

## San Mateo County Behavioral Health & Recovery Services WORKSHEET FOR YOUTH INITIAL ASSESSMENT

Name \_\_\_\_\_ MH Record# \_\_\_\_\_ Episode \_\_\_\_\_ DOB \_\_\_\_\_ Sex \_\_\_ SSN \_\_\_\_\_

### Tab 1. Identifying/Legal & CSI Information

**Assessment Type (Indicates the type of staff involved in completing the assessment. Does not change the requirements. Determines the title of printed form).**

<b>Assessment Date:</b>	Child's/Youth's Age (years):  Months:
<b>Assessment Type: Select Assessment Type first</b>  <input type="radio"/> Initial Assessment (Clinician, Casemngr) <input type="radio"/> Multi-Discpl. Assessment (Includes MD Eval. <input type="radio"/> Physician Initial Eval. (MD/NP Only) <input type="radio"/> Physician Supplemental Info <input type="radio"/> Prenatal to Three Assessment <input type="radio"/> School Based Mental Health	Current District/School Placement:   Grade Level:
Parent/Guardian (last, first middle name):	Child/Youth wants to be called:
Parent/Guardian Contact Information:	<b>Source of Information</b> (Check all that Apply) <input type="checkbox"/> School <input type="checkbox"/> Primary Care Physician
Primary Language of Child/Youth	<input type="checkbox"/> Referral Packet <input type="checkbox"/> Probation <input type="checkbox"/> Parent/Guardian/Caretaker
Preferred Language of Child/Youth:	<input type="checkbox"/> Family/Relative <input type="checkbox"/> Social Services <input type="checkbox"/> Child <input type="checkbox"/> PES
Primary Language of Family:	<input type="checkbox"/> Other
Preferred Language of Family:	<b>Language Services Offered? Check</b> <input type="checkbox"/> Bi Lingual Clinician <input type="checkbox"/> No <input type="checkbox"/> Yes, Accepted <input type="checkbox"/> Yes, Declined
Additional Parent/Guardian/Foster Parent Info (Indicate who Youth lives with, Contact Info, Signing Authority) (IEP Report)	
<b>Referral Reason</b>	
<input type="checkbox"/> Out of Home Placement	<input type="checkbox"/> Relating/Communication Problems.
<input type="checkbox"/> Hospitalization	<input type="checkbox"/> Developmental Problems
<input type="checkbox"/> Child/Caretaker Relationship Problems	<input type="checkbox"/> Affect/Mood/Anxiety Problems
<input type="checkbox"/> Trauma Exposure	<input type="checkbox"/> Adjustment reactions
<input type="checkbox"/> Delay on ASQ (P-3)	<input type="checkbox"/> Regulatory/Sleep/Feeding Problems (P-3)
<input type="checkbox"/> AOD Exposure (P-3)	<input type="checkbox"/> Premature (P-3)
<input type="checkbox"/> R/O GGRC Referral (P-3)	<input type="checkbox"/> CPS
<input type="checkbox"/> School Problems	<input type="checkbox"/> Behavior Problems
<input type="checkbox"/> Other	<input type="checkbox"/> Other

<b>Service Strategies (Check all that apply)</b>	
<input type="checkbox"/> Assertive Community Treatment	Highest School Grade Completed (CSI)
<input type="checkbox"/> Dlvr'd in Partnership w Health Care	
<input type="checkbox"/> Dlvr'd in Partnership w Law Enforcement	Employment Status (CSI)
<input type="checkbox"/> Dlvr'd in Partnership w Social Services	
<input type="checkbox"/> Dlvr'd in Partnership w Sub. Abuse Serv	Living Arrangement (CSI)
<input type="checkbox"/> Ethnic Specific Service Strategy	
<input type="checkbox"/> Family Psychoeducation	Conservatorship/Court Status (CSI)
<input type="checkbox"/> Family Support	
<input type="checkbox"/> Functional Family Therapy	Number of children under the age of 18 the client cares for or is responsible for at least 50% of the time (CSI)
<input type="checkbox"/> Illness Management & Recovery	
<input type="checkbox"/> Integrated Dual Dx Treatment	
<input type="checkbox"/> Integrated Services MH + Aging	
<input type="checkbox"/> Integrated Services MH + Dev.Disability	Number of dependent adults age 18 or older the client cares for or is responsible for at least 50% of the time (CSI)
<input type="checkbox"/> Medication Management	
<input type="checkbox"/> Multi-systemic Therapy	
<input type="checkbox"/> New Generation Medications	
<input type="checkbox"/> Peer/Family Delivered Services	
<input type="checkbox"/> Psychoeducation	
<input type="checkbox"/> Supportive Education	
<input type="checkbox"/> Supportive Employment	
<input type="checkbox"/> Therapeutic Foster Care	
<input type="checkbox"/> Unknown Service strategy	
<b>Special Education Eligibility Status (Check all that apply)</b>	
<input type="checkbox"/> Autism	<input type="checkbox"/> Speech Impaired
<input type="checkbox"/> Hard of Hearing	<input type="checkbox"/> Deaf-Blind
<input type="checkbox"/> Orthopedically Impaired	<input type="checkbox"/> Multi-Handicapped
<input type="checkbox"/> Specific Learning Disability	<input type="checkbox"/> Emotionally Disturbed
<input type="checkbox"/> Visually Handicapped	<input type="checkbox"/> Traumatic Brain Injury
<input type="checkbox"/> Deaf	<input type="checkbox"/> Yes, Unknown Eligibility
<input type="checkbox"/> Intellectual Disability	<input type="checkbox"/> Not Applicable
<input type="checkbox"/> Other Health Impaired	<input type="checkbox"/> Unknown
<b>Special Education Eligibility Date:</b>	
<b>Legal Status:</b>	
<input type="checkbox"/> CPS Investigation	<input type="checkbox"/> CPS Social Services (Dependent) 300
<input type="checkbox"/> LPS Conservatorship	<input type="checkbox"/> Probation (Informal/Diversion)
<input type="checkbox"/> Probation (Ward) 600	<input type="checkbox"/> Voluntary
<input type="checkbox"/> Adoption, Living Out of County	<input type="checkbox"/> Other
Other Legal Status, Special Education and Admission Details:	

**Tab 2. Clinical Information**

**Description of Current Presenting Problems (incl. referral reason, symptoms, behaviors and impairments) (IEP Report)**

**Behavioral/Mental Health History (incl. onset, severity of stressors & other changes) (IEP Report)**

**Developmental History (incl. pre-natal & peri-natal events; developmental milestones & delays; attachment & separation issues)**

**Current and Past Living Situation/CPS History**

<b>Youth's Gender Identity? (RESTRICTED)</b>	<b>Youth's Sexual Orientation? (RESTRICTED)</b>
<input type="radio"/> Female <input type="radio"/> Male	<input type="radio"/> Heterosexual <input type="radio"/> Bisexual
<input type="radio"/> Transgender	<input type="radio"/> Gay/Lesbian
<input type="radio"/> Intersex	<input type="radio"/> Questioning
<input type="radio"/> Declined to state <input type="radio"/> Unknown	<input type="radio"/> Declined to state <input type="radio"/> Unknown
<input type="radio"/> Other	<input type="radio"/> Other

**Youth and Family- Cultural/Spiritual/Acculturation/Immigration/Family Constellation, Dynamics and History**

**Youth and Family Strengths and Assets (incl. Positive Coping, Functioning, Strengths, Hobbies, Interests, Sources of Support) (IEP)**

**Education History (IEP Report)**

**Medical History/ Significant Illnesses/ Chronic Conditions/ Surgeries/ Allergies (incl. family medical & mental health hx)**

**Psychiatric Hospitalization/ Residential Placement/ Day Treatment History – (Include Provider & Dates)**

**Outpatient Treatment History (Incl. therapeutic interventions; past treatment responses; providers & dates)**

**Juvenile Justice History (incl. Gang Affiliation)**

**Tab 3 Risk and Co-Occurring**

<p><b>Risk of Harm to Self/Suicidal Thoughts/Behavior</b>  <input type="radio"/> Yes      <input type="radio"/> Denied      <input type="radio"/> Undetermined</p>	<p><b>PAST Risk of Harm to Self/Suicidal Thoughts/Behavior</b>  <input type="radio"/> Yes      <input type="radio"/> No      <input type="radio"/> Unknown</p>
<p><b>Current HARM to OTHERS/HOMOCIDAL Thoughts</b>  <input type="radio"/> Yes      <input type="radio"/> Denied      <input type="radio"/> Undetermined</p>	<p><b>Past HARM to OTHERS/HOMOCIDAL Thoughts</b>  <input type="radio"/> Yes      <input type="radio"/> No      <input type="radio"/> Unknown</p>
<p><b>Current Domestic Violence Issues</b>  <input type="radio"/> Yes      <input type="radio"/> No      <input type="radio"/> Unknown</p>	<p><b>Past Domestic Violence Issues</b>  <input type="radio"/> Yes      <input type="radio"/> No      <input type="radio"/> Unknown</p>
<p><b>Engaged in Violent Acts? (physical, sexual, vandalism)</b>  <input type="radio"/> Yes      <input type="radio"/> No      <input type="radio"/> Unknown</p>	<p><b>Victim of Violence?</b>  <input type="radio"/> Yes      <input type="radio"/> No      <input type="radio"/> Unknown</p>
<p><b>Access to FIREARMS/WEAPONS</b>  <input type="radio"/> Yes      <input type="radio"/> Denied      <input type="radio"/> Undetermined</p>	
<p><b>Does SUBSTANCE USE impact risk?</b>  <input type="radio"/> Yes      <input type="radio"/> No      <input type="radio"/> Unknown                  Substance Use Issues Impacting Client (Select 1 or more.)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Current Substance Abuse</li> <li><input type="checkbox"/> Use impacts Functioning/Presenting Problem</li> <li><input type="checkbox"/> Abuse/Misuse of OTC Medications</li> <li><input type="checkbox"/> Abuse/Misuse of Caffeine</li> <li><input type="checkbox"/> Current Substance Use in Parents/Caregivers</li> <li><input type="checkbox"/> Missed School or Impaired by Use</li> <li><input type="checkbox"/> AOD Exposure in Utero</li> <li><input type="checkbox"/> Other <input style="width: 150px; height: 30px; border: 1px solid black;" type="text"/></li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Past Substance Abuse History</li> <li><input type="checkbox"/> Use of Illicit Drugs</li> <li><input type="checkbox"/> Abuse/Misuse of Prescription Drugs</li> <li><input type="checkbox"/> Abuse/Misuse of Nicotine</li> <li><input type="checkbox"/> Current Substance Use in Parents/Caregivers</li> <li><input type="checkbox"/> Family is Concerned by Alcohol/Drug Use</li> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> Unknown</li> </ul>
<p><b>OTHER:</b></p>	

<b>Child/Youth Trauma History</b>	<b>Family Trauma History</b>
<input type="checkbox"/> Physical Abuse	<input type="checkbox"/> Physical Abuse
<input type="checkbox"/> Sexual Abuse	<input type="checkbox"/> Sexual Abuse
<input type="checkbox"/> Assault	<input type="checkbox"/> Assault
<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Domestic Violence
<input type="checkbox"/> Military Combat	<input type="checkbox"/> Military Combat
<input type="checkbox"/> Torture	<input type="checkbox"/> Torture
<input type="checkbox"/> Immigration/Displacement	<input type="checkbox"/> Immigration/Displacement
<input type="checkbox"/> Separation	<input type="checkbox"/> Separation
<input type="checkbox"/> Suspected	<input type="checkbox"/> Suspected
<input type="checkbox"/> Other	<input type="checkbox"/> Other
<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown
<input type="checkbox"/> None	<input type="checkbox"/> None

**Risk Evaluation/Trauma Info (incl.PTSD Symptoms)/ AOD Use (Drug Name, Frequency, Age of 1<sup>st</sup> Use, Date of Last Use)**

DRAFT

**Tab 4 CALOCUS**

<b>Is Youth Emancipated?</b>				
<input type="radio"/> Yes <input type="radio"/> No				
<b>1. Risk of Harm</b>				
<input type="radio"/> 1- Low Risk	<input type="radio"/> 2-Some Risk	<input type="radio"/> 3-Significant Risk	<input type="radio"/> 4-Serious Risk	<input type="radio"/> 5-Extreme Risk
<b>2. Functional Status</b>				
<input type="radio"/> 1-Miminal	<input type="radio"/> 2-Mild	<input type="radio"/> 3-Moderate	<input type="radio"/> 4-Serious	<input type="radio"/> 5-Severe
<b>3. Co-Morbidity</b>				
<input type="radio"/> 1-None	<input type="radio"/> 2-Minor	<input type="radio"/> 3-Significant	<input type="radio"/> 4-Major	<input type="radio"/> 5-Severe
<b>4a. Recovery Environment- Environmental Stressors</b>				
<input type="radio"/> 1- Minimally Stressful	<input type="radio"/> 2- Mildly	<input type="radio"/> 3- Moderately	<input type="radio"/> 4- Highly	<input type="radio"/> 5- Extremely Stressful
<b>4b. Recovery Environment- Environmental Support</b>				
<input type="radio"/> 1-Highly Supportive	<input type="radio"/> 2-Supportive	<input type="radio"/> 3-Limited	<input type="radio"/> 4-Minimally	<input type="radio"/> 5-No Support
<b>5. Resiliency and Treatment History</b>				
<input type="radio"/> 1-Full	<input type="radio"/> 2-Significant	<input type="radio"/> 3- Moderate/Equivocal	<input type="radio"/> 4-Poor	<input type="radio"/> 5-Negligible
<b>6a. Treatment, Acceptance, Engagement- Child/Adolescent</b>				
<input type="radio"/> 1- Optimal	<input type="radio"/> 2- Constructive	<input type="radio"/> 3- Obstructive	<input type="radio"/> 4- Adversarial	<input type="radio"/> 5- Inaccessible
<b>6b. Treatment, Acceptance, Engagement- Parent/Caretaker</b>				
<input type="radio"/> 0-N/A	<input type="radio"/> 2- Constructive	<input type="radio"/> 3- Obstructive	<input type="radio"/> 4- Adversarial	<input type="radio"/> 5- Inaccessible
<input type="radio"/> 1-Optimal				
<b>Calculate LOCUS Score</b>		<b>Total Score</b>		<div style="border: 1px solid black; width: 100px; height: 40px; margin: 0 auto;"></div>

**Tab 5 MSE and Behavioral Observation**

<p><b>May ONLY be completed by Licensed/Waivered MD/NP, MFT/MFTI, LCSW/ASW, Psy (PhD/PyD), RN with Psych MS or Trainee with co-signature.</b></p>	
<p><b>Does a Co-Morbid condition exist?</b>  <input type="radio"/> Yes      <input type="radio"/> No      <input type="radio"/> Unknown</p>	
<p>Is <b>General Appearance</b> Within Normal Limits?  <input type="radio"/> Yes      <input type="radio"/> No</p>	<p>Is <b>Affect</b> Within Normal Limits?  <input type="radio"/> Yes      <input type="radio"/> No</p>
<p><b>General Appearance:</b>  <input type="checkbox"/> Inappropriate      <input type="checkbox"/> Hygiene Problems  <input type="checkbox"/> Disheveled      <input type="checkbox"/> Odd/eccentric  <input type="checkbox"/> Other</p>	<p><b>Affect:</b>  <input type="checkbox"/> Sad      <input type="checkbox"/> Angry      <input type="checkbox"/> Anxious      <input type="checkbox"/> Flatten  <input type="checkbox"/> Withdrawn      <input type="checkbox"/> Incongruent      <input type="checkbox"/> Labile      <input type="checkbox"/> Other</p>
<p>General Appearance Comments:</p>	<p>Affect Comments:</p>
<p>Is <b>Speech</b> Within Normal Limits?  <input type="radio"/> Yes      <input type="radio"/> No</p>	<p>Is <b>Mood</b> Within Normal Limits?  <input type="radio"/> Yes      <input type="radio"/> No</p>
<p><b>Speech:</b>  <input type="checkbox"/> Pressured      <input type="checkbox"/> Mute  <input type="checkbox"/> Poverty of Speech      <input type="checkbox"/> Perseverative  <input type="checkbox"/> Impairment      <input type="checkbox"/> Other</p>	<p><b>Mood:</b>  <input type="checkbox"/> Within Normal Limits      <input type="checkbox"/> Depressed  <input type="checkbox"/> Anxious      <input type="checkbox"/> Expansive/Euphoric  <input type="checkbox"/> Irritable      <input type="checkbox"/> Angry  <input type="checkbox"/> Other</p>
<p>Speech Comments:</p>	<p>Mood Comments:</p>
<p>Is <b>Behavior</b> Within Normal Limits?  <input type="radio"/> Yes      <input type="radio"/> No</p>	<p>Is <b>Thought Content</b> Within Normal Limits?  <input type="radio"/> Yes      <input type="radio"/> No</p>
<p><b>Behavior:</b>  <input type="checkbox"/> Aggressive      <input type="checkbox"/> Hostile      <input type="checkbox"/> Impulsive  <input type="checkbox"/> Immature      <input type="checkbox"/> Evasive      <input type="checkbox"/> Uncooperative  <input type="checkbox"/> Other</p>	<p><b>Thought Content:</b>  <input type="checkbox"/> Visual Hallucinations      <input type="checkbox"/> Auditory Hallucinations  <input type="checkbox"/> Delusions      <input type="checkbox"/> Loose associations  <input type="checkbox"/> Flight of Ideas      <input type="checkbox"/> Paranoid Ideation  <input type="checkbox"/> Other</p>
<p>Behavior Comments:</p>	<p>Thought Content Comments:</p>



<p>Are <b>Physical</b> and <b>Motor Abilities</b> Within Normal Limits?  <input type="radio"/> Yes      <input type="radio"/> No</p>	<p>Is <b>Thought Process</b> Within Normal Limits?  <input type="radio"/> Yes      <input type="radio"/> No</p>
<p><b>Physical and Motor:</b>  <input type="checkbox"/> Increased/Excessive      <input type="checkbox"/> Decreased/Slowed  <input type="checkbox"/> Posturing/Repetitive      <input type="checkbox"/> Tremors  <input type="checkbox"/> Tics      <input type="checkbox"/> Other</p>	<p><b>Thought Process:</b>  <input type="checkbox"/> Blocking/Slowed      <input type="checkbox"/> Racing Thoughts  <input type="checkbox"/> Impaired Concentration      <input type="checkbox"/> Poor Insight  <input type="checkbox"/> Other</p>
<p>Physical and Motor Comments:</p>	<p>Thought Process Comments:</p>
<p>Is <b>Cognition/ Intellect</b> Within Normal Limits?  <input type="radio"/> Yes      <input type="radio"/> No</p>	<p><b>Formal Mental Status Obtained</b>  <input type="radio"/> Yes      <input type="radio"/> No</p>
<p><b>Cognition/Intellect:</b>  <input type="checkbox"/> Weak Vocabulary      <input type="checkbox"/> Concrete Thinking  <input type="checkbox"/> Poor Judgment      <input type="checkbox"/> Other</p>	<p><b>Formal MSE:</b>  <input type="checkbox"/> Impaired S-T Memory      <input type="checkbox"/> Impaired L-T Memory  <input type="checkbox"/> Can't Do Serial 7's      <input type="checkbox"/> Can do Serial 7's  <input type="checkbox"/> Paucity of Knowledge      <input type="checkbox"/> Poor Orientation</p>
<p>Cognition/ Intellect Comments:</p>	
<p>Other MSE Information</p>	

**Tab 6 Infant Assessment Information: Must Complete for Pre To Three Assessment Type**

<b>Developmental Tools Used</b>	
<input type="checkbox"/> First (Under 6 Months)	<input type="checkbox"/> Ages and Stages (ASQ) <input type="checkbox"/> Other
<input type="checkbox"/> Emotional ASQ	<input type="checkbox"/> CBCL (2-3y.o.)
<input type="checkbox"/> PRQP (Parent Relationship Questionnaire)	<input type="checkbox"/> Sensory Profile
<b>Other Tools</b>	<b>Child's Adjusted Age</b>
<b>Physical Appearance</b>	
<input type="checkbox"/> Age Appropriate	<input type="checkbox"/> Disheveled <input type="checkbox"/> Physical Abnormalities <input type="checkbox"/> Hygiene Problems
<input type="checkbox"/> Fetal Alcohol Syndrome	<input type="checkbox"/> Down's syndrome <input type="checkbox"/> Other
<b>Reaction to New Environment</b>	
<b>Physiologic Development</b>	
<b>Effects of Self Regulation on Organized/Disorganized Behaviors</b>	
<b>State Regulation</b>	
<b>Sleep Schedule and Concerns (Reported or Observed, Caregiver's Concerns)</b>	
<b>Feeding Schedule and Concerns (Reported or Observed)</b>	
<b>Describe Sensory Regulation (See Mini Sensory profile Scanned)</b>	
<b>Play</b>	

**Tab 7 Diagnosis**

**Must be reviewed by Licensed/Waivered MD/NP, MFT/MFTI, LCSW/ASW, Psy (PhD/PyD), RN with Psych MS or Trainee with co-signature.**

Type of Diagnosis

- Admission    Discharge    Update

Date of Diagnosis

Time of Diagnosis

Diagnosing Practitioner

- Name/ID Number    Unique Practitioner ID

Trauma (CSI)

- Yes    No    Unknown

Has Substance Abuse/Dependence Diagnosis (CSI)

- Yes    No    Unknown

Substance Abuse/Dependence Diagnosis (CSI)

**AXIS I Diagnosis**

AXIS I - 1 (Primary Diagnosis)

AXIS I - 2

Axis I - 3

**AXIS II**

AXIS II – 1 (NO DIAGNOSIS code as V71.09)

AXIS II – 2

**AXIS III – Medical Conditions**

- Allergies
- Anemia
- Arterial Sclerotic Disease
- Arthritis
- Asthma
- Birth Defects
- Blind/Visually Impaired
- Cancer
- Carpal Tunnel Syndrome
- Chronic Pain
- Cirrhosis
- Cystic Fibrosis
- Deaf/Hearing Impaired
- Diabetes
- Digestive Disorders (Reflux, IBS)
- Ear Infections
- Epilepsy/Seizures
- Heart Disease
- Hepatitis
- Hypercholestoralemia
- Hyperlipidemia
- Hypertension
- Hyperthyroid
- Infertility
- Migraines
- Multiple Sclerosis
- Muscular Dystrophy
- No General Medical Condition
- Obesity
- Osteoporosis
- Other
- Parkinson’s Disease
- Physical Disability
- Psoriasis
- Sexually Transmitted Disease (STD)
- Stroke
- Tinnitus
- Ulcers
- Unknown/Not Reported General Medical Condition

**AXIS IV – Psychosocial and Environmental Problems**

- Problems with Primary Support Group
- problems related to social environment
- Educational problems
- Occupational problems
- Housing problems
- Economic problems
- Problems with access to health care
- Problems related to legal system/crime
- Other psychosocial/environment problems
- None Known

**Axis V – GAF**

**Do not change unless the Primary Dx is an Axis II Dx.  
Do not make Substance Use Dx a Primary Dx unless there is no other Dx.**

**Primary Diagnosis**

**Diagnostic Comments**

**Tab 8 Clinical Formulation/Medical Necessity**

May ONLY be completed by Licensed/Waivered MD/NP, MFT/MFTI, LCSW/ASW, Psy (PhD/PyD), 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

A probability the child will not progress developmentally as individually appropriate

- Yes
- No

**Clinical Formulation/Summary: (Incl. what Child/Family/School see as Successful Outcome, Stage of Change Details)**

**Additional Factors and Comments**

**SBMH I.E.P. Summary and Recommendations (I.E.P. Report)**

<b>SBMH Eligible? (I.E.P. Report)</b>
<input type="radio"/> Yes <input type="radio"/> No

**Tab 9 Finalize**

**Indicate other staff contributing to this assessment and their contribution.**

Contributing Practitioner

Area of Contribution

Send To (For "Pending Approval" Co-Signature)

Contributing Practitioner

Area of Contribution

**Draft/Pending Approval/Final**

- Draft       Final
- Pending Approval