

## Mental Health Assessment

### Fee-for-Service Providers

**INSTRUCTIONS:** This template should be used by providers offering services to Medi-Cal clients in an outpatient office or clinic setting. It meets Medi-Cal requirements for documentation of initial assessments and updates. If used for updates, only relevant sections need to be completed. For additional details regarding required domains, see Documentation Guide for Clinical staff on the CalMHSA website at: [calmhsa.org/calaim-2/](http://calmhsa.org/calaim-2/)

Initial Assessment or  Update

Episode Opening Date:		Medical Record #:		RU #:	
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#### Provider Information

Provider's Full Name:	Title and Credentials:
Address:	Phone:

#### Client Information

Last Name (include Suffix):	First Name:		
Middle Name:	Date of Birth:	Age:	
Preferred Last Name:	Preferred First Name:		
Preferred Language:			
Sex Assigned at birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other:		
Gender Identity:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex <input type="checkbox"/> Gender Queer <input type="checkbox"/> Gender non-conforming <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Male to Female/Transgender Female/Trans Woman <input type="checkbox"/> Female to Male/Transgender Male/Trans Man <input type="checkbox"/> Other:		
Sexual Orientation:	<input type="checkbox"/> Unknown <input type="checkbox"/> Heterosexual/Straight <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Queer <input type="checkbox"/> Questioning <input type="checkbox"/> Other:		

#### Emergency Contact

Full Name:	Relationship:			
Address:	Phone:			
<input type="checkbox"/> Release for Emergency Contact obtained for the following time period:				
Source of Information: (Check All that apply)	<input type="checkbox"/> Client	<input type="checkbox"/> Family/Guardian	<input type="checkbox"/> Hospital	<input type="checkbox"/> Other:

#### Allergies

Yes  No Allergies were reported. If Yes, provide details:

**DOMAIN 1:**
**PRESENTING PROBLEM/ CHIEF COMPLAINT**

**Presenting Problem (Current and Historical)** - The person's and collateral sources' descriptions of problem(s), history of the problem(s) and impact on the person in care. When possible include duration, severity, context and cultural understanding of the chief complaint and its impact.

**Impairments in Functioning:** Functioning should be considered in a variety of settings, including at home, in the community, at school, at work and with friends or family.

Impairment Area	None	Mild	Mod	Severe	Impairment Area	None	Mild	Mod	Severe
Family Relations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School Performance/ Employment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Activities of Daily Living	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social/Peer Relations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food/Shelter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Self-Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Episodes of Decompensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other (Describe):				
Details of Impairments noted above:									

**Current Mental Status Exam (MSE):** Mental status at the time of assessment  
 (See APPENDIX A for Early Childhood MSE, 0-5 years old)

<b>Appearance/Grooming:</b>	<input type="checkbox"/> Unremarkable	<input type="checkbox"/> Remarkable for:		
<b>Behavior/Relatedness:</b>	<input type="checkbox"/> Unremarkable <input type="checkbox"/> Impulsive	<input type="checkbox"/> Motor Agitated <input type="checkbox"/> Motor Retarded	<input type="checkbox"/> Inattentive <input type="checkbox"/> Avoidant <input type="checkbox"/> Hostile	<input type="checkbox"/> Suspicious/ Guarded <input type="checkbox"/> Other
<b>Speech:</b>	<input type="checkbox"/> Unremarkable	<input type="checkbox"/> Remarkable for:		
<b>Mood/Affect:</b>	<input type="checkbox"/> Unremarkable <input type="checkbox"/> Labile	<input type="checkbox"/> Depressed <input type="checkbox"/> Irritable/Angry	<input type="checkbox"/> Elated/Expansive <input type="checkbox"/> Anxious	<input type="checkbox"/> Other
<b>Thought Processes:</b>	<input type="checkbox"/> Unremarkable <input type="checkbox"/> Odd/Idiosyncratic <input type="checkbox"/> Tangential	<input type="checkbox"/> Concrete <input type="checkbox"/> Obsessive <input type="checkbox"/> Blocking <input type="checkbox"/> Distorted	<input type="checkbox"/> Paucity of Content <input type="checkbox"/> Circumstantial <input type="checkbox"/> Loosening of Association	<input type="checkbox"/> Disorganized <input type="checkbox"/> Flight of Ideas <input type="checkbox"/> Racing Thoughts <input type="checkbox"/> Other
<b>Thought Content:</b>	<input type="checkbox"/> Unremarkable	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Delusions <input type="checkbox"/> Ideas of Reference	<input type="checkbox"/> Other
<b>Perceptual Content:</b>	<input type="checkbox"/> Unremarkable <input type="checkbox"/> Flashbacks <input type="checkbox"/> Derealization	<input type="checkbox"/> Hallucinations <input type="checkbox"/> Dissociation	<input type="checkbox"/> Homicidal Ideation <input type="checkbox"/> Depersonalization	<input type="checkbox"/> Paranoid <input type="checkbox"/> Other

<b>Fund of Knowledge:</b>	<input type="checkbox"/> Unremarkable	Remarkable for:
<b>Orientation:</b>	<input type="checkbox"/> Unremarkable	Remarkable for:
<b>Memory:</b>	<input type="checkbox"/> Unremarkable	Impaired:
<b>Intellect:</b>	<input type="checkbox"/> Unremarkable	Remarkable for:
<b>Insight/Judgment:</b>	<input type="checkbox"/> Unremarkable	Remarkable for:
<b>Describe Mental Status Exam abnormal/impaired findings:</b>		

**DOMAIN 2:  
TRAUMA**

**Trauma Exposure(s)** – A brief description of traumatic event(s) underlying or contributing to the person’s symptoms. It is not necessary to document the details of the trauma in depth.

**Trauma Reactions** – The person’s response to the traumatic event and it’s impact on the person’s behavioral health condition.

**Trauma Screening** – Results of any trauma screening tools [e.g., Adverse Childhood Experiences (ACEs)], indicating elevated risk for developing a behavioral health condition.

**Systems Involvement** – The person’s experience with homelessness, justice involvement, or involvement in the child welfare system.

**DOMAIN 3:  
BEHAVIORAL HEALTH HISTORY**

**Mental Health History** – Review of acute or chronic conditions not earlier described, including mental health conditions previously diagnosed or suspected. Current and past treatment and the person’s ability and willingness to participate.

**Substance Use/Abuse** – Review of past/present use of substances, including substance use conditions previously diagnosed or suspected. For youth, also assess for substance exposure.

No current or past substance abuse issues were identified. SKIP TO DOMAIN 4

Substance Name	Past	Current	Frequency	Method	Last Used
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			

**DOMAIN 4:  
MEDICAL HISTORY AND MEDICATIONS**

**Significant Weight Changes in the last 6 months:**

Yes

No

**If yes, explain:**

**Physical Health Conditions** – Relevant current and past medical conditions, including current and past treatment and the person’s ability and willingness to participate in treatment.

**Developmental History** – Prenatal and perinatal events and relevant or significant developmental history, if known and available (primarily for individuals 21 years old or younger)

<b>Medications</b> –Include psychotropic and non-psychotropic (physical health) medications.								
Current or Past	Reason for Use	Name	Dosage	Efficacy	Start Date	End Date	Prescriber	
<input type="checkbox"/> Current <input type="checkbox"/> Past								
<input type="checkbox"/> Current <input type="checkbox"/> Past								
<input type="checkbox"/> Current <input type="checkbox"/> Past								
<input type="checkbox"/> Current <input type="checkbox"/> Past								
<input type="checkbox"/> Current <input type="checkbox"/> Past								
<input type="checkbox"/> Current <input type="checkbox"/> Past								
<b>Other Medication Notes:</b>								
<b>Date of Last Physical Exam:</b>					<b>Date of Last Dental Exam:</b>			
<b>Name and Phone Number of Medical and Dental Providers (if known):</b>								

**DOMAIN 5:  
PSYCHOSOCIAL FACTORS**

**Family** - Family history, current family involvement, significant life events within family (e.g., loss, divorce, births)

**Social and Life Circumstances** – Current living situation, daily activities, social supports, legal/justice involvement, military history, community engagement.

**Cultural Considerations** – Cultural factors, linguistic factors, gender identity and sexual orientation, race, spirituality and/or religious beliefs, values, and practices.

**This section ONLY required for YOUTH under 18 years old (Otherwise skip to Domain 6)**

<b>Lives with:</b>	<input type="checkbox"/> Biological/Adoptive Family	<input type="checkbox"/> Kinship Family	<input type="checkbox"/> Resource/Foster Family	<input type="checkbox"/> Other:
<b>First Name of Others in Home (Children and Adults)</b>			<b>Age</b>	<b>Relationship</b>
<b>Education</b>	<input type="checkbox"/> Current School:			
<b>Grade:</b>	<b>Contact/Teacher/Ph#:</b>	<b>Active IEP/Special Ed Assessment/Services:</b>		
		<input type="checkbox"/> LD <input type="checkbox"/> DD/ID <input type="checkbox"/> SED <input type="checkbox"/> 504 Plan		

**This section ONLY required for individuals under 21 years old (Otherwise skip to Domain 6)**

**THERAPEUTIC FOSTER CARE (TFC), INTENSIVE CARE COORDINATION (ICC), and  
INTENSIVE HOME BASED SERVICES (IHBS)**

All Beneficiaries under 21 years of age must be assessed to determine if they qualify and need Therapeutic Foster Care (TFC), Intensive Care Coordination (ICC), and Intensive Home-Based Services (IHBS). **SEE APPENDIX B**

Check to indicate that client has been assessed for these services:  TFC/ICC/IHBS

Check to indicate that a referral is made to these services:  TFC/ICC/IHBS

**DOMAIN 6:  
STRENGTHS, RISKS AND PROTECTIVE FACTORS**

**Strengths and Protective Factors** – Personal or family motivations, hobbies and interests, positive coping skills, support systems including faith based supports, children, etc.

**Risk Factors and Behaviors** – Current and history of risk including family history of suicide/homicide, triggers, context for risk behaviors (e.g., loneliness, gang affiliations, psychosis, drug use/abuse). May include specific risk screening/assessment tools (e.g., Columbia Suicide Severity Rating Scale).

**Safety Planning** –Detailed, individualized safety plan to be used should risk behaviors arise. A comprehensive written safety plan is required if risk has been identified in the last 90 days.

Risk assessed. Safety Plan is not needed.

**Domain 7:**
**CLINICAL SUMMARY, TREATMENT RECOMMENDATIONS, LEVEL OF CARE DETERMINATION**

**Clinical Impressions** – Clinical formulation of the case based on information collected.

**Diagnostic Impression** – Current psychiatric diagnoses, including rule-outs, provisional or unspecified, as well as known medical diagnosis.

**CURRENT DSM Diagnosis**

DSM Descriptor	ICD-10	ICD-10 Descriptor	Primary or Rule Out
			<input type="checkbox"/> Primary <input type="checkbox"/> Rule Out
			<input type="checkbox"/> Primary <input type="checkbox"/> Rule Out
			<input type="checkbox"/> Primary <input type="checkbox"/> Rule Out
			<input type="checkbox"/> Primary <input type="checkbox"/> Rule Out
Diagnosis Established by Name:		License Type:	
Registered/Waivered: <input type="checkbox"/> Yes <input type="checkbox"/> No	Name and License Type of Clinician Co-Signing:		

**Treatment Recommendations** –Detailed and specific interventions and service types recommended based on clinical impression and overall goals for care.

Requested Records from: \_\_\_\_\_

**Referrals Provided:**

<input type="checkbox"/> Substance Use Disorder Services	<input type="checkbox"/> Primary Care Physician (Refer if last seen more than 1 year ago).	<input type="checkbox"/> Specialty Medical Services
<input type="checkbox"/> Dental	<input type="checkbox"/> TFC <input type="checkbox"/> ICC <input type="checkbox"/> IHBS	<input type="checkbox"/> Other

Link to ACBH SUD Resource Page: [BHCS Providers Website \(acbhcs.org\)](http://acbhcs.org)

**Referral Details:**

Forms Signed or Needed	Signed	Needed	Expiration Date
Informing Materials (Needed annually)	<input type="checkbox"/>	<input type="checkbox"/>	
Release of Information for Emergency Contact- Name:	<input type="checkbox"/>	<input type="checkbox"/>	
Release of Information for Other- Name:	<input type="checkbox"/>	<input type="checkbox"/>	

Other:

**Signatures**

Print Name of Service Provider		Title and Credentials	
Signature		Date	
Print Name of Supervisor (if needed)		Title and Credentials	
Signature		Date	



## Appendix A

### Early Childhood Mental Status Exam (ages 0-5)

Current Mental Status – Use for Early Childhood (Ages 0-5)				
<b>Appearance:</b>	<input type="checkbox"/> Disheveled <input type="checkbox"/> Well-groomed	<input type="checkbox"/> Atypical features <input type="checkbox"/> Other	<input type="checkbox"/> Small for age	<input type="checkbox"/> Visible marks/bruises
<b>Reactions:</b>	<input type="checkbox"/> Explores <input type="checkbox"/> Freezes <input type="checkbox"/> Cries	<input type="checkbox"/> Frustrates easily <input type="checkbox"/> Apathetic <input type="checkbox"/> Withdrawn	<input type="checkbox"/> Aggressive <input type="checkbox"/> Tantrums easily	<input type="checkbox"/> Within Normal Range (WNR) <input type="checkbox"/> Other
<b>Ability to Regulate:</b>	<input type="checkbox"/> Quiet Alert <input type="checkbox"/> Active Alert <input type="checkbox"/> Distressed	<input type="checkbox"/> Seeks excessive stimulation <input type="checkbox"/> Smooth transitions <input type="checkbox"/> Abrupt transitions	<input type="checkbox"/> Able to soothe self <input type="checkbox"/> Able to be soothed	<input type="checkbox"/> Hyper-responsive <input type="checkbox"/> Hypo-responsive <input type="checkbox"/> WN <input type="checkbox"/> Other
<b>Mood:</b>	<input type="checkbox"/> Depressed <input type="checkbox"/> Anxious	<input type="checkbox"/> Irritable	<input type="checkbox"/> Angry	<input type="checkbox"/> WNR
<b>Affect:</b>	<input type="checkbox"/> Flat <input type="checkbox"/> Restricted	<input type="checkbox"/> Fearful	<input type="checkbox"/> Labile	<input type="checkbox"/> WNR
<b>Cognition:</b>	<input type="checkbox"/> Precocious	<input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Other	<input type="checkbox"/> WNR
<b>Thought:</b>	<input type="checkbox"/> Nightmares <input type="checkbox"/> Dissociation	<input type="checkbox"/> Fear of Separation	<input type="checkbox"/> Specific fears	<input type="checkbox"/> WNR <input type="checkbox"/> Other
<b>Speech/Language:</b>	<input type="checkbox"/> Expressive language concerns	<input type="checkbox"/> Receptive language concerns	<input type="checkbox"/> Echolalia	<input type="checkbox"/> WNR <input type="checkbox"/> Other
<b>Motor Activity:</b>	<input type="checkbox"/> Calm <input type="checkbox"/> Agitated	<input type="checkbox"/> Decreased motor activity	<input type="checkbox"/> Unusual gait <input type="checkbox"/> Hyperactive	<input type="checkbox"/> Tremors <input type="checkbox"/> WNL
<b>Repetitive Behaviors:</b>	<input type="checkbox"/> Head banging	<input type="checkbox"/> Hand flapping	<input type="checkbox"/> Rocking	<input type="checkbox"/> Other
<b>Unusual Behaviors:</b>	<input type="checkbox"/> Sexual behavior <input type="checkbox"/> Self-harming <input type="checkbox"/> Aggressive	<input type="checkbox"/> Obsessive/Compulsive	<input type="checkbox"/> Regressive behavior <input type="checkbox"/> Indiscriminate attachment	<input type="checkbox"/> Other
<b>Describe Mental Status Exam abnormal/impaired findings:</b>				

## Appendix B

### Intensive Service Needs Assessment: Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), Therapeutic Foster Care (TFC)

All beneficiaries with full-scope Medi-Cal **under 21 years old** must be assessed to determine if they qualify for and need ICC, IHBS and/or TFC and referred to those services.

Links to Referral Forms in English are provided below. For Referral Forms in Spanish, use this website: [Child & Youth Services – Alameda County Behavioral Health \(acbhcs.org\)](http://Child & Youth Services – Alameda County Behavioral Health (acbhcs.org))

Based upon the clinical assessment, indicate if any of the services below are needed:

Service Type	Status	Required Next Steps
<a href="#">Intensive Care Coordination (ICC)</a> is needed and cannot be adequately provided under standard mental health case management services.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Already Connected	If checked, referral required <a href="#">ICC Referral Form</a>
<b>Intensive Home-Based Services (IHBS)</b> are needed to assist the child/youth in building the skills necessary to successfully function at home and in the community and to assist their family in developing the skills needed to support the child/youth in achieving this goal. These services cannot be adequately provided under standard mental health case management services.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Already Connected	If checked, contact the ICC provider listed on the face sheet to recommend IHBS at next Child and Family Team Meeting (CFT)
<b>Therapeutic Foster Care (TFC)</b> services are needed to address the child/youth's severe emotional issues by providing intensive therapeutic and behavior management services in an in-home, family-based care setting.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Already Connected	If checked, contact the Child and Family Team facilitator (from ICC, Child Welfare, or Probation) to make the recommendation for TFC