



## Initial Clinical Assessment – Clients 6-20 years old

NAME / MRN \_\_\_\_\_

**BILLING**

Program Name: \_\_\_\_\_ FAC/PROG: \_\_\_\_\_ Date: \_\_\_\_\_

Provider #: \_\_\_\_\_ Min(s): \_\_\_\_\_ Code Activity  331 Assessment  580 Lockout

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

**Location of Services: (Please check one)**

<input type="checkbox"/> Office	<input type="checkbox"/> School	<input type="checkbox"/> Faith-Based	<input type="checkbox"/> LicCommCarefac (adult)	<input type="checkbox"/> Telehealth – Pt Home
<input type="checkbox"/> Field	<input type="checkbox"/> Cor Fac	<input type="checkbox"/> Healthcare	<input type="checkbox"/> Mobile Service	<input type="checkbox"/> Telehealth – Other than Pt Home
<input type="checkbox"/> Phone	<input type="checkbox"/> Inpatient	<input type="checkbox"/> Age-spec Com ctr	<input type="checkbox"/> Non Trad Svc Loc	<input type="checkbox"/> Other _____
<input type="checkbox"/> Home	<input type="checkbox"/> Homeless/shelter	<input type="checkbox"/> Client's job site	<input type="checkbox"/> Res Tx Ctr (child)	<input type="checkbox"/> Unknown

**Service Strategies: (Check up to three, if applicable)**

<input type="checkbox"/> 50 Peer/Fam DelivSvcs	<input type="checkbox"/> 53 Supportive Education	<input type="checkbox"/> 56 Ptnrshp:Soc Svcs	<input type="checkbox"/> 59 Integrated Svcs: MH-Dvlp Disabled
<input type="checkbox"/> 51 Psych Education	<input type="checkbox"/> 54 Ptnrshp:Law Enfcmnt	<input type="checkbox"/> 57 Ptnrshp:Subs Abuse	<input type="checkbox"/> 60 Ethnic Specific Service Strategy
<input type="checkbox"/> 52 Family Support	<input type="checkbox"/> 55 Ptnrshp:Health Care	<input type="checkbox"/> 58 IntSvcs:MH/Aging	<input type="checkbox"/> 61 Age-Spec Svc Strategy <input type="checkbox"/> 99 Unknown

**Language:**

Primary Language: \_\_\_\_\_ Other Languages spoken in home: \_\_\_\_\_

**Interpreter** Name of Interpreter: \_\_\_\_\_

Language service provided in other than English:  Spanish  Other \_\_\_\_\_

**Identifying Information:**

Name: \_\_\_\_\_  Male  Female DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Referred by: \_\_\_\_\_

**CLIENT AND LEGAL 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): \_\_\_\_\_

Others in Home/Ages/Relationship to Child: \_\_\_\_\_

Compostion of Family of Origin (if different from above): \_\_\_\_\_



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**Current Legal Status:**

- Independent Adult     Child in custody of biological Parent(s), Adoptive 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 \_\_\_\_\_

**BEHAVIORAL/EMOTIONAL NEEDS**

What is the primary reason for current referral? Describe current precipitating event, primary stressors, primary symptoms and functional impairment.

**Developmental History:**  Birth and Developmental History is not available.

- Birth was:  On-Time     Early (< 36 weeks)     Late
- While Pregnant, did mother have any injuries, illnesses, physical trauma or use alcohol/drugs?     No     Yes
- Were there any complications at time of birth?     No     Yes
- Did the child experience any traumas during first 5 years?     No     Yes
- Did the child have any sleep, eating, or social problems the first 5 years?     No     Yes
- If "yes" to any of the above, please describe:

Developmental Milestones:  Early     On-Time     Delayed (If delayed, please describe):



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**Family/Social History:** (Summarize relevant data regarding significant interpersonal relationships (i.e. parents, siblings, etc.), living situations, family history or mental illness or substance abuse, and/or relevant traumatic events/losses)

**Medical History:**  Not available

Current Primary Medical Provider: \_\_\_\_\_  None  Unknown

Date of Last Physical Exam: \_\_\_\_\_  Unknown

Date of Last Dental Exam: \_\_\_\_\_  Unknown

Are there any health concerns (medical illness, medical symptoms) regarding this child?  No  Yes (if so, please describe):

Has the child had any allergic/serious reactions to medication(s)?  No  Yes (if so, please describe):

Has the child had any NON medication allergies (food, pollen, bee stings, etc.)?  No  Yes (if so, please describe):



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Is the child taking any medications? If yes, List name of any medication(s) child is taking at this time: (list all current medications including OTC, herbal, psychiatric, and homeopathic. Include start date/dose/frequency)  None

Medication compliance issues?  N/A  No  Yes (if yes, please describe)

Referral to Health Care Provider for further Evaluation/Assessment

**Treatment History:**  None  Unknown

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Psych Hospitalization   | <input type="checkbox"/> Psych Medication  | <input type="checkbox"/> Residential Treatment                           | <input type="checkbox"/> Day Treatment |
| <input type="checkbox"/> Substance Abuse Program | <input type="checkbox"/> Psychotherapy   | <input type="checkbox"/> Testing- Psychological/Neurological/Educational |  |
| <input type="checkbox"/> Previous Crisis Contact | <input type="checkbox"/> Use of Non Traditional or Alternative Healing Practices |  |  |

Comments on above history:

**Substance Use History:**  No Current or Past Substance Abuse  Unknown

Actively Using Substances  Currently Clean & Sober for:  < 6 months  > 6 months  > 1 year

**Please check all substances used in the past 6 months:**

Past	Present		Frequency
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol	_____
<input type="checkbox"/>	<input type="checkbox"/>	Amphetamine	_____
<input type="checkbox"/>	<input type="checkbox"/>	Caffeine	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cocaine/Crack	_____
<input type="checkbox"/>	<input type="checkbox"/>	Designer Drugs (GHB, PCP, Ecstasy)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hallucinogens (LSD, Mushrooms)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Inhalants (Paint, Gas, Aerosols)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Marijuana	_____
<input type="checkbox"/>	<input type="checkbox"/>	Opiates (Heroin, Opium, Methadone)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Over the Counter_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Pain Killers (Oxy, Norco, Vicodin)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other_____	_____

Comments:



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**Education History:**

Current School: \_\_\_\_\_ Grade: \_\_\_\_\_ Contact: \_\_\_\_\_

**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): \_\_\_\_\_

5150 Initiated  CPS Referral/Involvement  Tarasoff  Weapons Confiscated

**Criminal Justice History:**  None  Unknown  Probation  Parole

Probation/Parole Officer Contact: \_\_\_\_\_  Obtain Release (ROI)

Offense History (include jail/juvenile hall facility):

Comments:

**MENTAL STATUS EXAM**

General (appearance, attitude, behavior, speech): \_\_\_\_\_

Orientation: \_\_\_\_\_

Mood/Affect: \_\_\_\_\_

Memory \_\_\_\_\_

Thought Process: \_\_\_\_\_

Thought Content: \_\_\_\_\_

Insight/Judgment/Impulsivity: \_\_\_\_\_

Additional Observation(s):



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**DIAGNOSTIC IMPRESSION: ICD-10 Code, DSM-5 Diagnosis and Narrative**

ICD-10 Code: \_\_\_\_\_ DSM-5 Diagnosis: \_\_\_\_\_ (Primary)

DSM-5 Narrative Diagnosis: \_\_\_\_\_

ICD-10 Code: \_\_\_\_\_ DSM-5 Diagnosis: \_\_\_\_\_ (Secondary)

DSM-5 Narrative Diagnosis: \_\_\_\_\_

DSM-5 Diagnosis by: \_\_\_\_\_  
(Name of Diagnosing Clinician/Licensure)

**INITIAL TREATMENT PLAN**

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**Additional Comments:**

\_\_\_\_\_  
Clinician Signature/Licensure

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Co-Signature of Licensed Clinician

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Data Entry Clerk Initials



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**Space for Data Continuation (Specify which item you are continuing from)**