Print Form

CLIENT ASSESSMENT

HOST COUNTY: _____ (Mental Health Plan)

COUNTY OF ORIGIN: _____ (Mental Health Plan)

CLIENT NAME (First / Middle / Last) **DOB:** **Age Today:**

Sex: ◯ Male ◯ Female SSN: _____ Identification Number: _____

Ethnicity (How does the client identify): _____

Program: _____ Date of First Billed Service: _____

PRIMARY CAREGIVER: _____ Relationship: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Legal Guardian: _____ Relationship: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

PARENTS:

☐ **Mother:** _____ Phone: _____

Address: (if known) _____ City: _____ State: _____ Zip: _____

☐ **Father:** _____ Phone: _____

Address: (if known) _____ City: _____ State: _____ Zip: _____

☐ Same as caregiver/legal guardian above

☐ Unknown

Restrictions on Parental rights:

Parental rights held:

Client Name: **Record/Identification Number:**

Siblings:

_____ ◯ At home ◯ Foster placement ◯ Unknown/neither ◯ Other _____

_____ ◯ At home ◯ Foster placement ◯ Unknown/neither ◯ Other _____

Additional siblings / notes (include birth order if known):
Comments:

Language spoken at assessment:	Interpreter: ◯ Yes ◯ No If yes then who?

STRENGTHS AND RESOURCES

Check and describe all known client strengths and resources in achieving Client Plan goals.

SKILLS, INTERESTS & DESIRES OF CHILD/YOUTH

☐ Interpersonal:	
☐ Creative:	
☐ Academic:	
☐ Athletic:	
☐ Other:	

FAMILY

☐ Availability:	
☐ Involvement:	
☐ Skills:	
☐ Interests:	
☐ Financial resources:	
☐ Other:	

Client Name: **Record/Identification Number:**

COMMUNITY AND SOCIAL SUPPORTS FOR CHILD/YOUTH

☐ Positive peer /adult relationships:	
☐ School:	
☐ Job or volunteer activities:	
☐ Access to leisure Activities:	
☐ Cultural activities:	
☐ Spiritual activities:	
☐ Other:	

COMMUNITY AND SOCIAL SUPPORTS FOR FAMILY

☐ Supportive relationships:	
☐ School:	
☐ Job or volunteer activities:	
☐ Access to leisure activities	
☐ Cultural activities:	
☐ Spiritual activities:	
☐ Other:	

Comments

Presenting Problems/Target Symptoms: (User clients/caregivers's words when possible.)

Client Name: **Record/Identification Number:**

SYMPTOM CHECKLIST

Check the "Ever" box if symptom was ever present.
Also check the "6 months" box if symptom was present in the past 6 months.

DEPRESSION

☐ None

Ever	6 months		Ever	6 months	
☐	☐	Depressed mood	☐	☐	Suicidal behavior
☐	☐	Tearful	☐	☐	Irritable, easily annoyed
☐	☐	Loss of interest of pleasure	☐	☐	Often feels angry
☐	☐	Isolative or withdrawn	☐	☐	Homicidal ideation
☐	☐	Hopeless and/or helpless	☐	☐	Over-reactive (quick to anger)
☐	☐	Fatigue	☐	☐	Excessively happy or silly
☐	☐	Worthlessness, shame or guilt	☐	☐	Labile (sudden mood shifts)
☐	☐	Bored	☐	☐	Distinct mood cycles
☐	☐	Thoughts of non-suicidal self-harm	☐	☐	Episodes of excess energy, insomnia, and euphoria or rage
☐	☐	Non-suicidal self-harm			
☐	☐	Suicidal thoughts	☐	☐	Other (describe below)

ANXIETY

☐ None

Ever	6 months		Ever	6 months	
☐	☐	Anxious mood	☐	☐	Avoids talk or reminders of trauma
☐	☐	Separation anxiety	☐	☐	Hyper-vigilance or excessive startle
☐	☐	Feels tense or stressed	☐	☐	Panic attacks
☐	☐	Excessive worry	☐	☐	Agoraphobia
☐	☐	Fears or phobias	☐	☐	Dissociation
☐	☐	Intrusive memories	☐	☐	Obsessions or compulsions
☐	☐	Flashbacks (trauma re-experience)	☐	☐	Other (describe below)

SLEEP, APPETITE AND ELIMINATION

☐ None

Ever	6 months		Ever	6 months	
☐	☐	Initial insomnia	☐	☐	Poor appetite
☐	☐	Middle insomnia	☐	☐	Rapid weight gain
☐	☐	Late insomnia	☐	☐	Weight loss (unintentional)
☐	☐	Sleeps excessively	☐	☐	Excessive weight loss (intentional)
☐	☐	Nighttime fears	☐	☐	Bed wetting
☐	☐	Frequent nightmares	☐	☐	Daytime enuresis
☐	☐	Night terrors	☐	☐	Encopresis
☐	☐	Excessive appetite	☐	☐	Other (describe below)

THOUGHT AND PRECEPTION

☐ None

Ever	6 months		Ever	6 months	
☐	☐	Difficulty concentrating	☐	☐	Visual hallucinations
☐	☐	Disorganized thought process	☐	☐	Other hallucinations
☐	☐	Delusions	☐	☐	Perceptual distortions other than hallucinations
☐	☐	Auditory hallucinations	☐	☐	Bizarre behavior
☐	☐	Irrational or odd but not delusional thoughts (e.g., of persecution)	☐	☐	Other (describe below)

Client Name: **Record/Identification Number:**

	Ever	6 months		Ever	6 months	
ACTIVITY, ATTENTION & IMPULSE ☐ None	☐	☐	Overactive or fidgety	☐	☐	Difficulty completing tasks
	☐	☐	Slowed or lethargic	☐	☐	Talks excessively
	☐	☐	Short attention span	☐	☐	Impulsive (act without thinking)
	☐	☐	Easily distracted	☐	☐	Other (describe below)
CONDUCT ☐ None	☐	☐	Defiant, uncooperative, oppositional	☐	☐	Threatens, bullies, or intimidates
	☐	☐	Frequent lying	☐	☐	Runaways
	☐	☐	Blames others for own misbehavior	☐	☐	Cruel to animals
	☐	☐	Controlling, bossy, or manipulative	☐	☐	Truancy
	☐	☐	Breaks rules	☐	☐	Breaking into car or building
	☐	☐	Provokes	☐	☐	Stealing
	☐	☐	Property destruction	☐	☐	Vandalism, tagging/graffiti
	☐	☐	Physical aggression toward others	☐	☐	Gang involvement
	☐	☐	Impulsive, reactive aggression	☐	☐	Fire-setting
	☐	☐	Physical aggression toward others	☐	☐	Other (describe below)
ATTACHMENT ☐ None	☐	☐	Poor eye contact	☐	☐	Physically intrusive
	☐	☐	Disinterest in relationships	☐	☐	Resistant to being touched
	☐	☐	Difficulty making relationships	☐	☐	Overly attached to objects
	☐	☐	Clingy	☐	☐	Other (describe below)
SEXUALITY AND GENDER ☐ None	☐	☐	Sexualized behavior	☐	☐	Gender preference conflict
	☐	☐	Inappropriate or high-risk sexual behavior	☐	☐	Gender identity conflict
	☐	☐	Forced sexual contact - Victim	☐	☐	Inappropriate sexual comments
	☐	☐	Forced sexual contact - Perpetrator	☐	☐	Other (describe below)
NEURO-COGNITIVE ☐ None	☐	☐	Low intellectual functioning	☐	☐	Motor delay
	☐	☐	Learning disorder	☐	☐	Head injury
	☐	☐	Speech or language delay/disorder	☐	☐	Other (describe below)

Comment on the most prominent checked symptoms that need additional information:

RISK ASSESSMENT

Document special situations that present a risk to the child or others identified in the "Symptom Checklist".

Client Name: **Record/Identification Number:**

SUBSTANCE USE/ABUSE

Answer the following questions about all current drug and alcohol use.
List applicable drug(s) for items marked "Yes".

TYPE OF SUBSTANCE	Prenatal Exposure	Age At First Use	CURRENT SUBSTANCE USE					
☐ Not Applicable (Comments required)	None/ Unknown		None/ Denies	Current Use	Current Abuse	Current Dependence	In Recovery	Client-Preceived Problem
☐ Alcohol	☐		○	○	○	○	☐	○ Yes ○ No
☐ Amphetamines (Speed/Uppers, Crank Ritalin	☐		○	○	○	○	☐	○ Yes ○ No
☐ Cocaine/Crack	☐		○	○	○	○	☐	○ Yes ○ No
☐ Opiates (Heroin, Opium, Methadone)	☐		○	○	○	○	☐	○ Yes ○ No
☐ Hallucinogens (LSD, Mushrooms, Peyote, Ecstacy	☐		○	○	○	○	☐	○ Yes ○ No
☐ Sleeping Pills, Pain Killers, Valium, or Similar	☐		○	○	○	○	☐	○ Yes ○ No
☐ PCP (Phencyclidine) or Designer Drugs (GHB)	☐		○	○	○	○	☐	○ Yes ○ No
☐ Inhalants (Paint, Gas, Glue, Aerosols)	☐		○	○	○	○	☐	○ Yes ○ No
☐ Marijuana/Hashish	☐		○	○	○	○	☐	○ Yes ○ No
☐ Methamphetamines	☐		○	○	○	○	☐	○ Yes ○ No
☐ Tobacco/Nicotine	☐		○	○	○	○	☐	○ Yes ○ No
☐ Caffeine (Energy drinks, Sodas, Coffee, Etc.)	☐		○	○	○	○	☐	○ Yes ○ No
☐ Over the Counter: specify in comments below	☐		○	○	○	○	☐	○ Yes ○ No
☐ Other Substance(s): specify in comments below	☐		○	○	○	○	☐	○ Yes ○ No

Does the child report receiving any alcohol and drug services: ○ Yes, from this program ○ Yes, from a different program ○ No

Comment on any co-occurring substance abuse/use as they relate to mental health symptoms and behaviors.

Client Name: **Record/Identification Number:**

MENTAL STATUS EXAMINATION

Note cultural and age factors for descriptors when applicable

APPEARANCE	☐ Older than stated ☐ Younger than stated ☐ Eccentric	☐ Meticulous ☐ Appropriate grooming/ dress for age/culture	☐ Seductive ☐ Unique features ☐ Poor hygiene	Describe:
EYE CONTACT	☐ Good	☐ Fair	☐ Poor	Describe:
SPEECH	☐ Normal for age/situation ☐ Soft ☐ Loud ☐ Overly talkative ☐ Brief responses	☐ Non-verbal ☐ Rapid ☐ Pressured ☐ Rambling ☐ Monotone	☐ Excessive Profanity ☐ Slurred ☐ Stammer/Stutter ☐ Vocal tic ☐ Other speech difficulty	Describe:
ATTITUDE	☐ Responsive ☐ Engaging ☐ Cooperative ☐ Uncooperative	☐ Superficial ☐ Guarded/distant ☐ Provocative/limit testing ☐ Manipulative/deceitful	☐ Angry/hostile ☐ Shy/timid ☐ Dramatic ☐ Demanding/Insistent	Describe:
BEHAVIOR/ MOTOR ACTIVITY	☐ Normal for age/ situation ☐ Slowed ☐ Overactive/restless	☐ Impulsive ☐ Agitated ☐ Unusual mannerism	☐ Tremor ☐ Other involuntary movement	Describe:
MOOD	☐ Happy ☐ Sad	☐ Irritable or Angry ☐ Bored	☐ Anxious ☐ Fearful	Describe:
AFFECT	☐ Euthymic (normal) ☐ Sad ☐ Tearful ☐ Overly happy ☐ Irritable	☐ Angry ☐ Silly ☐ Anxious ☐ Fearful ☐ Bored	☐ Labile (rapidly shifting) ☐ Flat, blunted, constricted ☐ Incongruent with topic or thoughts	Describe:
PERCEPTIONS	☐ Normal	☐ Hallucinations ☐ Auditory ☐ Visual ☐ Other	☐ Other perceptual distortion	Describe:
THOUGHT FORM/PROCESS	☐ linear and rational ☐ Racing	☐ Disorganized or Loose	☐ Pervasive	Describe:
THOUGHT CONTENT	☐ Normal ☐ Delusions ☐ Obsessions	☐ Excessive preoccupation ☐ Other involuntary movement	☐ Unusual, non-delusional Ideations (suspicious, etc)	Describe:
THOUGHTS OF HARMING SELF OR OTHERS	☐ None ☐ Suicidal ideation ☐ Suicidal intent	☐ Thoughts or intent of non-lethal self-injury	☐ Thoughts or intent of harming another person	Describe:
SENSORIUM	Oriented to: ☐ Person ☐ Place ☐ Time ☐ Situation Memory intact for: ☐ Immediate ☐ Recent ☐ Remote	Alertness: ☐ Alert ☐ Clouded/confused ☐ Other Attention: ☐ Good ☐ Fair ☐ poor	Intellectual functioning: ☐ Average or higher ☐ Below average Insight/judgment: ☐ Good ☐ Fair ☐ Poor	Describe:

Client Name: **Record/Identification Number:**

FUNCTIONAL IMPAIRMENT

Assess the Impact of the client's impairment in the following areas

Home:

School:

Community:

Work:

Family relationships:

Peer relationships:

CULTURAL FACTORS

Explain how the client's cultural factors, including those previously described, impact current functioning and the treatment plan. Include immigration, acculturation, sexual orientation, and other significant factors in your explanation.

SOCIAL FACTORS

Explain how the client's social factors, including those previously described, impact current functioning and the treatment plan. Include living situation, daily activities, and other significant factors in your explanation.

Client Name: **Record/Identification Number:**

DEVELOPMENTAL STATUS

Categories	Within Normal Limits	Unknown	Concerns / issues (describe the specific concern or issue)
Parental Risk Factors: i.e.- Developmental delay, mental health issues, substance/physical abuse	○	○	
Cognitive Functioning: i.e.- Developmental delay, learning disability, making academic progress	○	○	
Sensory Functioning: i.e.- Visual or auditory deficits, other sensory Deficits	○	○	
Fine and gross motor skills: i.e.- Motor deficits, delay in acquiring skills	○	○	
Early Childhood: i.e.- Prenatal care, delivery complications, neglect or abuse, separation anxiety	○	○	
Middle Childhood: i.e.- Problems with peers and/or siblings, age appropriate behavior, problems at school	○	○	
Adolescence: i.e.- Sexuality/gender issues, truancy, illegal behavior, substance/alcohol use (including nicotine)	○	○	

Other:

CLIENT'S MENTAL HEALTH HISTORY

○ Yes ○ No Previous outpatient mental health services? When/Where? _____ Transfer ☐

○ Yes ○ No Previous crisis contact? Number of crisis unit visits without hospitalization in past 6 months: ○ 0 ○ 1 ○ 2 or more
Most recent date: _____

○ Yes ○ No Previous psychiatric hospitalization? Number of psychiatric hospitalizations in past 6 months: ○ 0 ○ 1 ○ 2 or more
Most recent date: _____

○ Yes ○ No Previous diagnosis (if yes, list in comments):

○ Yes ○ No Use of traditional or alternative healing practices (describe with results, below):

○ Yes ○ No Lab consultation/reports Date if known: _____ Examiner if known: _____

○ Yes ○ No Neurological Testing Date if known: _____ Examiner if known: _____

○ Yes ○ No Psychological Testing Date if known: _____ Examiner if known: _____

Comments: Include earliest symptoms, age at onset, other support/stressors at time of onset, family understanding of problem, response to treatment, other potential contributing factors, relevant family history and any **family mental health illness history.**

Client Name: **Record/Identification Number:**

CURRENT MEDICATIONS

If known, include drug names, dosages, when prescribed, and who prescribed them.
Document any experienced side effects and/or compliance issues

Current medications, including psychiatric, if known.

Past medications, including psychiatric, if known.

Additional comments:

MEDICAL HISTORY

☐ Unknown	☐ Not Available	Current Primary Medical Care Provider:	Phone:

Last Physical Exam:	◯ Within Past 12 months	◯ More than 12 Months	◯ Unknown	◯ No - Explain below
Last Dental Exam:	◯ Within Past 12 months	◯ More than 12 Months	◯ Unknown	◯ No - Explain below
Are there any health concerns (medical illness, medical symptoms?		◯ Unknown/None Reported	◯ No	◯ Yes - Explain below
Non-Medication Allergies (Food, Pollen, Bee sting, etc)		◯ Unknown/None Reported	◯ No	◯ Yes - Explain below
Medication Allergies (list type)		◯ Unknown/None Reported	◯ No	◯ Yes - Explain below

Has the child or caregiver reported any of the following problems/experiences? (check all that apply)

☐ Asthma	☐ Heart Problems	☐ Surgery of any kind. Explain below:
☐ Broken Bones	☐ High or Low Blood Pressure	☐ Thyroid Problem
☐ Convulsions or Seizure	☐ Immune System Problems	☐ Tuberculosis (TB)
☐ Diabetes	☐ Lever Problems or Hepatitis	☐ Obesity
☐ Exposure to Toxic Lead Levels	☐ Motor or Movement Problems	☐ Weight Gain or Loss. Explain below:
☐ Respiratory Problems	☐ Urinary Tract or Kidney Problems	☐ Eating Disorder
☐ Cancer	☐ Serious Rash or Other Skins Problem	☐ Appetite Changes
☐ Head injury	☐ Pregnancy	☐ Speech or Language Problems. Explain below:
☐ Hearing Problems	☐ Miscarriage	☐ Other
☐ Vision Problems	☐ Sexually Transmitted Disease (STD)	☐ Unknown
☐ Enuresis	☐ Encopresis	☐ Non/None Reported

Comments:

Client Name: **Record/Identification Number:**

Additional clarifying formulation information, as needed. Please document any additional comments or information.

DIAGNOSING LPHA:	**Lic/Reg:**	**Date:**
DSM IV CODE:		
Axis I Primary (ICD Code, if different):		
Axis I Secondary:		
Axis II (Code and description):		
Axis III:		
Axis IV (Primary):		
Axis IV (Secondary):		
Axis V:		

Notice of Privacy Practices Offered to Client/Primary Caregiver?	◯ Yes ◯ No	
LPHA Printed Name:		Date:
LPHA Signature:		Lic/Reg:
LPHA Co-Signature Printed Name (if required):		Date:
LPHA Co-Signature (if required):		Lic/Reg: