Initial Clinical Assessment - Clients 0-5 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)

☐ 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

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):

____

NAME / MRN ____________________

Current Legal Status:

☐ Independent Adult ☐ Child 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____

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):

____

NAME / MRN

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):

NAME / MRN

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

☐ Psych Hospitalization ☐ Psych Medication ☐ Residential Treatment ☐ Day Treatment
☐ Substance Abuse Program ☐ Psychotherapy ☐ Testing- Psychological/Neurological/Educational
☐ Previous Crisis Contact ☐ Use of Nontraditional 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
☐	☐	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:

____

NAME / MRN

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):

NAME / MRN ______________________________

Diagnostic Impression: DSM-5 Diagnosis and Narrative, ICD-10 Code

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

Additional Comments:

____________________________________ ____________________________ _________________
Clinician Signature/Licensure Printed Name Date

_________________________________ ____________________________ _________________
Co-Signature of Licensed Clinician Printed Name Date

____
Data Entry Clerk Initials

NAME / MRN

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