SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

CLIENT NAME _____ **MH ID #** _____

YOUTH ADMISSION ASSESSMENT

CLIENT _____ **MH ID #** _____

Date _____ Team/Provider # _____

IDENTIFYING INFORMATION Birthdate ___/___/___ Sex M ☐ F ☐

Primary Language _____ Interpreter Needed Yes ☐ No ☐

School _____ _____ _____
Name District Grade

Special Education Certified Yes ☐ No ☐ 26.5 Referral Yes ☐ No ☐

Siblings (birthdates) _____

_____

Lives with _____ Relationship _____

Address _____ Phone _____

Father _____ DOB ___/___/___ Occupation _____

Home Phone _____ Business Phone _____

Address _____
City State Zip

Mother _____ DOB ___/___/___ Occupation _____

Home Phone _____ Business Phone _____

Address _____
City State Zip

If does not live with parent(s), "Informal Guardian" (for school) _____

Legal Status:

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

Other Legal Status Details

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CLIENT NAME _____ **MH ID #** _____

Court Status (Ward or Dependent), if applicable _____

Court Appointed Legal Guardian (for medical care) _____

SW/PO Name _____ Phone _____

Referred by _____ Position _____ Phone _____

Prior Activity with Mental Health Yes ☐ No ☐

Agency Involvements:

_____

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

PRESENTING ISSUES / REASON FOR REFERRAL (Information from referral source, school, parent and child; description of behavior)

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INDIVIDUAL and FAMILY STRENGTHS (Competencies, strengths and resources, emphasizing child and family viewpoint)

PSYCHOSOCIAL HISTORY Include, school, cultural/spiritual background, family history, individual/family psychiatric history, and employment, if any. Specify incidents of abuse and/or neglect.

DEVELOPMENT HISTORY:

SUBSTANCE ABUSE HISTORY

Does the child use alcohol and/or drugs of abuse?	Yes ☐	No ☐
Has the child missed school or been otherwise impaired by alcohol and/or drug use?	Yes ☐	No ☐
Is the family concerned about child's alcohol and/or drug use?	Yes ☐	No ☐
Past or current abuse in parents or caregivers?	Yes ☐	No ☐

☐ **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					

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MEDICAL HISTORY

Primary Physician _____
Name Phone #

Other Medical Providers _____
Name Phone #

Records Requested Yes☐ Date _____ No☐

Hospitalizations (include psychiatric) _____

Dates and Types of Surgeries _____

Allergies _____

Current Medication _____

Previous Medications _____

RISK FACTORS ☐ Harm to Self ☐ Harm to Others ☐ None, Level of Risk: ☐Low ☐Moderate ☐High

Current ideation (describe using client statements)
Expressed intent (describe using client statements)
Specific Plan (describe using client statements. How detailed is the plan? Is client making preparations like giving away belongings or preparing a will?)
Ease & means of availability
Access to firearms/ weapons in the home
Degree of perceived Hopeless-/ helplessness
Reliability of impulse control and judgement
Amount of & ability to use, supportive resources

LETHALITY OF PRIOR SUICIDE/ SELF HARM ATTEMPTS		Seriousness of Previous Suicide Attempts **0 – 4 (minimal – severe)**
Description	**Date**	
1.		
2.		
3.		

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Overall Summary/Evaluation of current Risk/Trauma/AOD Use

MENTAL STATUS EXAM: *May ONLY be completed by Licensed/Registered/Waivered MD/NP, MFT/AMFT, LCSW/ASW,LPCC, PhD/PsyD, RN with Psych MS or training 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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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:

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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:

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)

Authorized Clinical Staff* involved in assessment interview
Signature and Date

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

Authorized Clinical Staff* involved in assessment interview
Signature and Date

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.**)

Authorized Clinical Staff* involved in assessment interview
Signature and Date
*Trainee or staff without qualifying degree or license.