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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. | | |
|  | | | |  | | | | | |  | |  | | | *Circle Preferred Pronoun: He/Him, She/Her, They/Them, Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | |
| EPISODE OPENING DATE | | | |  | | | | | | | | | | |  | | |
| Sex Assigned at Birth: Male | | | | | Female | | | | Intersex | | | | | Other: | | | |
| Gender Identity: Male | | Female | | | | Intersex | | € Gender Queer | | | | | Unknown | | | Male to Female | Female to Male |
| Decline to State | Gender non-conforming Other | | | | | | | | | | | | | | | | |

SEXUAL ORIENTATION: Unknown Heterosexual/Straight Lesbian Gay Bisexual  Queer Gender Queer Questioning Declined to State 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:** |
| **REFERRAL Source/ RESON FOR REFERRAL/ CLIENT COMPLAINT** | | | | | | |
| **Describe precipitating event(s) for Referral; Current Symptoms and Behaviors (intensity, duration, onset, frequency): Impairments in Life Functioning caused by the MH symptoms/Behaviors (from perspective of client and/or others):** | | | | | | |
| Narrative continued in Addendum | | | | | | |

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| **MENTAL HEALTH HISTORY** |
| **Inpatient & Outpatient Treatment, Trauma & Risk Factors (If any mandatory reports filed—discuss):**  Narrative continued in Addendum |

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| **PSYCHOSOCIAL HISTORY & FUNCTIONING** |
| **Include: Family History; *Family History (of mental illness, substance abuse, trauma, and neglect/abuse);* Complete Developmental History (children <18yrs.); Cultural factors; and History of Educational, Vocational, Social & Criminal Justice; Client/Family Strengths:** |
|  |
| Narrative continued in Addendum |

**Medical History**

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

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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:** | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | Narrative continued in Addendum | | | | | | | | | | | | | |
| **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): | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| 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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| **MEDICAL NECESSITY** | | | | | | | | | | |
| **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 | | | |
| **ICD-10 DX’s — 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: | |  |  | | | | | |  | |
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| General Medical Conditions: | | | | | | | | | | |
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|  | | | | | | | | | | |
| Optional Disability Measures (WHODAS, etc.): | | | | Diagnosis est.by (with license): | | | | | On date: | |

ADDENDUM

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