CONTRA COSTA BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

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** **Assessment Type:** ☐ Initial ☐ Annual

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Location of Services (Please check one)

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

☐ Nontraditional Location ☐ Other _____ ☐ Unknown

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

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

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):

Client Name: _____ **Client MRN/ID:** _____

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.

Client Name: _____ **Client MRN/ID:** _____

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.

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):

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.

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

Client Name: _____ **Client MRN/ID:** _____

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 _____