Clinical Assessment – Under 21

NAME / MRN ____________________

Billing Information

Program Name: ______________________________ Fac/Prog: __________ Date: __________

Staff #: __________ Hours: _____ Min(s): _____ Code Activity ☐ **331** Assessment ☐ **580** Lockout

Is Client Pregnant? ☐ **Yes** ☐ **No** Travel Time To/From included in above (if applicable) Hrs _____ Mins _____

Telehealth consent obtained (if applicable): ☐ **Yes** ☐ **No**

Location of Services (Please check one)

☐ Office
☐ Field
☐ Phone
☐ Home
☐ School
☐ Telehealth-Clt Home
☐ Satellite
☐ Inpatient Psychiatric
☐ Inpatient Health
☐ Emergency Room
☐ Jail
☐ Telehealth-Other than Clt Home
☐ Emergency Shelter
☐ Primary Care Health Clinic
☐ Res Tx Ctr (child)
☐ Res Tx Ctr (adult)
☐ Hospice
☐ Skilled nursing facility
☐ Mobile Service
☐ Job Site
☐ Age Specialty Center
☐ Faith-Based Location

☐ Nontraditional Location ☐ Other ____________________ ☐ Unknown

Service Strategies (Please check up to three, if applicable)

☐ Peer/Fam Deliv Svcs
☐ Psych Education
☐ Family Support
☐ Unknown
☐ Supportive Education
☐ Prtnrshp: Law Enfcmt
☐ Ptnrshp: Health Care
☐ Ptnrshp: Soc Svcs
☐ Ptnrshp: Subs Abuse
☐ IntSvcs : MH / Aging
☐ Integrated Svcs: MH-Dvlp Disabled
☐ Ethnic-Specific Service Strategy
☐ Age-Spec Svc Strategy

Identifying Information:

Name: ______________________________ Age: _____ DOB: __________

Gender: ☐ Male ☐ Female ☐ Nonbinary ☐ Other __________

Address: ______________________________ Phone: __________

Referred By: ______________________________

Language

Primary Language: ____________ Other Languages spoken in home: ____________

Language in which service was provided, if other than English: ☐ Spanish ☐ Other __________

☐ Interpreter Name of Interpreter: ____________________

Client Information:

Lives with: ☐ Immed. Family ☐ Extend. Family ☐ Unrel. Foster Family ☐ Jail/Juvenile Hall
☐ Acute Hospital ☐ Group Home ☐ Emergency Foster Care ☐ Residential

☐ Other ____________________ ☐ **Client is Homeless**

Residential Contact (Name & Phone):

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Others in Home/Ages/Relationship to Client:

Composition of Family of Origin (if different from above):

Current Legal Status:

Legal Status:

☐ Independent Adult ☐ Client in custody of biological Parent(s), Adpotive parent(s) ☐ Emancipated Minor

☐ Juvenile Dependent of Court ☐ Juvenile Ward of the Court (Probation 602) ☐ Other ______________________

Agencies/Other MH Providers Involved: (check all that apply, including contact names & phone numbers as appropriate)

☐ CC Mental Health Clinic ☐ CFS ☐ CBO
☐ Network Provider ☐ Regional Center ☐ Probation

☐ Other ____

Contact names and phone numbers for agencies/other MH providers involved:

Educational Status N/A ☐

Grade _____ School ___________________________________ Special Education? ☐ Yes ☐ No If yes, describe:

Presenting Problem: What is the primary reason for current referral? Describe client-identified problem(s), history of the presenting problem(s), impact of problem(s) on beneficiary, impairment(s) identified by the client including distress, disability, or dysfunction in an important area of life function.

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Mental Status Exam

Appearance/Grooming ***(appears stated age, good grooming/hygiene, disheveled, malodorous, etc.)***

Behavioral Relatedness ***(NAD, cooperative, playful, difficult to redirect, inappropriately laughing/smiling, etc.)***

Motor Activity ***(normokinetic, gait, posturing, tics/tremors/EPS, psychomotor agitation or retardation, etc.)***

Speech ***(fluent, rate/rhythm/volume, spontaneous, hyperverbal, dysarthric, mute, etc.)***

Mood/Affect ***(Congruent/incongruent, full, flat, blunted, restricted, elated, dysphoric, labile, inappropriate, etc.)***

Thought Process ***(linear, goal-oriented, tangential, flight of ideas, circumstantial, thought blocking, loose associations, etc.)***

Thought Content ***(suicidal/homicidal/paranoid ideations, grandiose/persecutory delusions, etc.)***

Perceptual Content ***(Auditory/visual hallucinations, responding to internal stimuli, etc.)***

Cognition/Orientation

Attention/Concentration

Memory

Abstract Reasoning

Insight/Judgment

History of Trauma Exposure / Stress Symptoms: Include current and previous experiences of homelessness and involvement with juvenile justice system or child welfare.

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Behavioral Health History

Mental Health History

List all acute and chronic mental health conditions and treatments received, including outpatient mental health services, crisis services, psychiatric hospitalizations, residential treatment, day treatment, partial hospitalization, and use of nontraditional or alternative healing practices.

Response to mental health treatments

Substance Use History

List all acute and chronic substance use exposures and treatment received, including outpatient substance use services, crisis services, inpatient admissions, intoxication/detox/withdrawal management-based admissions, residential treatment, and use of nontraditional or alternative healing practices.

Response to substance use treatments

Medical History

Are there any physical health concerns (medical illness, medical symptoms), including access to physical health services?

☐ No ☐ Yes (if so, please describe):

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Medication or non-medication allergies/serious reactions? ☐ No ☐ Yes (if so, please describe):

Current medication(s), including over-the-counter, herbal, psychiatric, and homeopathic. Include start date/dose/frequency and any compliance issues):

Relevant Family/Social History: Summarize relevant data regarding significant interpersonal relationships, including parental and marital status, children, siblings, living situations, education/work history, military history, current support system, family history of mental illness or substance use and issues regarding culture, language, faith/spirituality, sexual orientation, or gender identity.

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Risk Behaviors and Strengths

Risk Behaviors ☐ None Identified

Danger to self (intent, plan means):

Past:

Danger to others (intent, plan, means):

Past:

Grave Disability (unable to make use of available resources):

Client Name: ____ **Client MRN/ID:** __________________________

☐ 5150 Initiated ☐ CPS Referral/Involvement ☐ Tarasoff ☐ Weapons Confiscated

Other Risk Behaviors: (Sexual aggression, delinquent or runaway behavior, intentional misbehavior, fire-setting, etc.)

Strengths: (Family, interpersonal, talents, interests, spiritual, religious, cultural, community, resiliency, etc.)

Diagnosis:

DSM-5 Diagnosis: ____________________ ICD-10 Code: _________________________ (Primary)

DSM-5 Narrative Diagnosis: ____

DSM-5 Diagnosis: ____________________ ICD-10 Code: _________________________ (Secondary)

DSM-5 Narrative Diagnosis: ____

Clinical Summary/Additional Comments:

Client meets Specialty Mental Health Medical Necessity: ☐ Yes ☐ No

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Recommendations/Plan: (Level of care recommendations, access criteria, referrals, goals, plan for discharge)

Was the CANS completed as part of this assessment? ☐ Yes ☐ No Date completed: ______________________

Is this late documentation? ☐ Yes ☐ No

Clinician Signature/Licensure	Printed Name	Date
Co-Signature of Licensed Clinician	Printed Name	Date

Data Entry Clerk Initials _______________

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