: frustration tolerance, hostility, paranoia, command hallucination, violent thinking, exploitative, and gambling risk behaviors. Also include factors that might lessen risk, such as client’s commitment to self-control and involvement in treatment) | | | | |
| Narrative continued in Addendum | | | | |
| **Reports Filed as a result of this Assessment:** | **N/A** | **CPS** | **APS** | **Other:** |

|  |
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| ***FAMILY HISTORY*** |
| Narrative continued in Addendum |
| **FAMILY HISTORY OF MENTAL ILLNESS, SUBSTANCE ABUSE/NEGLECT (physical, sexual, emotional, etc.), AND/OR SUICIDE ( suicide attempt/ unexplained death):** |
| Narrative continued in Addendum |
| **Cultural factors which may influence presenting problems as viewed by client/family/caregiver and clinician (may include ethnicity, race religion, spiritual practice, sexual orientation, gender identity, caregiver socioeconomic status, living environment, etc.):** |
| Narrative continued in Addendum |
| **How is beneficiary’s/family’s diversity a strength for the beneficiary?** |
| Narrative continued in Addendum |
| **What special treatment issues result from beneficiary’s/ family’s diversity?** |
| Narrative continued in Addendum |
| **SEXUAL ORIENTATION:** **Unknown** **Heterosexual/Straight** **Lesbian** **Gay**  **Bisexual**  **Queer** **Gender Queer**  **Questioning** **Declined to State** **Other:** |
| **ADULTS, 18+ yrs. only (CHILDREN & YOUTH, *SEE PAGE 8* )** |
| *Childhood (where, who reared/lived in house where grew up, important/traumatic events, school experience and performance, history of physical/sexual abuse, placement history, etc.*). |
| Narrative continued in Addendum |
| *Adolescence (school and activities, friendships/relationships, sexual experiences, traumas, leaving home, placement history, etc.)* |
| Narrative continued in Addendum |
| *Adulthood (military service, marriage/divorce, children, geographical changes, traumas, current relationship with family/significant other, etc.)* |
| Narrative continued in Addendum |
| *Aging issues (retirement, grandchildren, support systems, sleep changes, losses, etc.)* |
| Narrative continued in Addendum |
| *Education and Vocational History (first job, longest job, current structured activities, type of work, etc.)* |
| Narrative continued in Addendum |

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| **CRIMINAL HISTORY** | |  | | | | | | | | | | | |
| **Criminal Justice History/Violent Incidents of Individual and/or Family** | **Within last 90 days** | | | **Past** | |  |  | **Within last 90 days** | | | **Past** | | |
|  | **Y** | | **N** | **Y** | **N** |  |  | | **Y** | **N** | | **Y** | **N** | |
| Assault on persons |  | |  |  |  |  | Probation | |  |  | |  |  | |
| Threat to persons |  | |  |  |  |  | Parole | |  |  | |  |  | |
| Property Damage |  | |  |  |  |  | Adjudicated | |  |  | |  |  | |
| Weapons Involved |  | |  |  |  |  | Diversion | |  |  | |  |  | |
| Legal History |  | |  |  |  |  | Other: | |  |  | |  |  | |

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| **Describe criminal justice involvement/incidents (include level of community threat/safety, dates, types of crimes, outcomes, etc.)** |
| Narrative continued in Addendum |
| **Describe any relevant family involvement with criminal justice (include level of community threat/safety, dates, types of crimes, outcomes, etc.)** |
| Narrative continued in Addendum |

**Medical History**

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| --- | --- | --- | --- |
|  | **Name:** | **Phone#:** | **Last Date of Service** |
| 1. **Primary Physician:** |  |  |  |
| 1. **Other medical provider(s):** |  |  |  |
|  |  |  |  |
| 1. **Date records requested:**   **From whom, if applicable:** |  | | |

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| **Relevant Medical History** (complete checklist and comment on those checked below): ***Check only those that are relevant*** | | | | | | | | | | | | | | | | | | | |
| **General Information:** | | Weight Changes: | |  | | | | Baseline Weight (if able to obtain): | | | | | |  | | BP: | | |  |
| *Cardiovascular/Respiratory:* | | Chest Pain | | | Hypertension | | | | Hypotension | | | | Palpitation | | | | Smoking | | |
| *Genital/Urinary/Bladder:* | | Incontinence | Nocturia | | | Urinary Tract Infection | | | | | Retention | | | | | Urgency | | | |
| *Gastrointestinal/Bowel:* | | Heartburn | | | Diarrhea | | | | | Constipation | | | Nausea | | Vomiting | | | | |
| Ulcers | | | Laxative Use | | | | | Incontinence | | |  | |  | | | | |
| *Nervous System:* | | Headaches | | | Dizziness | | | | | Seizures | | | Memory | | | | | Concentration | |
| *Musculoskeletal:* | | Back Pain | | | Stiffness | | | | | Arthritis | | | Mobility/Ambulation | | | | |  | |
| *Gynecology:* | | Pregnant | | | Pelvic Inflam. Disease | | | | | Menopause | | | TBI/ LOC | | | | |  | |
| *Skin:* | | Scar | | | Lesion | | | | | Lice | | | Dermatitis | | | | | Cancer | |
| *Endocrine:* | | Diabetes | | | Thyroid | | | | | Other: | |  | | | | | | | |
| *Respiratory:* | | Bronchitis | | | Asthma | | COPD | | | Other | |  | | | | | | | |
| *Others:* | |  | | | | | | | | | | | | | | | | | |
| Other: | Significant Accident/Injuries/Surgeries: | | |  | | | | | | | | | | | | | | | |
|  | Hospitalizations: | | |  | | | | | | | | | | | | | | | |
|  | Physical Disabilities: | | |  | | | | | | | | | | | | | | | |
|  | Chronic Illness: | | |  | | | | | | | | | | | | | | | |
|  | HIV disease: | | |  | | | | | | | | | | | | | | | |
|  | Liver disease: | | |  | | | | | | | | | | | | | | | |
| Comments: | | Narrative continued in Addendum | | | | | | | | | | | | | | | | | |

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| **Alternative healing practice/date (e.g., acupuncture, hypnosis, herbs, supplements, etc.)** | | | |
| **Date** | **Provider/Type** | **Reason for Treatment** | **Outcome (was it helpful and why)** |
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| Current/ previous medications (include all prescribed- psychotropics & non-psychotropics, over the counter, and holistic/ alternative remedies): | | | | | | | | | | | | | |
|  | **Rx Name** | | **Effectiveness/Side Effects** | | | | **Dosage** | | **Date Started** | | **Prescriber** | **Current** | **Past** |
| *Psychotropic* |  | |  | | | |  | |  | |  |  |  |
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| *Non-Psychotropic* |  | |  | | | |  | |  | |  |  |  |
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| **Allergies/Adverse Reactions/ Sensitivities** | | | | Check if Yes and List Food  Drugs(Rx/OTC/ILLICT) Unknown Allergies Other: | | | | | | | | | |
|  | | | |  | | | | | | | | | |
| **Date of last physical exam:** | |  | | | | **Date of last dental exam:** | | | |  | | | |
| **Referral made to primary care or specialty** | | | | **NO** | **YES** | | | **If yes, list:** | | | | | |
| **Additional Medical Information:** | | | | | | | | | | | | | |
| Narrative continued in Addendum | | | | | | | | | | | | | |

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| **This Section for YOUTH ONLY < 18 YRS OLD** | | | | | | | See MENTAL HEALTH ASSESSMENT ADDENDUM FOR INFANT/TODDLERS, AGES 0-5 | | | | | | | |
| LIVES WITH: | | | First Name of others in home (children & adults) | | | | | Age | Relationship | | | | | |
| Immediate Family | | |  | | | | |  |  | | | | | |
| Extended Family | | |  | | | | |  |  | | | | | |
| Foster Family | | |  | | | | |  |  | | | | | |
| Other | | |  | | | | |  |  | | | | | |
| DESCRIBE FAMILY OF ORIGIN: | | | | | Narrative continued in Addendum | | | | | | | | | |
| **EDUCATION** | | Current School: | | | |  | | | | Spec Ed | | YES | | NO |
| Grade: |  | Contact/Teacher/ Ph#: | | | | |  | | | | | | | |
| Active IEP/Special Assessment/Services: | | | | | | |  | | | LD | DD/ID | | SED | |
| Last School Attended: | | | |  | | | | | | | | | | |
| Vocational Activities: | | | | | | | | | | | | | | |
| **Developmental History (for each section also include any significant culturally related rites of passage, rituals, ceremonies, etc.)** | | | | | | | | | | | | | | |
| Prenatal/birth/childhood information (include pregnancy, developmental milestones, environmental stressors, and other significant events) 0-6yrs: | | | | | | | | | | | | | | |
| Narrative continued in Addendum | | | | | | | | | | | | | | |
| Latency (peer/sibling relations, extracurricular activities, delinquency, environmental stressors of other significant events) 7-11yrs.: | | | | | | | | | | | | | | |
| N/A | | | | | | | | | | | | | | |
| Narrative continued in Addendum | | | | | | | | | | | | | | |
| Adolescence (include onset of puberty, extracurricular activities, teen parenthood, delinquency, gang involvement, environmental stressors of other significant events) 12-17 yrs.: | | | | | | | | | | | | | | |
| N/A | | | | | | | | | | | | | | |
| Narrative continued in Addendum | | | | | | | | | | | | | | |

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| SUBSTANCE USE SCREENING | | | | | | | | | | | | | | |
| 0-10 yo:  Child is under 11 years and SUD screening not indicated per clinical judgment. See Substance Risk, Use, & Attitude Exposure, next page. | | | | | | | | | | | | | | |
| 11-17yo:  Client is unwilling to discuss at this time; will address as appropriate. | | | | | | | | | | | | | | |
| During the Past 12 months, did you: | | | | | **NO** | | | **YES** | | | | | | |
| 1. Drink any alcohol (more than a few sips)?   (Do not count sips of alcohol taken during family or religious events.) | | | | |  | | |  | | | | | | |
| 1. Smoke any marijuana or hashish? | | | | |  | | |  | | | | | | |
| 1. Use anything else to get high?   (anything else” includes illegal drugs, over the counter and prescription drugs, and things that you sniff or “huff”) | | | | |  | | |  | | | | | | |
| **For Clinic use only: Did patient answer “yes” to any question?** | | | | |  | | |  | | | | | | |
| **NO** | | | **YES** | | | | | | | | | | | |
| **Ask CAR question #1 below, then stop** | | | **Ask all 6 CRAFFT questions below** | | | | | | | | | | | |
|  | | | | | **NO** | | | **YES** | | | | | | |
| 1. Have you ever ridden in a **CAR** driven by someone (including yourself) who was “high” or had been using alcohol or drugs? | | | | |  | | |  | | | | | | |
| 1. Do you ever use alcohol or drugs to **R**ELAX, feel better about yourself, or fit it? | | | | |  | | |  | | | | | | |
| 1. Do you every use alcohol or drugs while you are by yourself or **A**LONE? | | | | |  | | |  | | | | | | |
| 1. Do you every **F**ORGET things you did while using alcohol or drugs? | | | | |  | | |  | | | | | | |
| 1. Do your **F**AMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use? | | | | |  | | |  | | | | | | |
| 1. Have you ever gotten into **T**ROUBLE while you were using alcohol or drugs? | | | | |  | | |  | | | | | | |
| **2 or more “yes” indicate need for further assessment.** | | | | | | | | | | | | | | |
| 18+yo | | | | | **NO** | | | **YES** | | | | | | |
| 1. Have you felt you should cut down or stop drinking or using substance? | | | | |  | | |  | | | | | | |
| 1. Has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using substance? | | | | |  | | |  | | | | | | |
| 1. Have you felt guilty or bad about how much you drink or use of substance? | | | | |  | | |  | | | | | | |
| 1. Have you been waking up wanting to drink or use substance?   **Any “yes” answer may indicate a problem and need for further assessment.** | | | | |  | | |  | | | | | | |
|  | | | | | | | | | | | | | | |
| SUBSTANCE EXPOSURE | | | | | | | | | | | | | | |
| **Check if ever used:** | **Prenatal Exposure**  **Unknown** | **AGE AT FIRST USE** | | **CURRENT SUBSTANCE USE** | | | | | | | | | | |
| None/  Denies | | | Current  Use | | Current  Abuse | Current  Dependence | | In Recovery | Client-perceived Problem? | |
| ALCOHOL |  |  | |  | | |  | |  |  | |  | Y | N |
| AMPHETAMINES (SPEED/UPPERS, CRANK, ETC) |  |  | |  | | |  | |  |  | |  | Y | N |
| COCAINE/CRANK |  |  | |  | | |  | |  |  | |  | Y | N |
| OPIATES (HEROIN, OPIUM, METHADONE) |  |  | |  | | |  | |  |  | |  | Y | N |
| HALLUCIENOGENS (LSD, MUSHROOMS, PEYOTE, ECTASY) |  |  | |  | | |  | |  |  | |  | Y | N |
| SLEEPING PILLS, PAIN KILLERS, VALIUM, OR SIMILAR |  |  | |  | | |  | |  |  | |  | Y | N |
| PSP (PHENCYCLIDINE) OR DESIGNER DRUGS (GHB) |  |  | |  | | |  | |  |  | |  | Y | N |
| INHALANTS (PAINT, GAS, GLUE, AREOSOLS) |  |  | |  | | |  | |  |  | |  | Y | N |
| MARIJUANA/ HASHISH |  |  | |  | | |  | |  |  | |  | Y | N |
| TABACCO/ NICOTINE |  |  | |  | | |  | |  |  | |  | Y | N |
| CAFFEINE (ENGERY DRINKS, SODAS, COFFEE, ETC.) |  |  | |  | | |  | |  |  | |  | Y | N |
| OVER THE COUNDER: |  |  | |  | | |  | |  |  | |  | Y | N |
| OTHER SUBSTANCE: |  |  | |  | | |  | |  |  | |  | Y | N |
| COMPLIMENETARY ALTERNATIVE MEDICATION |  |  | |  | | |  | |  |  | |  | Y | N |
| Is beneficiary receiving alcohol and drug services? | Yes, from this provider | | | | | Yes, from a different provider | | | | | No | | | |
| If yes, type of alcohol and drug services: | Residential | | | | | Outpatient | | | | | Community/ Support Group | | | |

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| --- | --- | --- | --- | --- |
| SUSBSTANCE RISKS, USE, & ATTITUDES/EXPOSURE | | | | |
|  | | **NO** | **YES** | **UNABLE TO ASSESS** |
| Were any risk factors identified based on clinical judgment? | |  |  |  |
| Does the client currently appear to be under the influence of alcohol or drugs? | |  |  |  |
| Has the client ever received professional help for his/her use of alcohol or drugs?  **Comments on alcohol/drug use:** | |  |  |  |
| Narrative continued in Addendum | |  | | |
| How is the mental health impacted by substance use (clinician’s perspective)? *Must be completed if any services will be directed towards substance Use/Abuse, such as Case Management.* | | Narrative continued in Addendum | | |
| SUBSTANCE ABUSE/SEVERITY ASSESSMENT: | | | | |
| 1. Beneficiary self-assessment (*check one)*: | | | | |
| No alcohol or drug use | | | | |
| Alcohol or drug use with no related problems | | | | |
| Alcohol or drug use with related problems | | | | |
| 1. Provider assessment (*check one*): | | | | |
| Use (minimal or no alcohol or drug relation problems) | | | | |
| Substance abuse (frequent and/or periodic use associated with alcohol or drug problems) | | | | |
| Substance dependence in recovery (prior significant, but now minimal or no substance related problems) | | | | |
| Substance dependence not in recovery (uncontrolled use with significant alcohol or drug related problems) | | | | |
| SUD REFERRALS | | | | |
| **Check below, for any referral made based on abuse assessment. List specific referral below.** | | | | |
| Referral to SUDS (Substance Use Disorder Services) ACCESS line #1-800-491-9099 for: | | | | |
| Self-help groups- groups for consumer’s interested in support of sobriety include AA, NA, and Dual Recovery Anonymous. Referral should ideally be to a group known to support clients in psychiatric recovery. • Alcoholic Anonymous 510-839-8900  •Moderation Management:paulstayley@comcast.net or [www.moderation.org](http://www.moderation.org) | | | | |
| Outpatient counseling- for consumer’s assessed at abuse level, and who have an environment supportive of recovery. | | | | |
| Residential treatment- for chemically dependent consumer’s with a low level of function, requiring an intense level of support to initiate sobriety. | | | | |
| Detoxification- for chemically dependent consumers who are at risk of at least moderate withdrawal symptoms, and who require high level of structure to initiate sobriety. | | | | |
| Other (specify): |  | | | |
| From the ACBHCS SUD Treatment Referral Guide, [www.acbhcs.org/providers/SUD/resources.htm](http://www.acbhcs.org/providers/SUD/resources.htm), indicate the specific referrals provided to client. Make a copy for the client to take with them to follow-up with referral..   |  |  |  | | --- | --- | --- | | **AGENCY** | **ADDRESS** | **TELEPHONE NUMBER** | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | | | | | |

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| MENTAL STATUS: *(Check and describe if abnormal or impaired)* | | | | | | |
| *Appearance/Grooming:* | Unremarkable | Remarkable for: | | | | |
| *Behavior/Relatedness:* | Unremarkable | Motor Agitated | | Inattentive | | Avoidant |
| Impulsive | Motor Retarded | | Hostile | | Suspicious/Guarded |
| Other: | | | | | |
| *Speech:* | Unremarkable | Remarkable for: | | | | |
| *Mood/Affect:* | Unremarkable | Depressed | | Elated/Expansive | | Anxious |
| Labile | Irritable/Angry | | Other: | | |
| *Thought Processes:* | Unremarkable | Concrete | | Distorted | | Disorganized |
| Odd/Idiosyncratic | Blocking | | Paucity of Content | | Circumstantial |
| Tangential | Obsessive | | Flight of Ideas | | Racing Thoughts |
| Loosening of Assoc | Other: | | | | |
| *Thought Content:* | Unremarkable | Hallucinations | | Delusions | Ideas of Reference | |
| Other | | | | | |
| *Perceptual Content:* | Unremarkable | Hallucinations | | Homicidal Ideation | Paranoid Reference | |
| Flashbacks | Depersonalization | | Derealization | Dissociation | |
| Other: | | | | | |
| *Fund of Knowledge:* | Unremarkable | Remarkable for: | | | | |
| *Orientation:* | Unremarkable | Remarkable for: | | | | |
| *Memory:* | Unremarkable | Impaired: | | | | |
| *Intellect:* | Unremarkable | Remarkable for: | | | | |
| *Insight/Judgment:* | Unremarkable | Remarkable for: | | | | |
| **Describe abnormal/impaired findings:** | | | | | | |
| **Additional Observations/Comments (if any):** | | | Narrative continued in Addendum | | | |

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| FUNCTIONAL IMPAIRMENTS: | | | | | | | | | | | | |
|  | None | Mild | Mod | Severe |  | None | | Mild | Mod | | Severe | |
| Family Relations |  |  |  |  | Circle appropriate: Substance Use/Abuse |  | |  |  | |  | |
| School Performance/Employment |  |  |  |  | Activities of Daily Living |  | |  |  | |  | |
| Self-Care |  |  |  |  | Episodes of decompensation & increase of symptoms, each of extended duration |  | |  |  | |  | |
| Food/Shelter |  |  |  |  | Other (Describe): |  |  | | |  | |  |
| Narrative continued in Addendum | | | | | | | |
| Social/Peer Relations |  |  |  |  |
| Physical Health |  |  |  |  |
| Comments (if any): | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| TARGETED SYMPTOMS: | | | | | | | | | | |
|  | None | Mild | Mod | Severe |  | | None | Mild | Mod | Severe |
| Cognition/Memory/Thought |  |  |  |  | Perceptual Disturbance | |  |  |  |  |
| Attention/Impulsivity |  |  |  |  | Oppositional/Conduct | |  |  |  |  |
| Socialization/Communication |  |  |  |  | Destructive/Assaultive | |  |  |  |  |
| Depressive Symptoms |  |  |  |  | Agitation/Lability | |  |  |  |  |
| Anxiety/phobia/Panic Attack |  |  |  |  | Somatic Disturbance | |  |  |  |  |
| Affect Regulation |  |  |  |  | Other: | |  |  |  |  |
| Comments (if any): | | | | | | Narrative continued in Addendum | | | | |

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| **Impairment Criteria (must have one of the following :)** | | | **AND:** | **Intervention Criteria (proposed INTERVENTION will….))** | |
|  | 1. Significant impairment in an important area of life function. | **AND** | | | 1. Significantly diminish impairment |
|  | 1. Probability of significant deterioration in an important area of functioning. | **AND** | | | 1. Prevent significant deterioration in an important area of life functioning. |
|  | 1. (Under 21) Without treatment will not progress developmentally as individually appropriate. | **AND** | | | 1. (Under 21) Probably allow the child to progress developmentally as individually appropriate. |
|  | 1. None of the above. | **AND** | | | 1. None of the above |

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| Diagnostic Summary: (Be sure to include assessment for risk of suicidal/homicidal behaviors, significant strengths/weaknesses, observations/descriptions, symptoms/impairments in life functioning, i.e. Work, School, Home, Community, Living Arrangements, etc. and justification for diagnosis) |
| Narrative continued in Addendum |

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| **ICD-10 DIAGNOSIS — NOT BY HISTORY, MUST BE CURRENT DIAGNOSTIC FORMULATION** | | | | | |
| **Dimensions:** | **ICD-10 Code:** | | **DSM –5\* Description WITH all specifiers:**  **\****for Codes F84.5, F84.9, F84.2, F84.3 & F84: list DSM-IV-TR Descriptor (Dx Name)* | **Primary & Secondary Dx’s** | |
| MH Diagnoses: |  | |  | **PRIMARY DX** | |
|  | |  | Secondary Dx | |
|  | |  | Secondary Dx | |
|  | |  | Secondary Dx | |
| Substance Use Diagnoses: |  | |  | Secondary Dx | |
|  | |  | Secondary Dx | |
|  | |  | Secondary Dx | |
| Psychosocial Conditions Diagnoses: |  | |  |  | |
|  | |  |
|  | |  |
|  | |  |
| General Medical Conditions: | | | | | |
|  | | | | | |
|  | | | | | |
| Optional Disability Measures (WHODAS, etc.) | | | Diagnosis est. by (with license): | | On date: |
| **Disposition / Recommendations/ Plan** | | | | | |
| Narrative continued in Addendum | | | | | |

**Signatures (OR SEE PROVIDER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PROGRESS NOTE DATED:\_\_\_\_\_\_\_\_\_\_):**

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|  |  |  |  |
| **Assessor’s Signature & M/C Credential** | **Date** | **Co-Signature & M/C Credential** | **Date** |
|  |  |  |  |
| **Printed Name** | **Date** | **Printed Name** | **Date** |

**ADDENDUM**