MENTAL HEALTH ASSESSMENT

INITIAL AND ANNUAL

REVISED 10/19

AGES 6 - 10 YRS

GUIDELINES/PROMPTS:

1. A Full MH Assessment may not be required for every new episode of care. Use the one page MH Assessment Update if: importing a full MH Assessment that was done in the past 12 months in your program, or importing a full MH Assessment from a different program conducted in the past 6 months.
2. If a full MH Assessment may not be completed by day 60 for clinical reasons, indicate reason and you may continue to claim for unplanned services (crisis, assessment, plan development, case mgt for linkage, meds for urgent need).
3. If a one page Interim MH Assessment is completed by day 30 of EOD, a full MH Assessment is not due until day 60.
4. If any information is unable to be collected in the MH Assessment, or inappropriate to collect at this time (due to client's individual circumstances) indicate this and when attempts will be made again.
5. Pay special attention to wording such as "when clinically relevant". Examples may be provided, but it is not necessary to inquire into each one—this is determined by the assessor's clinical judgement.
6. Any statements beginning with "PROMPT" are instructions and will not be present in the finalized MH Assessment copy.

Demographic Information

Episode Opening Date: 04/10/2018 **Birthdate:** 01/01/2010 **Age:** 9				**Preferred Language:** English
Preferred Last Name:		**Preferred First Name:**		
What is your Pronoun:	☐ She/Her	☐ He/Him	☐ They/Them	☐ Unknown/ Not Reported
	☐ Other			

Sex Assigned at Birth: ○ Male ○ Female ○ Other

Gender Identity: ☐ Unknown ☐ Male ☐ Female ☐ Intersex ☐ Gender Queer ☐ Gender non-conforming
☐ Prefer Not to Answer ☐ Other

Transgender: ☐ Male to Female/Transgender Female/Trans Woman ☐ Female to Male/Transgender Male/Trans Man

SEXUAL ORIENTATION: ☐ Unknown ☐ Bisexual ☐ Declined to State ☐ Gay ☐ Gender Queer
☐ Heterosexual/Straight ☐ Lesbian ☐ Questioning ☐ Queer
☐ Other:

Emergency Contact: Relationship:

Contact address (Street, City, State, Zip): Contact Phone #:

☐ Release for Emergency Contact obtained for this time period (or contact is legal representative and release not needed):

Allergies

○ **Yes** ○ **No**

No new allergies reported

Assessment Mental Health

☐ Initial ☐ Annual

☐ Informing Materials signed (annually) ☐ Release of Information Forms signed (annually)

ASSESSMENT SUMMARY

Assessment Sources of Information (Check All that Apply):

☐ Client ☐ Family Guardian ☐ Hospital ☐ Other:

REFERRAL SOURCE/REASON FOR REFERRAL/CLIENT COMPLAINT:

Describe precipitating event(s) for Referral:

Current Symptoms and Behaviors (intensity, duration, onset, frequency; present/new precipitants/stressors; for episodic illnesses describe first episode, onset, precipitants, duration & Rx response; etc.):

Impairments in Life Functioning caused by the MH symptoms/Behaviors (from perspective of client and/or others):

MENTAL HEALTH HISTORY

Psychiatric Hospitalizations / Outpatient Treatment: ○ Yes ○ No ○ Unable to Assess

If Yes, describe any known dates, locations, reasons, response to, and satisfaction with treatment:

Prior Mental Health Records Requested: ○ Yes ○ No

(See InSyst Face Sheet for current and history of past services)

Prior Mental Health Records Requested from:

History of Trauma or Exposure to Trauma: ○ Yes ○ No ○ Unable to Assess

PROMPT: Describe clinically relevant traumas that may be like: (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 (8) Prolonged separation from parent/caregiver/family? **Describe:**

Risk factors: ○ Yes ○ No ○ Unable to Assess

Indicate all clinically relevant risk factors.

PROMPT: DHCS has elaborated the following circumstances as placing the client at higher risk: Current or History of Danger to Self (DTS) or Danger to Others (DTO); Previous inpatient hospitalizations for DTS or DTO; Prior suicide attempts; Lack of family or other support systems; Arrest history; Probation status; History of alcohol/drug abuse; History of trauma or victimization; History of self-harm behaviors (e.g., cutting); History of assaultive behavior; Physical impairments (e.g. limited vision, deaf, wheelchair bound) which makes the beneficiary vulnerable to others; Psychological or intellectual vulnerabilities [e.g., intellectual disability (low IQ), traumatic brain injury, dependent personality]. Describe any relevant factors that increase risk (frustration tolerance, hostility, paranoia, command hallucination, exploitative behaviors) and any relevant factors that might lessen such risk such as client's commitment to self-control and involvement in treatment.

Please check if occurred within the last 30 days.) *Date of onset:*

☐ Safety plan will be completed with Client Plan if any S/I, H/I, or other High Risk in past 90 days.

Reports Filed as a result of this Assessment: ☐ N/A ☐ CPS ☐ APS ☐ Other

PSYCHOSOCIAL HISTORY

Family History

Include any clinically relevant factors such as: current family make-up--required; family of origin; family history of: mental illness and suicide--required, substance abuse, domestic or child abuse/neglect (physical, sexual, emotional, etc.); arrests/court proceedings; immigration status, etc.

Cultural Formulation:

PROMPT: Consider any clinically relevant cultural factors which may influence presenting problems as viewed by client/family/caregiver and the clinician. Factors may include ethnicity, race, religion, spiritual practice, sexual orientation, gender identity, caregiver or client socio economic status, living environment. Consider how special treatment issues result from the client's/family diversity AND how it may be a strength for the client.

This Section for YOUTH ONLY < 18 YRS OLD

LIVES WITH: ☐ Immediate Family ☐ Extended Family ☐ Foster Family ☐ Other

First Name of others in home (children & adults)	Age	Relationship

EDUCATION Optional Notes: Special Ed: ○ Yes ○ No

Grade: Optional Contact/Teacher Ph#:

Active IEP/Special Assessment/Services (Describe): ☐ LD ☐ DD/ID ☐ SED

Last School Attended:

Vocational Activities (Optional):

Would client like assistance with accessing any vocational activities such as education, vocational training, job supports, etc.?

○ Yes ○ No

Developmental History (for each section also include any significant culturally related rites of passage, rituals, ceremonies, etc.)

Prenatal/birth/childhood 0 – 6 yrs.

PROMPT: As clinically relevant describe events such as: pregnancy, developmental milestones, environmental stressors, and other significant events.

Latency 7 – 11 yrs.: ☑ N/A

PROMPT: *As clinically relevant* describe events such as: peer/sibling relations, extracurricular activities, delinquency, environmental stressors of other significant events).

Adolescence 12-17 yrs. ☑ N/A

PROMPT: *As clinically relevant* describe events such as: onset of puberty, extracurricular activities, teen parenthood, delinquency, gang involvement, environmental stressors of other significant events.

LEGAL HISTORY

Legal History:

PROMPT: Describe any *clinically relevant* legal encounters for client or family such as: landlord/tenancy; employment; family; criminal; immigration, etc.

MEDICAL HISTORY

	Name (or indicate None)	Address (if known)	Phone # (if known)	Last Date of Service (if known)
a. Primary Physician:				
b. Other medical provider(s): if any				
c. Date records requested: From whom, if applicable:				

Relevant Medical History: ***Indicate or check only those that are relevant***

General Information: Reported Weight (lbs): Reported Height (in): ☐ Height/Weight WNL

☐ Weight Changes **Describe:**

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	☐ Breast Feeding
Skin:	☐ Scar	☐ Lesion	☐ Lice	☐ Dermatitis	☐ Cancer
Endocrine:	☐ Diabetes	☐ Thyroid	☐ Other:		
Respiratory:	☐ Bronchitis	☐ Asthma	☐ COPD		
	☐ Other:				

Optional Comments

○ Other: (check if relevant and describe)

- Significant Accident/Injuries/Surgeries:
- Hospitalizations:
- Physical Disabilities:
- Chronic Illness:
- HIV disease:
- Age of Menarche and Birth Control Method:
- History of Head Injury:
- Liver Disease:

○ None of the Above

Alternative healing practice/date (e.g., acupuncture, hypnosis, herbs, supplements, etc.) if applicable

Date if known	Provider / Type if known	Reason for Treatment if known	Outcome (was it helpful and why) if known

MEDICATIONS

CURRENT MEDICATIONS

(include all non-abused prescribed, over the counter, and holistic/complimentary/alternative remedies):

	Medication Name	Effectiveness/Side Effects if known	Dosage if known	Date Started if known	Prescriber if known
Psychotropic					
Non-Psychotropic					

PREVIOUS MEDICATIONS

(include all non-abused prescribed, over the counter, and holistic/complimentary/alternative remedies):

	Medication Name	Effectiveness/Side Effects if known	Dosage if known	Date Started if known	Prescriber if known
Psychotropic					
Non-					

Psychotropic					

Date of last physical exam (if known): **Date of last dental exam (if known):**

Referral made to primary care or specialty: ○ No ○ Yes **If yes, list:**

Providers, including Address, Phone, E-mail (if known):

Additional Medical Information: If needed, describe any relevant medical conditions.

SUBSTANCE USE SCREENING

☐ Check if child is under 11 years and SUD screening only indicates known exposure.

SUBSTANCE USE/EXPOSURE & DISORDERS - REQUIRED

Category (indicate if ever used)	Exposure (children)		Past	CURRENT SUBSTANCE USE & PROBLEMS						Client-Perceived Problem?	
	Prenatal	Current	Age at first use (if known)	None/ Denies	Current Use					Yes	No
ALCOHOL	☐	☐		◉	○					○	○
AMPHETAMINES (SPEED/UPPERS, CRANK, ETC)	☐	☐		◉	○					○	○
COCAINE/CRACK	☐	☐		◉	○					○	○
OPIATES (HEROIN, OPIUM, METHADONE)	☐	☐		◉	○					○	○
HALLUCINOGENS (LSD, MUSHROOMS, PEYOTE, ECSTASY)	☐	☐		◉	○					○	○
SLEEPING PILLS, PAIN KILLERS, VALIUM, OR SIMILAR	☐	☐		◉	○					○	○
PCP (PHENCYCLIDINE) OR DESIGNER DRUGS (GHB)	☐	☐		◉	○					○	○
INHALANTS (PAINT, GAS, GLUE, AEROSOLS)	☐	☐		◉	○					○	○
MARIJUANA/ HASHISH	☐	☐		◉	○					○	○
TOBACCO/NICOTINE	☐	☐		◉	○					○	○
CAFFEINE (ENGERY DRINKS, SODAS, COFFEE, ETC.)	☐	☐		◉	○					○	○
OVER THE COUNTER	☐	☐		◉	○					○	○
RX MEDS - NOT PRESCRIBED OR TAKEN PER RX	☐	☐		◉	○					○	○
COMPLIMENTARY/ALTERNATIVE MEDICATION NOT PER RX	☐	☐		◉	○					○	○
OTHER SUBSTANCE	☐	☐		◉	○					○	○

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 (Required if "Higher Risk")

	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 (indicate if unable to assess at this time but plan on doing so in the future as treatment proceeds):

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.*

MEDICAL NECESSITY – MENTAL STATUS

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	☐ Anxious	☐ Depressed	☐ Elated/Expansive
	☐ Labile	☐ Irritable/Angry	☐ Other	
Thought Processes:	☑ Unremarkable	☐ Concrete	☐ Distorted	☐ Disorganized
	☐ Odd/Idiosyncratic	☐ Blocking	☐ Circumstantial	☐ Paucity of Content
	☐ 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
	☐ Suicidal Ideation	☐ Other		
Fund of Knowledge:	☑ Unremarkable	☐ Remarkable for		
Orientation:	☑ Unremarkable	☐ Remarkable for		
Memory:	☑ Unremarkable	☐ Impaired		
Intellect:	☑ Unremarkable	☐ Remarkable for		
Insight/Judgment:	☑ Unremarkable	☐ Remarkable for		

REQUIRED: **Describe all Mental Status Exam abnormal/impaired findings from above:**

FUNCTIONAL IMPAIRMENTS

	None	Mild	Mod	Severe		None	Mild	Mod	Severe
Family Relations	◉	○	○	○	Substance Use/Abuse	◉	○	○	○
School Performance/Employment	◉	○	○	○	Activities of Daily Living	◉	○	○	○
Self-Care	◉	○	○	○	Episodes of decompensation & increase of symptoms, each of extended duration	◉	○	○	○
Food/Shelter	◉	○	○	○					
Social/Peer Relations	◉	○	○	○	Other (Describe):	◉	○	○	○
Physical Health	◉	○	○	○					

REQUIRED, describe Impairments checked above:

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 (Describe):	◉	○	○	○

Comments (if any)

BARRIERS / IMPAIRMENTS

Impairment Criteria (must have one of the following): Select A, B, and C as they apply		**AND:**	**Intervention Criteria (proposed INTERVENTION will....):**
☐ A.	Significant impairment in an important area of life function.	**AND**	Significantly diminish impairment
☐ B.	Probability of significant deterioration in an important area of functioning.	**AND**	Prevent significant deterioration in an important area of life functioning.
☐ C.	(Under 21) Without treatment will not progress developmentally as individually appropriate.	**AND**	(Under 21) Probably allow the child to progress developmentally as individually appropriate.
☐ D.	None of the above	**AND**	None of the above

Diagnostic Summary (Optional): (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)

Diagnostic Impression

DSM-5: Mental Health

DSM-5 Descriptor	ICD-10	ICD-10 Descriptor	
(Select)	(Select)	(Select)	PRIMARY

Signs & Symptoms that Support Diagnosis or Per History:

Add Additional Diagnosis

IF DX HAS CHANGED, YOU MUST CORRECT INSYST FOR CORRECT CLAIMING.
Coordinate Diagnoses with other clinicians

DSM-5: Substance Use

DSM-5 Descriptor	ICD-10	ICD-10 Descriptor	
(Select)	(Select)	(Select)	☐ Rule Out

Signs & Symptoms that Support Diagnosis or Per History:

Add Additional Diagnosis

IF DX HAS CHANGED, YOU MUST CORRECT INSYST FOR CORRECT CLAIMING.
Coordinate Diagnoses with other clinicians

Physical Health: General Medical Codes

General Medical Codes		
(Select c...	(Select diagnosis description)	☐ Rule Out

Signs & Symptoms that Support Diagnosis or Per History:

Add Additional Diagnosis

IF DX HAS CHANGED, YOU MUST CORRECT INSYST FOR CORRECT CLAIMING.
Coordinate Diagnoses with other clinicians

DSM-5: Psycho Social

DSM-5 Descriptor	ICD-10	ICD-10 Descriptor

(Select) (Select) (Select) ☐ Rule Out

Signs & Symptoms that Support Diagnosis or Per History:

Add Additional Diagnosis

Optional Disability Measures (WHODAS, etc.)

Disposition / Recommendations/ Plan (Optional)

Diagnosis Established by:

Date: Responsible Staff: License (professional suffix)

Staff Select One

If established by waivered clinician, also provide licensed supervisor's name and licensure.

Licensed LPHA Co-Signer Of Waivered Staff Above License (professional suffix)

☐ Staff member waivered Select One

Mild-Moderate vs Moderate-Severe Level Determination

List A (Check all that apply)	List B (Check all that apply)	List C
☐ Impulsivity/Hyperactivity	☐ 1 or more psychiatric hospitalization(s) in past year	☐ Substance abuse
☐ Trauma/recent loss	☐ Suicidal/homicidal preoccupations or behaviors in past year	
☐ Withdrawn/Isolative	☐ Self-injurious behaviors	
☐ Mild-moderate depression/anxiety	☐ Paranoia, delusions, hallucinations	
☐ Behavior problems (aggressive/self-destructive/assaultive/bullying/oppositional)	☐ Currently in out-of-home foster care placement	
☐ Significant family stressors *	☐ Juvenile probation supervision with current placement order	
☐ CPS report in the last 6 months	☐ Functionally significant depression/anxiety	
☐ Excessive truancy or failing school	☐ Eating disorder with medical complications	
☐ Difficulty developing and sustaining peer relationships	☐ At risk of losing home or school placement due to mental health issues	
☐ Eating disorder without medical complications		
☐ Court dependent or ward of court		
☐ May not progress developmentally as individually appropriate without mental health intervention		

*** Significant family stressors:** Caretaker(s) with serious physical, mental health, substance use disorders or developmental disabilities, domestic violence, unstable housing or homelessness.

	Referral Algorithm	
1	Remains in **PCP care** with Beacon consult or therapy only	☐ 1 in List A and none in List B
2	Refer to **Appropriate Managed Care Plans (MCP):** Alameda Alliance/Beacon Phone: 1-855-856-0577 Fax: 866-422-3413 Kaiser Permanente Phone: 510-752-1075 Anthem Blue Cross Phone: 1-888-831-2246	☐ 2 in list A and none in List B OR ☐ Diagnosis excluded from county MHP
3	Refer to **County Mental Health Plan** for assessment (Phone: 1-800-491-9099 Fax: 510-346-1083)	☐ 3 or more in List A OR ☐ 1 or more in List B
4	Refer to **County Program** or community resources	☐ 1 in list C

Referring Provider Name: **Phone:**

Referring/Treating Provider Type ☐ PCP ☐ MFT/LCSW ☐ ARNP ☐ Psychiatrist ☐ Other

Requested service ☐ Outpatient therapy ☐ Medication management ☐ Assessment for Specialty Mental Health Services

Cancel | Spell Check | Save and Continue | Save as Pending | Save as Draft | Finalize

PERSONAL INFO | SECURITY (PASSWORD) | -

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