



Annual Clinical Assessment – Clients 6-20 Years Old

NAME / MRN _____

BILLING

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

Provider #: _____ Minutes: _____ Code Activity: 331 Assessment 580 Lockout

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 Encmt	<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

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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Educational Update: (Include any updates to child's school placement, attendance, performance, grades, special education, or other school updates)

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(s) 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

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
<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:

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***)

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