Mental Health Assessment

Name: _____

Insyst# _____

RU# _____

For Provider Use	
☐ Initial	☐ Update
☐ Informing Materials signed (annually)	
☐ Release of Information Forms signed (annually)	

PROVIDER	ADDRESS	PHONE	FAX
CLIENT LAST NAME	CLIENT FIRST NAME	MIDDLE NAME	SUFFIX(Sr.,Jr.)
PREFERRED LAST NAME	PREFERRED FIRST NAME		D.O.B.
EPISODE OPENING DATE	INDICATE 12 MO. AUTHORIZATION CYCLE *MM/DD/YY* **---** *MM/DD/YY*		

Sex Assigned at Birth: ☐Male ☐Female ☐Intersex ☐Other:

Gender Identity: ☐Male ☐Female ☐Intersex ☐ Gender Queer Transgender: ☐Male to Female ☐Female to Male

☐Other:

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:

☐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

Mental Health Assessment Continued

MENTAL HEALTH HISTORY CONTINUED

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**

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:**____

Mental Health Assessment Continued

PSYCHOSOCIAL HISTORY

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

Name: _____

Insyst# _____

RU# _____

Mental Health Assessment Continued

PSYCHOSOCIAL HISTORY CONTINUED

CRIMINAL HISTORY

Criminal Justice History/Violent Incidents of Individual and/or Family	Within last 90 days		Past	
	Y	N	Y	N
Assault on persons				
Threat to persons				
Property Damage				
Weapons Involved				
Legal History				

	Within last 90 days		Past	
	Y	N	Y	N
Probation				
Parole				
Adjudicated				
Diversion				
Other:				

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

	Name:	Phone#:	Last Date of Service
a. Primary Physician:			
b. Other medical provider(s):			
c. 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	☐ 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

Mental Health Assessment Continued

MEDICAL HISTORY CONTINUED

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

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

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							
Non-Psychotropic							

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

Name: _____

Insyst# _____

RU# _____

Mental Health Assessment Continued

<18 Yrs. Only YOUTH, FAMILY, EDUCATION, & DEVELOPMENTAL HISTORY

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

Name: _____

Insyst# _____

Mental Health Assessment Continued

RU# _____

SUBSTANCE USE

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.)	☐	☐
2. Smoke any marijuana or hashish?	☐	☐
3. 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 ↓ **Ask CAR question #1 below, then stop**

YES ↓ **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?	☐	☐
2. Do you ever use alcohol or drugs to **R**ELAX, feel better about yourself, or fit it?	☐	☐
3. Do you every use alcohol or drugs while you are by yourself or **A**LONE?	☐	☐
4. Do you every **F**ORGET things you did while using alcohol or drugs?	☐	☐
5. Do your **F**AMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. 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
A. Have you felt you should cut down or stop drinking or using substance?	☐	☐
B. Has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using substance?	☐	☐
C. Have you felt guilty or bad about how much you drink or use of substance?	☐	☐
D. 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		

Mental Health Assessment Continued

SUBSTANCE USE CONTINUED

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:

A. 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

B. 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
- ☐ 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, 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

Name: _____

Insyst# _____

RU# _____

Mental Health Assessment Continued

MEDICAL NECESSITY

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

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	☐	☐	☐	☐
					Other (Describe):	☐	☐	☐	☐
Food/Shelter	☐	☐	☐	☐					
Social/Peer Relations	☐	☐	☐	☐					
Physical Health	☐	☐	☐	☐					

Comments (if any): ☐Narrative continued in Addendum

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

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

Name: _____

Insyst# _____

RU# _____

Mental Health Assessment Continued

MEDICAL NECESSITY CONTINUED

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

DSM IV DIAGNOSIS—NOT BY HISTORY, MUST BE CURRENT DIAGNOSTIC FORMULATION

Axis	**Code DSM IV/ICD-10**	**Description**	**Check one Primary below**
Axis I: Clinical disorders (include substance abuse dx)			☐
			☐
			☐
Axis II: Personality & Developmental disorders			☐
			☐
			☐
Axis III: Physical disorders			

Axis IV Psychological and Environmental Problems which may affect diagnosis, treatment, or prognosis

Primary Problem#: _____

Check as many that apply:

1. ☐ Primary support group
2. ☐ Social environment
3. ☐ Education
4. ☐ Occupational
5. ☐ Housing
6. ☐ Economics
7. ☐ Access to health care
8. ☐ Involve with legal sys.
9. ☐ Other psychosocial/environmental
10. ☐ Inadequate information

Axis V	Current GAF:	Diagnosis est. by:	On date:

Disposition / Recommendations/ Plan

☐ Narrative continued in Addendum

Signatures (OR SEE PROVIDER _____ PROGRESS NOTE DATED:_____):

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

Mental Health Assessment Continued

Addendum, narrative continued (Indicate Assessment Section before narrative)

Mental Health Assessment Continued

Addendum, narrative continued (Indicate Assessment Section before narrative)

Name: _____

Insyst# _____

RU# _____

Mental Health Assessment Continued

0-5 ADDENDUM

Alameda County Behavioral Health Care Services Mental Health Assessment
Infant/Toddler (0-5 yrs.) ADDENDUN TO INTAKE DATE:

Provider: _____
Beneficiary: _____

MENTAL STATUS – *check all that are appropriate:*

Appearance	**Reactions**	**State-Regulation**	**Unusual Behavior**	**Activity Level**
☐ Well-groomed	☐ Explores	☐ Asleep	☐ Mouthing after 1yr	☐ Squirming
☐ Disheveled	☐ Freezes	☐ Quiet Alert	☐ Head Banging	☐ Sitting Quietly
☐ Small for sage	☐ Cries	☐ Active Alert	☐ Smelling objects	☐ Constantly moving
☐ Large for age	☐ Hides face	☐ Distress	☐ Spinning/twirling	☐ Climbing
☐ Inappropriate dress	☐ Acts Excited	☐ Smooth Transition	☐ Hand flapping	☐ Visual Fixing
☐ Dysmorphic features	☐ Acts Apathetic	☐ Abrupt Transitions	☐ Finger flickering	☐ Tracking
☐ Abnormal head size	☐ Anxious	☐ Able to sooth self	☐ Rocking	☐ Attention to faces
☐ Cutaneous lesions	☐ Difficulty with transitions	☐ Seeks simulation excessively	☐ Tow walking	☐ Attention to own hands
☐ Looks young for age	☐ Adapts to situation	☐ Hyper-responsive	☐ Staring at lights	☐ Frozen
☐ Looks mature for age	☐ Avoidance	☐ Hypo-responsive	☐ Preservative speech	☐ Average of attention to task
☐ Other:	☐ Withdrawal	☐ Other:	☐ Bizarre behaviors	☐ Other:
	☐ Aggression		☐ Hair Pulling	
	☐ Easily frustrated		☐ Breath Holding	
	☐ Other:		☐ Ruminating	

Gross Motor	**Fine Motor**	**Speech/ Language**	**Mood**	**Affect**
☐ Pushes up	☐ Grasps/releases	☐ Responds to sounds	☐ Depressed	☐ Flat
☐ Controls heads	☐ Transfer hands	☐ Follow commands	☐ Anxious	☐ Blunted
☐ Rolls over	☐ Pincer grasps	☐ Points “where is?”	☐ Euphoric	☐ Restricted
☐ Sits alone	☐ Banging	☐ Vocalizes sounds	☐ Irritable	☐ Broad
☐ Stands	☐ Throwing	☐ Single Words #	☐ Angry	☐ Labile
☐ Walks	☐ Stacking	☐ Short phrases	☐ Bored	☐ Congruent
☐ Runs	☐ Scribing	☐ Full sentences	☐ Shy	☐ Other:
☐ Jumps	☐ Cutting	☐ Caregiver understands	☐ Responsive to caregiver	
☐ Climbs	☐ Handles Toys	☐ Echolalia	☐ Other:	
☐ Other:	☐ Other:	☐ Overgeneralizations		

Cognition	**Thought**	**Play**
☐ WNL	☐ Specific Fears	☐ Sensorimotor Play
☐ Developmental Delay	☐ Feared object	☐ (0-6 mo.) mouthing, dropping, banging, throwing
☐ Precocious	☐ Worry about being lost	☐ (6-12 mo.) exploring, moving, poking, pulling
☐ Other:	☐ Fear of separation	☐ Functional play (12-18 mo.) shows understanding of use/function
	☐ Dreams/Nightmares	☐ Early symbolic splay (18+ mo.) presents with increasing complexity
	☐ Dissociative state	☐ Complex symbolic play (30+ mo.) plans/acts out dramatic play
	☐ Sudden withdrawal	☐ Uses imaginary objects
	☐ Eyes glazed	☐ Imitation, turn taking, problem solving
	☐ Failure to track	☐ Emotional themes
	☐ Hallucinations	☐ Other:
	☐ Other:	

Mental Health Assessment Continued

0-5 ADDENDUM CONTINUED

History of Caregiving	Duration and separations?
☐ Day Care	
☐ Relative Care	
☐ Hospital	
☐ Foster Care	
Number of placements	

ATTACHMENT OBSERVED: Check all that are appropriate:	
Pre-attachment (4-6 weeks)	☐ Orients to people, social smile ☐ Signal for help
Attachment in the Making (1-8 months)	☐ 4-6 weeks recognizes sound and feel ☐ 4 months- visual discrimination ☐ 5-6 months- reaches, actively prefers through actions
Clear cut attachment (7-12 months)	☐ Object Constancy ☐ Protests Separations, responds to internal needs ☐ Normal Stranger Anxiety ☐ Normal Separation Anxiety
Goal Directed Partnership (12-36 months)	☐ Attachment sequences with modulation of affect ☐ Two-way communication of feelings ☐ Intentional communication of needs & goals ☐ Demonstrates problem solving skills integrated with affect ☐ Able to remain organized in challenging situations

Clinician:			
Print	Signature, Discipline	License/Registration#	Date
Licensed Supervisor:			
Print		License#	Date