

2 - Telehealth	11 - Office	20 - Urgent Care Facility	30 - Faith Based	56 - Psychiatric Residential Tx Center
3 - School	12 - Client Home	23 - Emergency Room/Hosp.	51 - Inpatient Psychiatric Facility	99 - Other Place of Service
9 - Correctional Facility	14 - Group Home	28 - Non Face-to-Face	55 - Residential Substance Abuse Tx Facility	

DBH: Billing information in this section is a reference for billings to be submitted; assessment date should be the first date of contact. First Contact Date:

DATE: _____	BILLING TIME: _____	LOCATION: _____	SERVICE TYPE: _____	PREFERRED LANGUAGE: _____
DATE: _____	BILLING TIME: _____	LOCATION: _____	SERVICE TYPE: _____	PREFERRED LANGUAGE: _____
DATE: _____	BILLING TIME: _____	LOCATION: _____	SERVICE TYPE: _____	PREFERRED LANGUAGE: _____

NOTE: Shaded items with superscripts trigger CANS-SB Module. Completion of triggered CANS-SB Modules are required.

Gender:	<input type="checkbox"/> Another Gender Identity	<input type="checkbox"/> Declined to Answer	<input type="checkbox"/> Female	<input type="checkbox"/> Genderqueer	Age:	<input type="checkbox"/> Under 6Y/O: Early Childhood Module ¹
	<input type="checkbox"/> Male	<input type="checkbox"/> Questioning/Unsure of Gender Identity	<input type="checkbox"/> Transgender			<input type="checkbox"/> Over 15 Y/O: TAY Module ²

Person giving treatment consent: Parent(s) Guardian CFS Court Self Other
Referral source: Person(s) child is living with School CFS Court Probation Access Unit Health Plan Self
Other agencies/providers client is involved with: Yes No Other Agency Involved
Sources of information: Minor Caregiver Other: (name & role)

PRESENTING PROBLEM / HISTORY OF CURRENT PROBLEMS

Include significant problems with regard to daily living, such as with responsibilities, social relations, living arrangement, mental health and physical health. Include cultural explanations if these are important to the client.

Motives for services / What does the client really want from services?

What do caregivers really want from services?

Why is client coming in for help now?

REFER TO CANS-SB MANUAL FOR DETAILED SCORING INFORMATION

KEY
0 = NO EVIDENCE TO BELIEVE ITEM REQUIRES ANY ACTION
1 = NEEDS WATCHFUL WAITING, MONITORING OR POSSIBLY PREVENTIVE ACTION
2 = NEEDS ACTION. STRATEGY NEEDED TO ADDRESS PROBLEM/NEED
3 = NEEDS IMMEDIATE/INTENSIVE ACTION. IMMEDIATE SAFETY CONCERN/PRIORITY FOR INTERVENTION

CHILD BEHAVIORAL/EMOTIONAL NEEDS

	0	1	2	3		0	1	2	3
Psychosis (Thought Disorder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attachment Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impulsivity/Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anger Control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emotional/Physical Dysregulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mania	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Behavioral Regressions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oppositional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Somatization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conduct	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance Use ⁹	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adjustment to Trauma ⁸	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

CHILD/ADOL CLINICAL ASSESSMENT
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NAME: _____
CHART NO: _____
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PROGRAM: _____

Dysfunction requiring treatment (consider work, school, home, peer, family, parenting, self-care, etc.): None

LIFE DOMAIN FUNCTIONING

	n/a	0	1	2	3		n/a	0	1	2	3
Family Functioning ³	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medical/Physical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Living Situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Development ⁵	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gender Identity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developmental/Intellectual ⁴	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	School Behavior ⁶	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Job Functioning ¹⁴	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	School Achievement ⁶	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal ¹⁰	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	School Attendance ⁶	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decision Making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						

MENTAL HEALTH HISTORY

Type of Treatment (e.g., inpatient, outpatient)	Provider	Therapeutic Modality (e.g., therapy, medication)	Date(s)	Response to Treatment

ASSESSMENT OF RISK

CLINICAL MASTERS LEVEL OR ABOVE ONLY

Danger to Self: None Ideation Plan Intent w/o means Intent w/means
Danger to Others: None Ideation Plan Intent w/o means Intent w/means
 Identifiable victim(s) (Tarasoff) See note dated: _____
 Please describe actions taken: _____

Grave Disability: Yes No, As evidenced by: _____

Suicide Hx: Yes No, Describe if yes: _____

Homicide Hx: Yes No, Describe if yes: _____

Abuse Hx: Yes No, Describe if yes: _____

Risk for Abuse and/or Victimization: Yes No, Describe if yes: _____

CHILD RISK BEHAVIORS

	0	1	2	3		0	1	2	3
Suicide Risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fire Setting ¹³	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-Suicidal Self-Injurious Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intentional Misbehavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Self-Harm (Recklessness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exploitation ¹⁵	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Danger to Others ¹⁰	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Grave Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Aggression ¹¹	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Number of Prior Psychiatric Hospitalizations ¹⁶	0=0	1=1	2=2	3=3+
Runaway ¹²	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Instances: Past 6 Months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delinquent Behavior ¹⁰	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Crisis Episodes w/o Hospitalization				
					Instances: Past 90 Days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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TRAUMA

	No					Yes			
	0	1	2	3		0	1	2	3
Sexual Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Natural or Manmade Disaster	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	War/Terrorism Affected	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Witness/Victim to Criminal Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neglect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Disruption in Caregiving/Attachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Losses? Parental Criminal Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Witness to Family Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bullied by Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Witness to Community/School Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL HISTORY

Current health problems: Yes No, Explain if yes:
Current health conditions placing client at special risk: Yes No, Explain if yes:
Currently pregnant? Yes No Unknown
Allergies to medicine or other substances: Yes No, Explain Allergies:

Client Reported Medications: (for medical and mental health conditions)
 Medication section will be captured in a Note format in myAvatar

Medication/Herbal Tx	Dose	Variable Dose	Frequency	Start Date	Stop Date
1.		<input type="checkbox"/>			
Directions and/or Additional Information:					
2.		<input type="checkbox"/>			
Directions and/or Additional Information:					
3.		<input type="checkbox"/>			
Directions and/or Additional Information:					
4.		<input type="checkbox"/>			
Directions and/or Additional Information:					
5.		<input type="checkbox"/>			
Directions and/or Additional Information:					

SUBSTANCE EXPOSURE/SUBSTANCE USE (PAST AND PRESENT)

Issues with Substance Exposure: Yes No (If No, proceed to next section)

SUBSTANCE	EVER USED?	CURRENTLY USING?	AGE WHEN FIRST USED	TIME OF LAST USE	FREQUENCY & QUANTITY OF USE	PROBLEMS ASSOCIATED W/USE (e.g., LEGAL, INTERPERSONAL)	WITHDRAWAL AND/OR TOLERANCE?	EFFORTS TO STOP OR CUT DOWN AND TX
Tobacco	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N					<input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> N/A	
Alcohol	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N					<input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> N/A	
Caffeine	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N					<input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> N/A	
Marijuana	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N					<input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> N/A	
Complementary / Alt. Medications:	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N					<input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> N/A	
OTC Medications:	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N					<input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> N/A	
Illicit Drugs: (include IV drug use)	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N					<input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> N/A	
Other:	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N					<input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> N/A	

Additional information:

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NAME: _____
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DEVELOPMENTAL HISTORY

Developmental History: Known Unknown

Pregnancy Planned Yes No Unknown

Drug/Alcohol Impact Yes No Unknown

Birth Complications Yes No Unknown

Complications? Yes No Unknown

Premature Birth? Yes No Unknown

Age When Crawled?

Walked?

Spoke Single Words?

Spoke Sentences?

Toilet Trained?

Age-Appropriate Self-Care: WLN, Other:

Current Developmental Delays and Problems: Yes No, Explain:

FAMILY HISTORY

Birth order: _____ of _____ Raised by: Birth Parents Other:

Parents are: Married Living Together Separated Divorced No longer connected, Explain:

Age at parents' divorce: N/A, Age:

Problems with parents: Yes No, Explain:

Cultural or acculturation-related parenting issues: Yes No, Explain:

Out of home placements: Yes No, Explain:

Siblings: Yes No, Explain:

Problems with siblings: Yes No, Explain:

Support system support/involvement of family in client's life: Yes No, Explain:

Client's desire for involvement of family or others in treatment: Yes No, Explain:

CAREGIVER STRENGTHS/NEEDS

Caregiver Identified: Yes No

Caregiver name:

Caregiver role:

	0	1	2	3		0	1	2	3
Supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Involvement with Care ³	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Developmental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knowledge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family Relationship to the System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Legal Involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Residential Stability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emotional Responsiveness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical/Physical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Adjustment to Traumatic Experiences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

PROBLEM HISTORY

Behavior problems: Yes No, Describe:

Temper/Violence/Harm to Animals/Property: Yes No, Describe:

Past and current arrests and legal problems: Yes No, Describe:

Sexually active: Yes No Unknown, Describe:

Sexual problems: Yes No Unknown, Describe:

Sexual orientation issues: Yes No Unknown, Describe:

Sleep problems: Yes No, Describe:

Eating problems: Normal Binge Purge Underweight Obese Compulsive Eating Distorted Body Image
 Other, Describe:

Past and present employment: Yes Never employed, Describe:

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SCHOOL/PEER RELATIONS

Is client in school? Not School-Aged/Not Enrolled Enrolled School-Aged/Not Enrolled Graduated

School history: School: _____ Grade: _____ Teacher(s): _____
 Grades usually received: _____

Current problems with: None Teachers Grades Peers Suspensions/Expulsions Truancy
 Resists going to school Problems separating from home/parents
 Recent drop in grades Receiving special services

Explanation:

Peer issues: None Isolates Shy Usually a follower Provokes/Teases Frequently loses friends
 Usually a leader Cries a lot Few Friends Bullies Fights Makes friends easily
 Frequently teased about:

Explanation:

CULTURE/DIVERSITY

Assess unique aspects of the client, including culture, background, and sexual orientation, that are important for understanding and engaging the client and for care planning.

Preferred language for receiving our services: English Other: _____ (If not English, complete all items in this section)

Nature of services and staff assigned will need to be significantly culturally-related: No Yes (Explain)

(If "yes" complete all items in this section)

If the answers to the abovementioned items are "English" and "No," respectively, the remainder of this section is optional.

Mother's country of origin: _____ Father's country of origin: _____
 Number of years client and parents have been in this country: Parents: _____ Client: _____
 Culture client most identifies with: _____
 Has client had problems because of his/her cultural background: Yes No, (Explain)
 Culture-related healing practices used: Yes No, (Explain)
 Additional cultural/diversity assessment: (optional) Yes No, (Explain)

Importance of religion/spirituality for client: Yes No, (Explain)

CULTURAL FACTORS

	0	1	2	3		0	1	2	3
Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Discrimination Bias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traditions and Rituals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cultural Differences within the Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cultural Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cultural Diversity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Orientation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cultural Appropriateness of Service Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CLIENT STRENGTHS

Client strengths:

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STRENGTHS

	n/a	0	1	2	3		0	1	2	3
Family Strengths		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Natural Supports				
Interpersonal		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Relationship Permanence ⁷	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Optimism		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Well-being	<input type="checkbox"/>	<input type="checkbox"/>		
Educational Setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Resiliency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vocational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Resourcefulness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Talents and Interests		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Treatment Involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spiritual/Religious		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Progress to Goals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cultural Identity		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Discharge Preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community Life										

MENTAL STATUS (CLINICAL MASTERS LEVEL OR ABOVE ONLY)

Please check one or more of the following boxes below

APPEARANCE: Clean Groomed Dirty Disheveled *(Describe)*

SPEECH: Organized Coherent Pressured Rapid Slow Mumbling *(Describe)*

ORIENTATION: Person Place Time Situation *(Describe)*

AFFECT: Appropriate Blunted/Flat Restricted Labile Tearful *(Describe)*

INSIGHT: Good Average Poor None *(Describe)*

JUDGMENT: Good Average Poor *(Describe)*

MOOD: Stable Depressed Irritable Anxious Manic Elevated *(Describe)*

PERCEPTION: Normal Auditory Hallucinations Visual Hallucinations Other: *(Describe)*

THOUGHT CONTENT: Normal Delusional Grandiose Paranoid Phobic Other *(Describe)*

THOUGHT PROCESS: Organized Poor Concentration Obsessive Flight of Ideas Thought Blocking *(Describe)*

MEMORY (intact for): Immediate Recent Remote Memory Not Intact *(Describe)*

INTELLECTUAL FX ESTIMATE: Above Average Average Below Average Intellectual Disability *(Describe)*

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CANS-SB MODULES

No Modules Triggered (no information to be completed in this section)

Early Childhood (EC) Module 0-5¹

Not Applicable

	Unknown	0	1	2	3		Unknown	0	1	2	3
Motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Maternal/Primary Caregiver Availability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Parent or Sibling Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Curiosity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Playfulness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Regulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Adaptability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Failure to Thrive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PICA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Self-Care/Daily Living Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Birth Weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Atypical Behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prenatal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Early Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Labor and Delivery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Social and Emotional Functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exposure (Substance Exposure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exploited (0-5)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Transitional Age Youth (TAY) Module²

Not Applicable

	0	1	2	3		0	1	2	3
Independent Living Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intimate Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Residential Stability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medication Compliance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Educational Attainment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parenting Roles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vocational Career	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpersonal/Social Connectedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meaningfulness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personality Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Victimization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Family Difficulties (FAM) Module³

Not Applicable

	0	1	2	3		0	1	2	3
Relationship with Bio-Mother Only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Parental/Caregiver Collaboration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship with Bio-Father Only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship with Primary Caregiver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family Role Appropriateness/Boundaries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship Among Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family Conflict	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Developmental Needs (DD) Module⁴

Not Applicable

	0	1	2	3		0	1	2	3
Cognitive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Self-Care/Daily Living	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skills Atypical Behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developmental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

Sexuality Module⁵

Not Applicable

	0	1	2	3		0	1	2	3
Promiscuity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Knowledge of Sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Masturbation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Choice of Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reactive Sexual Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

School Module⁶

Not Applicable

	0	1	2	3		0	1	2	3
Attention-Concentration in School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression in School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensory Integration Difficulties in School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peer Relations in School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Affect Dysregulation in School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oppositional in School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety in School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Conduct in School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Permanency Module⁷

Not Applicable

	0	1	2	3		n/a	0	1	2	3
Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Grief and Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biological/Adoptive Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family Identity and Belonging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biological/Adoptive Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family Finding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Significant Adults	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Years in Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Current Living Situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Placement History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Traumatic Stress Module⁸

Not Applicable

	0	1	2	3		0	1	2	3
Intrusions/Re-Experiencing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperarousal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dissociation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traumatic Grief & Separation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Avoidance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Substance Use Disorder (SUD) Module⁹

Not Applicable

	0	1	2	3		0	1	2	3
Severity of Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Parental Influences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Duration of Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Environmental Influences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stage of Recovery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recovery Community Supports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peer Influences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

Violence/Juvenile Justice (JJ) Module¹⁰

Not Applicable

Violence

	0	1	2	3		0	1	2	3
History of Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Secondary Gains from Anger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bullying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Violent Thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frustration Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aware of Violence Potential	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hostility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Response to Consequences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paranoid Thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Commitment to Self-Control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Juvenile Justice

	0	1	2	3		0	1	2	3
History of Delinquency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Parental Criminal Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seriousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Environmental Influences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arrests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Incarceration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peer Influences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Legal Compliance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Sexually Aggressive Bx (SAB) Module¹¹

Not Applicable

	0	1	2	3		0	1	2	3
Relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Response to Accusation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Force/Threat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Temporal Consistency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of Sexually Aggressive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Age Differential	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Behavior Severity of Sexual Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type of Sex Act	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prior Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Runaway Module¹²

Not Applicable

	0	1	2	3		0	1	2	3
Frequency of Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Likelihood of Return on Own	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consistency of Destination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Involvement with Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safety of Destination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Realistic Expectations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Involvement in Illegal Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Fire Setting (FS) Module¹³

Not Applicable

	0	1	2	3		0	1	2	3
History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Community Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seriousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Response to Accusation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Remorse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of Accelerants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Likelihood of Future Fire Setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intention to Harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

Vocational (VOC) Module¹⁴

Not Applicable

	0	1	2	3		0	1	2	3
Job History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Job Relations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Job Attendance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Job Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Job Performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

Commercial Sexual Exploitation of Children (CSEC) Module¹⁵

Not Applicable

	0	1	2	3		n/a	0	1	2	3
Duration of Exploitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Incarceration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perception of Dangerousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knowledge of Exploitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trauma Bonding/Stockholm Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abortions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exploitation of Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attitude Toward Education Prior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unprotected Intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	School Success	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intimate Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						

Hospitalization Module¹⁶

Not Applicable, Refer to SB-CANS Manual for scoring time frames

	0	1	2	3		0	1	2	3
Longest Length of Stay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Time Since Most Recent Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Duration of Most Recent Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

Residential Module¹⁷

Not Applicable

	0	1	2	3		0	1	2	3
Off-Site Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Caregiver Participation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home Visits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Caregiver Interaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DISPOSITION

Diagnosis: See diagnosis form for full diagnosis

Case Status: Case Open NOABD Issued Rationale for NOABD: *(Medi-Cal Only)*

Disposition: List actions taken, recommendations, and referrals made (*mental health tx, drug/alcohol tx, community resources, medical care, etc.*). Include preferred language for services and provider gender and ethnicity if these are important to the client.

(All staff participating sign below)

Signature: _____ Print Name: _____ Date: _____

Signature: _____ Print Name: _____ Date: _____

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ASSESSMENT UPDATE

Update entries, of important background information or other assessment information about changes in the client's circumstances discovered during the course of services, may be made here. All entries will be dated and signed as a regular chart note. If an interview takes place, it may be charted here and billed by adding the MHS-Assess heading, the filling time, and the location code.

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