CONTRA COSTA BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

Annual Clinical Assessment – Clients 0-5 years old

NAME / MRN

BILLING

Program Name: _____ FAC/PROG: _____ Date: _____

Provider #: _____ Min(s): _____ Code Activity ☐ 331 Assessment ☐ 580 Lockout

Place of Service (check one)

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

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

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

Is the client pregnant? ☐ **Yes** ☐ **No** **(If yes, please document how service was pregnancy-related)**

☐ **Interpreter** Name of Interpreter: _____

Language service provided in other than English: ☐ Spanish ☐ Other _____

Identifying Information:

Name:_____ Age:_____ DOB:_____

Address:_____ Phone_____

Emergency Contact/Name & Phone: _____

MH Provider: _____

Current Mental Health Functioning: (Include current symptoms, improvements in functioning, on-going functional impairments, **updated psychiatric treatment/hospitalizations** and other pertinent changes in past year)

Family/Social/Economic Update: (Include living situation, legal status, income, socialization, work or educational activity, judicial involvement, support system and any changes in life circumstances.)

CHECK THIS BOX IF CLIENT IS HOMELESS ☐

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Medical History:

Primary Care Provider:	Last Physical Exam:	Last Dental Exam:
Psychiatrist:	Location:	

List all Medical Conditions/Physical Health Update:

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):

Med Compliant? ☐ Yes ☐ No ☐ Unknown

List name of medication(s) client is taking at this time.
(List all current meds including OTC, herbal, and homeopathic. Include start date/dose/frequency.)

Risk Behaviors:

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 ☐ Tarasoff ☐ Arrests/Incarcerations in last 12 months

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Substance Use:

☐ No Past Substance Abuse ☐ Actively Using Substances ☐ Currently Clean & Sober for: _____
☐ Unknown

Please list all substance being used or list current treatment interventions.

Please check all substances used in the past 6 months:

Past	Present		Frequency
☐	☐	Alcohol	_____
☐	☐	Amphetamine	_____
☐	☐	Caffeine	_____
☐	☐	Cocaine/Crack	_____
☐	☐	Designer Drugs (GHB, PCP, Ecstasy)	_____
☐	☐	Hallucinogens (LSD, Mushrooms)	_____
☐	☐	Inhalants (Paint, Gas, Aerosols)	_____
☐	☐	Marijuana	_____
☐	☐	Opiates (Heroin, Opium, Methadone)	_____
☐	☐	Over the Counter: _____	_____
☐	☐	Pain Killers (Oxy, Norco, Vicodin)	_____
☐	☐	Other: _____	_____

Comments:

Mental Status Exam:

General (Appearance, attitude, behavior, speech): _____

Orientation: _____

Mood/Affect: _____

Memory: _____

Thought Process: _____

Thought Content: _____

Insight/ Judgment/ Impulsivity: _____

Additional Observations:

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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 Diagnosis by: _____
(Name of Diagnosing Clinician/Licensure)

Justification for Continued Care Services *(Use Data Continuation Page if needed)*

Discharge Plan Update: (Clinical Presentation) *(Use Data Continuation Page if needed)*

Signature/License/Designation	Printed Name	Date
Co-Signature/license (if applicable)	Printed Name	Date

Data Entry Clerk Initials

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