SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

CLIENT NAME _____ **MH ID#** _____

YOUTH REASSESSMENT

Agency/Program_____ **Assessment Date** _____

Admission Date _____

Address _____ **Birth Date** _____ **Age** _____

Phone Number (Home) _____**Cell #** _____ **Work #** _____

Emergency Contact: Name _____**Phone Number**_____

Source of Information: ☐ Client interview ☐CI ☐Previous Records ☐Other_____

Ethnicity _____

Primary Language of Child/Youth_____**Primary Language of Family**_____

If Primary Language is not English, how will language needs be met?_____

Is Client able to communicate in English? ☐Yes ☐No **Interpreter Name** (if needed) _____

Other people or agencies actively involved in the client's care:

_____

_____

LEGAL STATUS:

- ☐ CPA Investigation
- ☐ Probation (Informal/Diversion)
- ☐ Probation (Ward) 600
- ☐ LPS Conservatorship
- ☐ CPS Social Services (Dependent) 300
- ☐ Voluntary

Other Legal Status Details

UPDATES TO PRESENTING PROBLEM, AND CURRENT SYMPTOMS (state presenting problem/reason for treatment):

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UPDATES TO PSYCHOSOCIAL HISTORY
(Include current living situation, family history, legal issues, strengths, cultural and spiritual info)

UPDATES TO PSYCHIATRIC AND MEDICAL HISTORY (Include changes in the past year, medication changes, current medication, psychiatric treatment, hospitalization)

OVERALL CONCERNS / RISK
☐ Yes ☐ No ☐ Undetermined
Suicide/Harm to Self ☐Yes ☐No **Homicide/Harm to Others** ☐Yes ☐No

Changes in Substance Use Status (since last assessment)
☐ Yes ☐ No ☐ Undetermined. If yes, explain:_____

SUBSTANCE ABUSE HISTORY ☐ **None/Not Relevant**

Substance	Age of 1st Use	Highest Usage Amount and Frequency dur. Time Period	Current Usage with Amount/Frequency/Route	Date of Last Use	Rating of current abuse 0 – 4 minimal- severe
Alcohol					
Amphetamines					
Cocaine					
Opiates					
Sedatives					
PCP					
Hallucinogens					
Inhalants					
Marijuana					
Cigarettes					
RX Drugs					

Other information: ☐ Client supplied a urine specimen for tox screen. Results:_____

Does TRAUMA Impact Functioning or Presenting Problems
☐ Yes ☐ No ☐ Unknown

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OVERALL SUMMARY/EVALUATION OF CURRENT RISK/TRAUMA/AOD USE

SEXUAL ORIENTATION AND GENDER IDENTIFY

What is your preferred name? _____

What is your sexual orientation?

☐ Straight or heterosexual ☐ Lesbian or Gay ☐ Bisexual ☐ Queer ☐ Asexual ☐ Don't Know/Declined to answer ☐ Did not ask ☐ Another

What is your current gender identity?

☐ Male ☐ Female ☐ Female to Male/Transgender Male ☐ Male to Female/Transgender Female
☐ Genderqueer not exclusive male/female ☐ Declined to answer ☐ Did not ask
☐ Another

What are your pronouns?

☐ He/Him ☐ She/Her ☐ They/Them ☐ Declined to Answer ☐ Did not ask
☐ Another

What sex were you assigned at birth on your original birth certificate?

☐ Male ☐ Female ☐ Declined to answer ☐ Did not ask
☐ Another

Have you been diagnosed by a Doctor with an intersex condition?

☐ Yes ☐ No ☐ Declined to answer ☐ Did not ask

MENTAL STATUS EXAM:

May ONLY be completed by Licensed/Waivered MD/NP, MFT/MFTI, LCSW/ASW, LPCC/PCCI, PhD/PsyD, RN with Psych MS or Trainee with co-signature.

General Appearance
☐ Appropriate ☐ Disheveled ☐ Bizarre
☐ Inappropriate ☐ Other

Affect
☐ Within Normal Limits ☐ Constricted
☐ Blunted ☐ Flat
☐ Angry ☐ Sad
☐ Anxious ☐ Labile
☐ Inappropriate ☐ Other

Physical and Motor
☐ Within Normal Limits ☐ Hyperactive
☐ Agitated ☐ Motor Retardation
☐ Tremors/Tics ☐ Unusual Gait
☐ Muscle Tone Issues ☐ Other

Mood
☐ Within Normal Limits ☐ Depressed
☐ Anxious ☐ Expansive
☐ Irritable ☐ Other

Thought Content and Process
☐ Within Normal Limits
☐ Vis. Hallucinations
☐ Paranoid Ideation
☐ Suicidal Ideation
☐ Flight of Ideas
☐ Poor Insight
☐ Fund of Knowledge

☐ Aud. Hallucinations
☐ Delusions
☐ Bizarre
☐ Homicidal Ideation
☐ Loose Associations
☐ Attention Issues
☐ Other

Speech
☐ Within Normal Limits
☐ Tangential
☐ Slowed
☐ Other

☐ Circumstantial
☐ Pressured
☐ Loud

Cognition
☐ Within Normal Limits
☐ Memory Problems
☐ Poor Concentration
☐ Other

☐ Orientation
☐ Impulse Control
☐ Poor Judgment

MSE Summary:

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DSM 5 Diagnosis:

Does the client have a substance abuse/dependence issue? ☐Yes ☐No ☐Unknown

Has client experienced traumatic events? ☐Yes ☐No ☐Unknown

Check one entry in √ P column to specify the Primary diagnosis. (You may report additional diagnoses.)

Place a check in the √ AOD column if the diagnosis is substance abuse/dependence related.

DSM5 Diagnosis	ICD-10	√ AOD	√ P
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

General Medical Conditions

17 = Allergies	☐	12 = Diabetes	☐	29 = Muscular Dystrophy	☐
16 = Anemia	☐	09 = Digest-Reflux,Irrit'lBowel	☐	15 = Obesity	☐
01 = Arterial Sclerotic Disease	☐	34 = Ear Infections	☐	21 = Osteoporosis	☐
19 = Arthritis	☐	26 = Epilepsy/Seizures	☐	30 = Parkinson's Disease	☐
35 = Asthma	☐	02 = Heart Disease	☐	31 = Physical Disability	☐
06 = Birth defects	☐	18 = Hepatitis	☐	08 = Psoriasis	☐
23 = Blind/Visually Impaired	☐	03 = Hypercholesterolemia	☐	36 = Sexually TransmittedD.	☐
22 = Cancer	☐	04 = Hyperlipidemia	☐	32 = Stroke	☐
20 = Carpal Tunnel Syndrome	☐	05 = Hypertension	☐	33 = Tinnitus	☐
24 = Chronic Pain	☐	14 = Hyperthyroid	☐	10 = Ulcers	☐
11 = Cirrhosis	☐	13 = Infertility	☐		
07 = Cystic Fibrosis	☐	27 = Migraines	☐	00 = No Gen. Medical Cond'n	☐
25 = Deaf/Hearing Impaired	☐	28 = Multiple Sclerosis	☐	99 = Unk/Not Report'd. GMC	☐
37 = Other: (Please list)					

Number of children under the age of 18 the client cares for or is responsible for at least 50% of the time _____

Number of dependent adults age 18 or older the client cares for or is responsible for at least 50% of the time _____

Diagnostic Comments:

Service Strategies: Check any service strategy likely to be used during the course of this plan.

☐ Peer/Family Delivered Services (50)
☐ Psychoeducation (51)
☐ Family Support (52)
☐ Supportive Education (53)
☐ Delivered in wt LawEnforcement (54)
☐ Delivered in Partnership wt. Health Care (55)
☐ Delivered in Partnership wt. Social Services (56)
☐ Delivered in Partnership wt Substance Tx (57)
☐ Integrated Services Mental Health & Aging (58)
☐ Integrated Mental Health/Developmental Dis (59)
☐ Ethnic-Specific (60)
☐ Age-Specific Service (61)
☐ Unknown Service Strategy (99)

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Clinical Formulation
May ONLY be completed by Licensed/Registered/Waivered MD/OD/NP, MFT, LCSW, LPCC, PhD/PsyD, RN with Psych MS or Trainee with co-signature.

As a result of the Primary Diagnosis, the client has the following functional impairments:
Treatment is being provided to address, or prevent, significant deterioration in an important area of life functioning.

☐ School/Work Functioning ☐ Social Relationships ☐ Daily Living Skills
☐ Ability to Maintain Placement ☐ Symptom Management

Clinical Formulation:

(Include current presenting issues, course of treatment, impairments, diagnostic criteria, strengths, and treatment recommendations)

Additional Factors or Comments:

Authorized Clinical Staff* involved in assessment interview Signature and Date

Authorized Clinical Staff* involved in assessment interview Signature and Date

Assessor's Name/Discipline – Printed **Date**
Conducted the Mental Status Exam and provided Diagnosis.

Assessor's Signature and Discipline **Date**

Assessor must be a *Licensed/Registered/Waivered MD/OD/NP, MFT, LCSW, LPCC, PhD/PsyD, RN with Psych MS or Trainee with co-signature.*(At minimum the assessor is responsible for reviewing the completed assessment, conducting the mental status exam, providing a clinical formulation and providing the diagnosis. **Assessor signs here to co-sign for assessments provided by trainees.**)