



MR#:
Name:

**1** = Required for Initial Assessment  
**2** = Required for Initial Assessment – Pre to Three (PT3)  
**3** = Required for Initial Assessment – SBMH  
**4** = Required for Reassessment

**LPHA Only** = Only an LPHA may complete these sections/items

## Client Information and Registration

Client Information		1	2	3	4
Client Legal Name	Medical Record #				
Client Preferred Name (if different from Legal Name)					
Birth Date	Age				
Agency/Program	Admission Date				
Current Insurance (Check all that apply) <input type="checkbox"/> Medicare <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Private Insurance: _____					

Assessment Information		1	2	3	4
Assessment Type	<input type="checkbox"/> Initial Assessment <input type="checkbox"/> Initial Assessment – PT3 <input type="checkbox"/> Reassessment <input type="checkbox"/> Initial Assessment – SBMH <input type="checkbox"/> Update Assessment				
Assessment Date					
Source of Information	<input type="checkbox"/> School <input type="checkbox"/> PES <input type="checkbox"/> Family / Relative <input type="checkbox"/> Referral Packet <input type="checkbox"/> Primary Care Physician <input type="checkbox"/> Child <input type="checkbox"/> Probation <input type="checkbox"/> Parent / Guardian / Caretaker <input type="checkbox"/> Other _____ <input type="checkbox"/> Social Services				

Referral Information					
Referral Source	<input type="checkbox"/> Self <input type="checkbox"/> Family Member <input type="checkbox"/> Significant Other <input type="checkbox"/> Friend / Neighbor <input type="checkbox"/> School <input type="checkbox"/> Fee-For-Service Provider <input type="checkbox"/> Medi-Cal Managed Care Plan <input type="checkbox"/> Federally Qualified Health Center <input type="checkbox"/> Emergency Room	<input type="checkbox"/> Mental Health Facility/ Community Agency <input type="checkbox"/> Social Services Agency <input type="checkbox"/> Substance Abuse Treatment Facility / Agency <input type="checkbox"/> Faith-based Organization <input type="checkbox"/> Other County / Community Agency <input type="checkbox"/> Homeless Services <input type="checkbox"/> Street Outreach	<input type="checkbox"/> Juvenile Hall / Camp / Ranch/Division of Juvenile Justice <input type="checkbox"/> Probation/Parole <input type="checkbox"/> Jail / Prison <input type="checkbox"/> State Hospital <input type="checkbox"/> Crisis Services <input type="checkbox"/> Mobile Evaluation <input type="checkbox"/> Other referred _____		
Referral Contact Name		Agency/Program			
Referrer Phone		Referrer Email			



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Referral Reason			1	2	3		
Referral Reason	<input type="checkbox"/> Delay on ASQ (P-3)	<input type="checkbox"/> School Problems	<input type="checkbox"/> Hospitalization				
	<input type="checkbox"/> AOD Exposure (P-3)	<input type="checkbox"/> Relating / Communication Problems	<input type="checkbox"/> Child / Caretaker Relationship Probs.				
	<input type="checkbox"/> Regulatory / Sleep / Feeding Problems (P-3)	<input type="checkbox"/> Developmental Problems	<input type="checkbox"/> Trauma Exposure				
	<input type="checkbox"/> Premature (P-3)	<input type="checkbox"/> Affect / Mood / Anxiety Problems	<input type="checkbox"/> CPS				
	<input type="checkbox"/> R/O GGRC Referral (P-3)	<input type="checkbox"/> Adjustment Reactions	<input type="checkbox"/> Behavior Problems				
		<input type="checkbox"/> Out of Home Placement	<input type="checkbox"/> Other _____				

Minor Consent Information		1	2	3	4	
Is client consenting to services under minor consent?	<input type="checkbox"/> Yes <input type="checkbox"/> No					
If Yes to above, does minor have Minor Consent Medi-Cal?	<input type="checkbox"/> Yes <input type="checkbox"/> No					

## Client Contact Information

*Ensure that all Releases of Information are current for all individuals / entities with whom communication will or may occur.*

Client Contact Information		1	2	3		
Phone Number (Primary)	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work					
Phone Number (Second)	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work					
Phone Number (Third)	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work					
Address	Apt/Suite					
City	Zipcode					

Parent / Guardian Contact information		1	2	3		
Parent / Guardian Full Name						
Phone Number (Primary)	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work					
Phone Number (Second)	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work					
Phone Number (Third)	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work					
Additional Parent / Guardian / Foster Parent Info (e.g., who youth lives with, Contact Information, Custody arrangements, Signing Authority) [IEP Report]						



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Emergency Contact		1	2	3		
Name		Phone Number				
Relationship		ROI Current <input type="checkbox"/> Yes <input type="checkbox"/> No				

Other Providers Contact Information									
Current Provider	Name / Agency	Job Title	Phone	Email					
<input type="checkbox"/>									
<input type="checkbox"/>									
<input type="checkbox"/>									
<input type="checkbox"/>									
<input type="checkbox"/>									
<input type="checkbox"/>									

Other Contact Information								
Name	Phone	Email	Relationship					



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**Domain 1 – Presenting Problems**

*Presenting Problem(s), Current Mental Status, History of Presenting Problem(s), Member-Identified Impairment(s)*

**Presenting Problem**

**Description of Presenting Problems** *(Current Problem, Acute Condition, Level of Distress, Collateral, Severity, Context, and Cultural Understanding)* ① ② ③ ④ [IEP Report]

**History of Presenting Problems** ① ② ③ [IEP Report]

**Client's Impairments in Functioning as Identified by Client and/or Collaterals** ① ② ③ ④



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Mental Status Exam					LPHA Only
<p><i>May ONLY be completed by Licensed/Registered/Waivered MD/OD/NP, MFT/AMFT, LPCC, LCSW/ASW, PhD/PsyD, RN with Psych MS or training or Clinical Trainee with co-signature.</i></p>					
<p><b>General Appearance</b> ① ③ ④</p> <p><input type="checkbox"/> Within Normal Limits    <input type="checkbox"/> Hygiene Problems  <input type="checkbox"/> Disheveled                <input type="checkbox"/> Odd/Eccentric  <input type="checkbox"/> Other*</p>			<p><b>Thought Content</b> ① ③ ④</p> <p><input type="checkbox"/> Within Normal Limits    <input type="checkbox"/> Loose Associations  <input type="checkbox"/> Visual Hallucinations    <input type="checkbox"/> Flight of Ideas  <input type="checkbox"/> Auditory Hallucinations   <input type="checkbox"/> Paranoid Ideation  <input type="checkbox"/> Delusions                    <input type="checkbox"/> Other*</p>		
<p><b>Affect</b> ① ③ ④</p> <p><input type="checkbox"/> Within Normal Limits    <input type="checkbox"/> Anxious  <input type="checkbox"/> Sad                            <input type="checkbox"/> Labile  <input type="checkbox"/> Withdrawn                 <input type="checkbox"/> Flatten  <input type="checkbox"/> Angry                        <input type="checkbox"/> Other*  <input type="checkbox"/> Incongruent</p>			<p><b>Thought Process</b> ① ③ ④</p> <p><input type="checkbox"/> Blocking / Slowed            <input type="checkbox"/> Poor Insight  <input type="checkbox"/> Racing Thoughts            <input type="checkbox"/> Other*  <input type="checkbox"/> Impaired Concentration</p>		
<p><b>Physical and Motor</b> ① ③ ④</p> <p><input type="checkbox"/> Within Normal Limits    <input type="checkbox"/> Posturing / Repetitive  <input type="checkbox"/> Increased / Excessive    <input type="checkbox"/> Tremors  <input type="checkbox"/> Decreased / Slowed      <input type="checkbox"/> Other*  <input type="checkbox"/> Tics</p>			<p><b>Speech</b> ① ③ ④</p> <p><input type="checkbox"/> Within Normal Limits    <input type="checkbox"/> Poverty of Speech  <input type="checkbox"/> Pressured                    <input type="checkbox"/> Mute  <input type="checkbox"/> Perseverative              <input type="checkbox"/> Other*  <input type="checkbox"/> Impairment</p>		
<p><b>Mood</b> ① ③ ④</p> <p><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"/> Other*  <input type="checkbox"/> Angry</p>			<p><b>Cognition / Intellect</b> ① ③ ④</p> <p><input type="checkbox"/> Within Normal Limits    <input type="checkbox"/> Poor Judgment  <input type="checkbox"/> Weak Vocabulary         <input type="checkbox"/> Other*  <input type="checkbox"/> Concrete Thinking</p>		
<p><b>Behavior</b> ① ③ ④</p> <p><input type="checkbox"/> Within Normal Limits    <input type="checkbox"/> Immature                    <input type="checkbox"/> Evasive                      <input type="checkbox"/> Uncooperative  <input type="checkbox"/> Aggressive                <input type="checkbox"/> Hostile                      <input type="checkbox"/> Impulsive                  <input type="checkbox"/> Other*</p>					
<p><b>Was a Formal Mental Status Obtained?</b></p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>			<p><b>Formal Mental Status Exam Results</b></p> <p><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><b>*Other Mental Status Exam Information</b> (also include explanation if "other" was selected for any of the items above)</p>					



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**Domain 2 – Trauma**

*Trauma History, Trauma Symptoms and Reactions, Trauma Screening Results*

Trauma History				1	2	3	4
<b>Child / Youth Trauma History</b> (select 1 or more) 1 2 3 4							
<input type="checkbox"/> Physical Abuse	<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Immigration/Displacement	<input type="checkbox"/> Other				
<input type="checkbox"/> Sexual Abuse	<input type="checkbox"/> Military Combat	<input type="checkbox"/> Separation	<input type="checkbox"/> Unknown				
<input type="checkbox"/> Assault	<input type="checkbox"/> Torture	<input type="checkbox"/> Suspected	<input type="checkbox"/> None				
<b>Family Trauma History</b> (select 1 or more) 1 2 3 4							
<input type="checkbox"/> Physical Abuse	<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Immigration/Displacement	<input type="checkbox"/> Other				
<input type="checkbox"/> Sexual Abuse	<input type="checkbox"/> Military Combat	<input type="checkbox"/> Separation	<input type="checkbox"/> Unknown				
<input type="checkbox"/> Assault	<input type="checkbox"/> Torture	<input type="checkbox"/> Suspected	<input type="checkbox"/> None				
<b>Current Domestic Violence Issues?</b> 1 2 3 4				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Past Domestic Violence Issues?</b> 1 2 3 4				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Victim of Violence?</b> 1 2 3 4				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Trauma History Not Previously Specified</b> (including but not limited to past or present, juvenile justice, criminal justice, social services involvement, adverse childhood events, etc.)							

**Trauma Symptoms and Reactions**

**Trauma Reactions** *The client's reaction / impact of traumatic situations (e.g., PTSD symptoms, avoidance of feelings, irritability, interpersonal problems, etc.).*

**Trauma Screening**

\_\_\_\_\_



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## Domain 3 – Behavioral Health History

*Behavioral Health History, Co-occurring Substance Use*

### Mental Health History

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**Mental Health Outpatient Treatment History** *(incl. Providers and dates, therapeutic interventions, and responses)*

- ① ② ③ ④

**Psychiatric Hospitalization / Partial Hospitalization History / Residential** *(incl. provider and dates)* ① ② ③ ④

**Additional Information Regarding Mental Health History That Has Not Yet Been Mentioned**

### Co-Occurring Substance Use History

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**SUD Outpatient Treatment History** *(incl. Providers and dates, therapeutic interventions, and responses)*

**SUD Hospitalization / Partial Hospitalization History / Residential Treatment History** *(incl. provider and dates)*



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**Substance Use / Abuse / Misuse History**

**Substance Use Issues Impacting Client** (select 1 or more) **1 2 3 4**

- Current Substance Abuse
- Abuse / Misuse of Prescription Drugs
- Abuse / Misuse of Caffeine
- Abuse / Misuse of Narcotics
- Abuse / Misuse of OTC Medications
- Past Substance Abuse History
- Use of Illicit Drugs
- Use Impacts Functioning/Presenting Problems
- None
- Unknown
- Other

**Does Substance Use Impact Risk?**     Yes     No     Unknown

**Current and Past Use** (*Drug Name, Method, Frequency, and Date of Last Use*) – You may use the free text box and/or the grid below.

Substance	Age of 1 <sup>st</sup> 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					

Client supplied a urine specimen for tox screen.     Yes     No     Not Applicable

Results of Tox Screen





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## Domain 4 – Medical History

Medical History, Current Medications, Co-occurring Conditions (other than substance use)

### Medical History

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**Co-Occurring Conditions** (Includes Current Chronic Medical Conditions, Sleep Disorders, etc.) (Does Not Include Co-Occurring Substance Use) **1 2 3 4**

**Medical History** (Other Conditions Not Mentioned, Including Significant Illnesses, Past Chronic Conditions / Treatment History / Surgeries / Allergies) **1 2 3 4**

**Developmental History** (incl. pre-natal and peri-natal events; developmental milestones and delays; attachment and separation issues) **1 2 3**



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**Medication History**

- 1
- 2
- 3
- 4

**Current Medications** (incl. Prescriber, Medication Name, Usage, Dosage, Frequency, Adherence, Adverse Reactions, Response, Start Dates) – You may use the free text box and/or the grid below.

Current RX Med.	Amount	Frequency	Prescribed By	Purpose of Med.
OTC/Herbs	Amount	Frequency	Prescribed By	Purpose of Med.

**Past Medications (Medication History)** (incl. Prescriber, Medication Name, Usage, Dosage, Frequency, Adherence, Adverse Reactions, Response, Start/End Dates)



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**Domain 5 – Social and Cultural History**

*Social and Life Circumstances, Culture/Religion/Spirituality*

Social and Life Circumstances (CSI)		1	2	3	4
Number of Children <b>Under the Age of 18</b> the Client Cares for or Is Responsible For At Least 50% of the Time (CSI)					
Number of Dependent Adults <b>Age 18 or Older</b> the Client Cares for or Is Responsible For At least 50% of the Time (CSI)					
<b>Living Arrangement (CSI)</b>					
<input type="checkbox"/> House or apartment (includes trailers, hotels, dorms, barracks, etc.)	<input type="checkbox"/> Adult Residential Facility, Social Rehabilitation Facility, Crisis Residential, Transitional Residential, Drug Facility, Alcohol Facility	<input type="checkbox"/> Mental Health Rehabilitation Center (24 hour)	<input type="checkbox"/> Residential Treatment Center (includes Levels 13-14 for children)		
<input type="checkbox"/> House or apartment and requiring some support with daily living activities (applies to adults only)	<input type="checkbox"/> Justice Related (Juvenile Hall, CYA home, correctional facility, jail, etc.)	<input type="checkbox"/> Skilled Nursing Facility / Intermediate Care Facility / Institute of Mental Disease (IMD)	<input type="checkbox"/> Group Home (includes Levels 1-12 for children)		
<input type="checkbox"/> House or apartment and requiring daily support and supervision (applies to adults only)	<input type="checkbox"/> Community Treatment Facility	<input type="checkbox"/> Inpatient Psychiatric Hospital, Psychiatric Health Facility (PHF), or Veterans Affairs (VA) Hospital	<input type="checkbox"/> Foster family home		
<input type="checkbox"/> Supported housing (applies to adults only)		<input type="checkbox"/> State Hospital	<input type="checkbox"/> Homeless, no identifiable residence*		
<input type="checkbox"/> Board and Care			<input type="checkbox"/> Other		
			<input type="checkbox"/> Unknown / Not Reported		
<b>Homeless Category (CSI)*</b>		<input type="checkbox"/> Shelter	<input type="checkbox"/> Street (Including vehicle, RV, tent)		
<i>*Required if indicated Homeless above</i>		<input type="checkbox"/> Transitional	<input type="checkbox"/> Permanent Supportive Housing		
		<input type="checkbox"/> Doubling Up	<input type="checkbox"/> Unknown		

Social and Life Circumstances					
<b>Daily Activities, Social Networks, Community Engagement</b> <i>Psychosocial History / Family History / Immigration History / Relationships / Interests / Social Activities and Supports</i>					



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Education	
<b>Education (Highest Grade level Completed) (CSI) ① ③ ④</b> <input type="checkbox"/> None, Kindergarten <input type="checkbox"/> Other - Includes vocational education and training. <input type="checkbox"/> Unknown / Not Reported	
<input type="checkbox"/> Grade levels - Indicate highest grade completed. Grades 1-20: _____ <i>(If the highest grade completed is greater than 20, code 20 as the highest grade completed.)</i>	
Current Grade Level ③	
Current District / School Placement ③	
<b>Education Details [IEP Report] ③</b>           	

Special Education	
<b>Special Education Eligibility Date</b>	
<b>Special Education Eligibility Status</b>	<input type="checkbox"/> Autism <input type="checkbox"/> Deaf <input type="checkbox"/> Deaf-Blind <input type="checkbox"/> Hard of Hearing <input type="checkbox"/> Intellectual Disability <input type="checkbox"/> Multi-Handicapped
	<input type="checkbox"/> Orthopedically Impaired <input type="checkbox"/> Other health Impaired <input type="checkbox"/> Emotional Disturbance <input type="checkbox"/> Specific Learning Disability <input type="checkbox"/> Speech Impaired
	<input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Visually Handicapped <input type="checkbox"/> Yes, Unknown Eligibility <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown
<b>Other Legal Status, Special Education and Admission Details</b>	



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**Employment**

**Employment Status (CSI) 1 3 4**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Employed in competitive job market<br>(Full Time, 35 hours or more per week)      | <input type="checkbox"/> Actively looking for work | <input type="checkbox"/> Resident / Inmate of Institution |
| <input type="checkbox"/> Employed in competitive job market<br>(Part Time, less than 35 hours per week)    | <input type="checkbox"/> Homemaker                 | <input type="checkbox"/> Other                            |
| <input type="checkbox"/> Employed in noncompetitive job market<br>(Full Time, 35 hours or more per week)   | <input type="checkbox"/> Student                   | <input type="checkbox"/> Unknown / Not Reported           |
| <input type="checkbox"/> Employed in noncompetitive job market<br>(Part Time, less than 35 hours per week) | <input type="checkbox"/> Volunteer Worker          |   |
|  | <input type="checkbox"/> Retired                   |   |

**Employment Details**

**Legal Involvement**

**Conservatorship / Court Status (CSI) 1 2 3 4**

- |   |   |
|---|---|
| <input type="checkbox"/> Temporary Conservatorship                    | <input type="checkbox"/> Juvenile Court, Dependent of the Court   |
| <input type="checkbox"/> Lanterman-Petris-Short                       | <input type="checkbox"/> Juvenile Court, Ward - Status Offender   |
| <input type="checkbox"/> Murphy                                       | <input type="checkbox"/> Juvenile Court, Ward - Juvenile Offender |
| <input type="checkbox"/> Probate                                      | <input type="checkbox"/> Not Applicable                           |
| <input type="checkbox"/> PC 2974                                      | <input type="checkbox"/> Unknown / Not Reported                   |
| <input type="checkbox"/> Representative Payee Without Conservatorship |   |

**Juvenile Justice History (incl. Gang affiliation, etc.)**



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Military History					

Culture / Religion / Spirituality	1	2	3	4	



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SOGIE		1	2	3	4
What is your sexual orientation?	<input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Lesbian or Gay <input type="checkbox"/> Another If Another Sexual Orientation:	<input type="checkbox"/> Bisexual <input type="checkbox"/> Queer <input type="checkbox"/> Asexual	<input type="checkbox"/> Don't know / Declined to Answer <input type="checkbox"/> Did not ask		
What is your current gender identity?	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Another If Another Gender Identity:	<input type="checkbox"/> Male to Female / Transgender Female <input type="checkbox"/> Female to Male / Transgender Male	<input type="checkbox"/> Genderqueer not exclusive male / female <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Did not ask		
What are your pronouns?	<input type="checkbox"/> He / Him <input type="checkbox"/> Another If Another Pronoun:	<input type="checkbox"/> She / Her <input type="checkbox"/> They / Them	<input type="checkbox"/> Declined to Answer <input type="checkbox"/> Did not ask		
What sex were you assigned at birth on your original birth certificate?	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Another If Another Sex Assigned at Birth:	<input type="checkbox"/> Declined to Answer <input type="checkbox"/> Did not ask			
Have you been diagnosed by a Doctor with an intersex condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Declined to Answer <input type="checkbox"/> Did not ask			

Ethnicity			1	2	3	4
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Puerto Rican	<input type="checkbox"/> Not Of Hispanic Origin				
<input type="checkbox"/> Cuban	<input type="checkbox"/> Other Hispanic	<input type="checkbox"/> Unknown/ Not Reported				

Race				1	2	3	4
<input type="checkbox"/> Amerasian	<input type="checkbox"/> Guamanian	<input type="checkbox"/> Laotian	<input type="checkbox"/> Other Pacific Islander				
<input type="checkbox"/> American Native	<input type="checkbox"/> Hawaiian Native	<input type="checkbox"/> Mien	<input type="checkbox"/> Samoan				
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Multiple	<input type="checkbox"/> Tongan				
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Hmong	<input type="checkbox"/> Other	<input type="checkbox"/> Unknown/ Not Reported				
<input type="checkbox"/> Cambodian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Vietnamese				
<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Other Asian or Pacific Islander	<input type="checkbox"/> White / Caucasian				
<input type="checkbox"/> Filipino							



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Language for Assessment		1	2	3	4
Is Client able to communicate in English?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Was Interpreter Used?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Interpreter			
Language in which Assessment was conducted					

Client's Language(s)							1	2	3	4
Client's Primary Language	Client's Preferred Language	Language of Client's Family		Client's Primary Language	Client's Preferred Language	Language of Client's Family				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	American Sign Language (ASL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				Mandarin
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arabic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				Mien
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Armenian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				Other Chinese Dialects
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cambodian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				Other Non-English
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cantonese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				Other Sign Language
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				Polish
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Farsi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				Portuguese
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	French	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				Russian
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hebrew	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				Samoan
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hmong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				Spanish
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Llocano	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				Tagalog
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Italian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				Thai
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Japanese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				Turkish
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Korean	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				Unknown / Not Reported
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lao	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				Vietnamese





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**Domain 6 – Strengths and Risk Factors**

*Strengths, Risk Behaviors, and Protective Factors*

Strengths and Protective Factors	1	2	3	4
<p><b>Youth and Family Strengths, Positive Coping Skills, Values, Motivations, Desires, Hobbies, Interests, Available Resources and Supports [IEP Report]</b></p>				

Risk Factors and Behaviors		1	2	3	4
<p><b>Risk HARM TO SELF/SUICIDAL Thoughts/Behavior</b>  <b>1 2 3 4</b></p> <p><input type="checkbox"/> Yes                      <input type="checkbox"/> Undetermined  <input type="checkbox"/> Denied</p>	<p><b>Past HARM TO SELF/SUICIDAL Thoughts/Behavior</b>  <b>1 2 3 4</b></p> <p><input type="checkbox"/> Yes                      <input type="checkbox"/> Unknown  <input type="checkbox"/> Denied</p>				
<p><b>Current HARM TO OTHERS/HOMICIDAL Thoughts</b>  <b>1 2 3 4</b></p> <p><input type="checkbox"/> Yes                      <input type="checkbox"/> Undetermined  <input type="checkbox"/> Denied</p>	<p><b>Past HARM TO OTHERS/HOMICIDAL Thoughts</b>  <b>1 2 3 4</b></p> <p><input type="checkbox"/> Yes                      <input type="checkbox"/> Unknown  <input type="checkbox"/> Denied</p>				
<p><b>Recklessness / Engaged in Violent Acts?</b> (physical, sexual, vandalism) <b>1 2 3 4</b></p> <p><input type="checkbox"/> Yes                      <input type="checkbox"/> Unknown  <input type="checkbox"/> Denied</p>	<p><b>Access to FIREARMS / WEAPONS</b>  <b>1 2 3 4</b></p> <p><input type="checkbox"/> Yes                      <input type="checkbox"/> Undetermined  <input type="checkbox"/> Denied</p>				
<p><b>Risk factors For Danger to Self or Others, and Gravely Disabled</b></p>					



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Risk Factors and Behaviors				
<p><b>Sexual History / HIV Risk (RESTRICTED)</b></p>          				
<p><b>Triggers for Risk</b> <i>(if not previously mentioned in Trauma section)</i></p>          				



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Name:

## Domain 7 – Clinical Summary

*Clinical Summary and Recommendations, Diagnostic Impression, Medical Necessity Determination/LOC/Access Criteria. All items in Domain 7 must be completed by an LPHA.*

LPHA Required Fields for CSI	1	2	3	4	LPHA Only
Has client experienced traumatic events?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes    No    Unknown	
Does client have a substance abuse/dependence diagnosis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes    No    Unknown / Not Reported	
Substance Abuse / Dependence Diagnosis					

Treatment Recommendation	1	2	3	4	LPHA Only
<b>Treatment is being provided to address an important area of life functioning</b>					
<input type="checkbox"/> School / Work Functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Social Relationships    Daily Living Skills	
<input type="checkbox"/> Ability to maintain placement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Symptom Management    Does Not Meet Criteria to Access SMHS	
<b>Recommendations for Interventions and Goals</b>					

Service Strategies (CSI)		1	2	3	4	LPHA Only
Evidenced Based Practices						Service Strategies
<input type="checkbox"/> Assertive Community Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peer/Family Delivered    Delivered in Partnership with Substance Abuse Services	
<input type="checkbox"/> Supportive Employment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psycho-Education    Integrated Services for MH & Aging	
<input type="checkbox"/> Supportive Housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family Support    Integrated Services for MH & Developmental Disability	
<input type="checkbox"/> Family Psychoeducation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Supportive Education    Ethnic-Specific Service Strategy	
<input type="checkbox"/> Integrated Dual Diagnosis Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Delivered in Partnership with Law Enforcement    Age-Specific Service Strategy	
<input type="checkbox"/> Illness Management and Recovery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Delivered in Partnership with Health Care	
<input type="checkbox"/> Medication Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Delivered in Partnership with Social Services	
<input type="checkbox"/> New Generation Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Delivered in Partnership with Social Services	
<input type="checkbox"/> Therapeutic Foster Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Delivered in Partnership with Social Services	
<input type="checkbox"/> Multisystemic Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Delivered in Partnership with Social Services	
<input type="checkbox"/> Functional Family Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Delivered in Partnership with Social Services	
<input type="checkbox"/> Unknown Evidence-Based Practice/ Service Strategy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Delivered in Partnership with Social Services	



MR#:
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Clinical Impressions				
<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>LPHA Only</b>
<b>Clinical Formulation / Summary</b> <i>(incl. current presenting issues, course of treatment, impairments, diagnostic criteria, strengths)</i>				
<b>Additional Factors or Comments</b>				

School Based Mental Health			
		<b>3</b>	<b>LPHA Only</b>
<b>SBMH Eligible? [IEP Report]</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>SBMH IEP Summary and Recommendations [IEP Report]</b>			



**CalAIM Assessment  
 Youth (17 and Younger)**

MR#: \_\_\_\_\_  
 Name: \_\_\_\_\_

Problem List							1	2	3	4	LPHA Only
DSM V Diagnosis / Problem List Item	ICD 10 Code	Date Added	Date Removed	Added or Removed By (Full Name of Staff)	Provider Title / Discipline	Primary Dx					SUD Dx
						<input type="checkbox"/>					<input type="checkbox"/>
						<input type="checkbox"/>					<input type="checkbox"/>
						<input type="checkbox"/>					<input type="checkbox"/>
						<input type="checkbox"/>					<input type="checkbox"/>
						<input type="checkbox"/>					<input type="checkbox"/>
						<input type="checkbox"/>					<input type="checkbox"/>
						<input type="checkbox"/>					<input type="checkbox"/>
						<input type="checkbox"/>					<input type="checkbox"/>
						<input type="checkbox"/>					<input type="checkbox"/>
						<input type="checkbox"/>					<input type="checkbox"/>

General Medical Conditions (CSI) Check identifying physical health condition(s) as reported by client.												1	2	3	4	LPHA Only
17 = Allergies	<input type="checkbox"/>	11 = Cirrhosis	<input type="checkbox"/>	04 = Hyperlipidemia	<input type="checkbox"/>	31 = Physical Disability	<input type="checkbox"/>									
16 = Anemia	<input type="checkbox"/>	07 = Cystic Fibrosis	<input type="checkbox"/>	05 = Hypertension	<input type="checkbox"/>	08 = Psoriasis	<input type="checkbox"/>									
01 = Arterial Sclerotic Disease	<input type="checkbox"/>	25 = Deaf/Hearing Impaired	<input type="checkbox"/>	14 = Hyperthyroid	<input type="checkbox"/>	36 = Sexually Transmitted	<input type="checkbox"/>									
19 = Arthritis	<input type="checkbox"/>	12 = Diabetes	<input type="checkbox"/>	13 = Infertility	<input type="checkbox"/>	32 = Stroke	<input type="checkbox"/>									
35 = Asthma	<input type="checkbox"/>	09 = Digest Reflux, Irritable Bowel	<input type="checkbox"/>	27 = Migraines	<input type="checkbox"/>	33 = Tinnitus	<input type="checkbox"/>									
06 = Birth defects	<input type="checkbox"/>	34 = Ear Infections	<input type="checkbox"/>	28 = Multiple Sclerosis	<input type="checkbox"/>	10 = Ulcers	<input type="checkbox"/>									
23 = Blind/Visually Impaired	<input type="checkbox"/>	26 = Epilepsy/Seizures	<input type="checkbox"/>	29 = Muscular Dystrophy	<input type="checkbox"/>	00 = No Gen. Medical Condition	<input type="checkbox"/>									
22 = Cancer	<input type="checkbox"/>	02 = Heart Disease	<input type="checkbox"/>	15 = Obesity	<input type="checkbox"/>	37 = Other	<input type="checkbox"/>									
20 = Carpal Tunnel Syndrome	<input type="checkbox"/>	18 = Hepatitis	<input type="checkbox"/>	21 = Osteoporosis	<input type="checkbox"/>	99 = Unk/Not Report'd. GMC	<input type="checkbox"/>									
24 = Chronic Pain	<input type="checkbox"/>	03 = Hypercholesterolemia	<input type="checkbox"/>	30 = Parkinson's Disease	<input type="checkbox"/>	31 = Physical Disability	<input type="checkbox"/>									



MR#:
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Diagnosis Comments	1	2	3	4	LPHA Only

Contributing Practitioner					LPHA Only
Contributing Practitioner 1					
Area of Contribution					
Contributing Practitioner 2					
Area of Contribution					

\_\_\_\_\_  
**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.)