**San Diego County Mental Health Services**

**BEHAVIORAL HEALTH ASSESSMENT – CHILDREN**

**\*Client Name**:       \***Case #:**

**\*Assessment Date**       \***Program Name**:

**BHA CHILDREN TAB**

**PATHWAYS TO WELL-BEING/KTA**

Client is involved with Child Welfare Services [ ]  No [ ]  Yes

May call CWS at: 858-514-6995 to obtain name of current worker.

CWS PSW:       PSW Phone:       PSW Email:

1. Legal Status for CWS client:

[ ]  VS – Voluntary Services: *(CWS has not filed a petition due to intent to divert from dependency by providing services; Court does not have jurisdiction.)*

[ ]  Pre-Adjudication: *(CWS has filed a petition in Court; child may be with parents or may have been removed and dependency has not yet been established.)*

[ ]  FM – Family Maintenance: *(Court has jurisdiction; dependent placed at home with parent.)*

[ ]  FR – Family Reunification: *(Court has jurisdiction; dependent in out of home placement.)*

[ ]  EFC – Extended Foster Care:

[ ]  PP – Permanent Plan *(Court has jurisdiction)* – specify:

* + 1. [ ] APPLA: another planned permanent living arrangement
		2. [ ] Legal Guardianship is pending; once finalized, dependency ends
		3. [ ] Adoption is pending; once finalized, dependency ends
1. CWS Child Living Arrangement:

[ ]  Parents

[ ]  Relative

[ ]  Non-Relative Extended Family Member *(NREFM)*

[ ]  Licensed Foster Home

[ ]  San Pasqual Academy

[ ]  Supervised Independent Living Placement *(SILP)*

[ ]  Foster Family Agency Home *(FFA)*

[ ]  Licensed Group Home *(LGH)*

[ ]  Residential Treatment Center *(RTC)* *[LGH with a Mental Health Contract]*

[ ]  Short Term Residential Therapeutic Program *(STRTP)*

FFA Name:

LGH Name:

RTC Name:       [ ]  RTC Level 12 [ ]  RTC Level 14

STRTP Name:

1. Petition True Finding *(may be multiple)***:** (*Based on Welfare and Institution Code, Section 300, as adjudicated by Juvenile Court)*

[ ]  Physical Abuse

[ ]  Neglect *(general or severe)*

[ ]  Emotional Abuse

[ ]  Sexual Abuse

[ ]  Severe Physical Abuse of child under the age of five

[ ]  Death of another child *(caused by parent)*

[ ]  No parent or guardian

[ ]  Freed for adoption and adoption petition not granted

[ ]  Cruelty

[ ]  Child/client at risk due to abuse of sibling

1. **Katie A. Class or Sub-Class status (select one based on completed Katie A. Eligibility form):**

*(Not member of class or Sub-Class; no Child Welfare Services involvement; CWS section not applicable. Eligibility status pending; must determine Class vs. Sub-Class status within 30 days of assignment opening.)*

[ ]  Member of Class

[ ]  Member of Sub-Class

[ ]  Not member of Class or Sub-Class

[ ]  Eligibility status pending

1. **ICC and/or IHBS Eligibility *Screening*:** *(Based on assessment of child/youth strengths and needs as documented in presenting problem and based on the following indications):*

ICC may be indicated when a youth is:

* Risk of psychiatric hospitalization
* Recently discharged from hospitalization *(generally within last 90 days)*
* Recently discharged from Emergency Screening Unit/ North County Crisis, Intervention and Response Team *(generally within last 90 days)*
* At risk of needing crisis stabilization *(Emergency Screening Unit or North County Crisis, Intervention and Response Team)*
* Placed in, being considered for, or recently discharged from an STRTP, CFT, or PHF
* Receiving intensive services from programs such as:
	+ Crisis Action Connection
	+ Therapeutic Behavioral Services *(TBS)*
	+ Wraparound
	+ Comprehensive Assessment and Stabilization Services *(CASS)*
	+ Foster Family Agency Stabilization and Treatment *(FFAST)*

**Child/Youth meets minimum criteria for ICC and/or IHBS:** *(which requires pre-authorization)*

**[ ]** Yes [ ]  No

OTHER AGENCY INVOLVEMENT:**[ ]** Regional Center [ ]  Probation [ ] Other:

\*SOURCE OF INFORMATION:*(Select from Source of Information Table located in the Instructions sheet)*

 If other, specify

 Reports Reviewed:

Referral Source: *(Select from Referral Source Table below. Include name, person or agency, relationship, and contact information.)*

Choose an item.

If Other, specify:

**DOMAIN #1 AND #2 PRESENTING PROBLEMS/NEEDS:** *(Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe beneficiary-identified problem(s), as well as history and impact of presenting problem(s), on beneficiary. Include impairment(s) identified by the beneficiary including distress, disability, or dysfunction in an important area of life. Describe juvenile justice or foster care involvement and experience of trauma. Include summary of beneficiary’s request for services including client’s most recent baseline.*

**DOMAIN #1 PAST PSYCHIATRIC HISTORY** *(Previous history of symptoms and/or mental health treatment. Describe in chronological order - where, when, and length of time of acute and chronic conditions. Include dates and providers related to any previous community-based treatment, including providers, therapeutic modality (e.g., medications, therapy, rehabilitative interventions, etc.) and response to interventions. Include prior psychiatric inpatient admissions and/or crisis-based admissions. Include prior psychiatric inpatient admissions and/or crisis-based admissions).*

History of Early Intervention:

[ ]  Speech-Language [ ]  Occupational [ ]  Behavioral

[ ]  Physical [ ]  Hearing [ ]  Counseling

[ ]  Parent Training [ ]  Educational [ ]  Developmental

[ ]  Psychological **[ ]** Special Education

Describe:

Education:

 Area of Concerns: [ ] Academic [ ] Behavioral [ ] Social

 [ ] No issue reported [ ] Other:

Education (last grade completed):

Failed the following grade(s):

Client has an active 504 Plan: [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Client has an active IEP: [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Special Education: [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Is Client receiving mental health services through a school district?

[ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Describe:

Educational Strengths:

Employment:[ ] Does not apply

History of volunteer/community service: [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

History of work experience: [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Current work experience: [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Last date worked:

Area of Concerns: [ ] Skills Readiness [ ] Barriers [ ] Training [ ] Job retention

 [ ] No issue reported/NA [ ] Other:

Describe:

Employment Strengths:

**DOMAIN #5 SOCIAL CONCERNS**:

Peer/Social Support [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Substance use by peers [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Gang affiliations [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Family/community support system [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Religious/spirituality [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

 **\***Justice system [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

**A YES response to any of the above requires detailed documentation:**

**DOMAIN #6 CLIENT STRENGTHS**: (*Describe client strengths which may support them in addressing their mental health/behavioral health needs)*

**DOMAIN #5 FAMILY HISTORY**:

**DOMAIN #5 LIVING ARRANGEMENT:** *(Select from Living Arrangement Table listed on the Instruction Sheet.)*

**DOMAIN #5 THOSE LIVING IN THE HOME WITH CLIENT:**

Have any relatives ever been impacted by the following: *(Select from Relatives table listed in the Instructions Sheet. Indicate who and expand below if applicable)*

Suicidal thoughts, attempts:

 Violence:

 Domestic violence:

 Substance abuse or addiction:

 Other addictions:

 Gang involvement:

 Emotional/mental health issues:

 Physical health conditions:

 Intellectual developmental disorder:

 Developmental delays:

 Arrests:

 Abuse:

Abuse reported: [ ]  N/A [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

**DOMAIN #5 INCLUDE RELEVANT FAMILY INFORMATION IMPACTING THE CLIENT:** (*Provide relevant family history and current family information – include domestic violence, substance use, neglect/abuse, family involvement and structures and level of support*):

**DOMAIN #5 FAMILY STRENGTHS:** (*describe beneficiary and family strengths as they may relate to and support beneficiary’s mental/behavioral health needs)*:

**DOMAIN #5 and DOMAIN #2 CULTURAL INFORMATION***: (Considerations could include language of client/family, primary language spoken at home,* ***religious, spiritual beliefs****, family structures, customs, moral/legal systems, life-style changes, socio-economic background, ethnicity, race – including tribal, BIPOC and/or LGBTQ affiliations or identification, immigration history/experience, age, and subculture (homelessness, gang affiliations, substance use,* ***foster care****, military background),* ***exposure to violence****,* ***abuse and neglect****, experience with racism, discrimination, and social exclusion. Describe* ***unique cultural and linguistic needs and strengths*** *that may impact treatment. Cultural information includes an understanding of how client’s mental health is impacted. Consider using the Cultural Formulation Interview in the DSM 5 for further guidance).*

Pronouns *(Examples: He, Him, His; She, Her, Hers; They, Them, Their; Ze, Hir, Hirs; Per/Per/Pers as told by client. A client may identify as any combination or use additional optional options not listed)*:

Preferred Name *(What name does the client wish to be addressed by)*:

Gender Identity: [ ]  Cisgender [ ]  Transgender [ ]  Intersex [ ]  Other [ ]  Decline to state

Legal Sex *(This is sex on CAID or other legal documents and not sex assigned at birth)*:

 [ ]  Male [ ]  Female [ ]  Non-Binary [ ]  Decline to state

Current Gender: [ ]  Female [ ]  Male [ ]  Non-Binary/Genderqueer [ ]  Questioning/Unsure

 [ ]  Other [ ]  Decline to state

Sexual Orientation: [ ]  Heterosexual/Straight [ ]  Gay [ ]  Lesbian [ ]  Bisexual/Pansexual

 [ ]  Queer [ ]  Asexual [ ]  Questioning/Unsure [ ]  Other [ ]  Decline to state

Clinical Considerations:

**DOMAIN #6 HISTORY OF SELF-INJURY/SUICIDE/VIOLENCE:**

History of self-injury (cutting, burning) [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

History of suicide attempt/s: [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

History of violence toward another: [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

History of significant property destruction: [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

History of domestic violence: [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess History of abuse: [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess Abuse reported: [ ]  N/A [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess Experience of traumatic event/s: [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

**DOMAIN #6 A YES or REFUSE/CANNOT ASSESS RESPONSE TO ANY OF THE ABOVE REQUIRES DETAILED DOCUMENTATION**:

Substance Use Information:

Have you ever used tobacco/nicotine products? [ ] No [ ] Yes [ ]  Refuse/Cannot Assess

At what age did you first use tobacco/nicotine products:

Smoker Status:

In the past 30 days, what tobacco product did you use most frequently?

If other, specify:

What age did you stop using tobacco/nicotine products?

Has the client been informed of the risks? *(Smoking is a serious health risk that leads to cancer, cardiovascular disease, and possibility of premature death.)* [ ] No [ ] Yes [ ]  Refuse/Cannot Assess

Have Smoking Cessation Resources been offered? [ ] No [ ] Yes [ ]  Refuse/Cannot Assess

CRAFFT *(Administer measure by providing handout or reading questions verbatim, in order and without interpretation)*

Copyright held by Children’s Hospital Boston, 2001. Reproduced with permission from the Center for Adolescent Substance Abuse Research, CeASAR, Children’s Hospital Boston.

For more information, contact infor@CRAFFT.org or visit [www.crafft.org](http://www.crafft.org)

|  |  |  |
| --- | --- | --- |
| HAVE YOU EVER? | Yes | No |
| C -Have you ever ridden in a CAR driven by someone (including yourself) who was “high” or had been using alcohol or drugs? |       |       |
| R -Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in? |       |       |
| A -Do you ever use alcohol or drugs while you are by yourself ALONE? |       |       |
| F -Do you ever FORGET things you did while using alcohol or drugs? |       |       |
| F -Does your family or FRIENDS ever tell you that you should cut down on your drinking or drug use? |       |       |
| T -Have you ever gotten into TROUBLE while you were using alcohol or drugs? |       |       |

2 or more “Yes” answers suggest a significant problem. TOTAL:

Have you ever experimented (only 1-3 times) with any substances? [ ]  No [ ] Yes [ ]  Refuse/Cannot Assess

*(“Yes” is only to be endorsed when client is exclusively experimenting and has not progressed to regular use or abuse of any substances.)*

Client has a parent or caregiver with a substance abuse problem? [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

DOMAIN #3 HISTORY OF SUBSTANCE ABUSE? (*Include use of alcohol, caffeine, over-the-counter and illicit drugs*.) [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

***(If yes, specify substances used)***

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of Drug** | **Priority** | **Method of Admin-istration** | **Age 1st used** | **Freq-uency of Use** | **Days of use in last 30 days** | **Date of last use** | **Amount of last use** | **Amount used on a typical Day** | **Largest Amount Used in One Day** |
|       |       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |       |

**DOMAIN #3 HISTORY OF SUBSTANCE USE AND / OR SUBSTANCE USE TREATMENT:***(Exposure/substance use including past and present use; previous community-based treatment including providers, therapeutic modality (e.g. medication-assisted treatment, rehabilitative interventions) and response to interventions; intoxication/detox/withdrawal management-based admissions).*

**DOMAIN #3 DOES CLIENT HAVE A CO-OCCURRING DISORDER (COD):**

[ ] No [ ] Yes [ ] Refuse/Cannot Assess

Quadrant:

[ ] Q. I: Low / Low [ ] Q. II: High / Low

[ ] Q III: Low / High [ ] Q. IV: High / High

Stages of Change: Substance Abuse Recovery

 [ ] Pre-Contemplation [ ] Contemplation

 [ ] Preparation/Determination [ ] Action

 [ ] Maintenance [ ] Not applicable

**DOMAIN #3 WHEN APPLICABLE, OUTLINE HOW SUBSTANCE USE IMPACTS CURRENT**

 **LEVEL OF FUNCTIONING:**

**DOMAIN #3 RECOMMENDATION FOR FURTHER SUBSTANCE USE TREATMENT:**

[ ] No [ ] Yes [ ] Not applicable

**IF YES**:

Gambling:

Have you ever felt the need to bet more and more money? [ ] No [ ] Yes [ ] Refuse/Cannot Assess

Have you ever had to lie to people important to you

about how much you gambled? [ ] No [ ] Yes [ ] Refuse/Cannot Assess

If Yes:

**DOMAIN #6 PROSPECTIVE RISK ANALYSIS TAB**

**DOMAIN #6 ASSESSMENT OF RISK FACTORS:** Any “Yes” response should be addressed in the overall risk and safety planning section. For all unlicensed staff and trainees, documentation of a consultation with a Program Manager or Licensed/Reg/Waivered designee is required. **Any “Yes” response for questions with an (\*) should elicit enhanced precaution, which would require review and creation of a safety plan with a licensed supervisor prior to the end of session with client.**

**Has client had suicidal ideation in the past 12 months:** [ ] Yes [ ] No [ ] Unable to Assess

 **If Yes:**

 Thoughts but not intention or plan? [ ] Yes [ ] No [ ] Unable to Assess

 Thoughts with intention, but no plan? [ ] Yes [ ] No [ ] Unable to Assess

 **\***Thoughts, intention, and plan? (method/means?) [ ] Yes [ ] No [ ] Unable to Assess

**Does client have past suicidal behaviors?** [ ] Yes [ ] No [ ] Unable to Assess

(Things to consider: first attempt, most serious attempt, substance involvement,

complications, how was it prevented?)

**Has client had violent/homicidal ideation or impulses in the** [ ] Yes [ ] No [ ] Unable to Assess

**past 12 months?**

 **If Yes:**

 Thoughts/impulses, but no intention or plan? [ ] Yes [ ] No [ ] Unable to Assess

 Thoughts/impulses with intention, but no plan? [ ] Yes [ ] No [ ] Unable to Assess

 **\***Thoughts/impulses with intention and plan? [ ] Yes [ ] No [ ] Unable to Assess

 (method/means?)

**Does the client have past violent behaviors?** [ ] Yes [ ] No [ ] Unable to Assess

(Things to consider: toward property or animals, toward people, domestic

violence, antisocial, intimidation, predatory)

**Does client have non-suicidal self-injurious behaviors?** [ ] Yes [ ] No [ ] Unable to Assess

(Things to consider: method, severity, frequency, remote vs. ongoing)

**Does the client have any recent (within the past 12 months) activating stressors? (select all that apply)**

 [ ]  Family/primary support group

 [ ]  Social environment

 [ ]  Economic/occupational/educational problems

 [ ]  Housing problems

 [ ]  Health problems

 [ ]  Legal problems

 [ ]  Other

**\*If yes, are these stressors experienced as “catastrophic”** [ ] Yes [ ] No [ ] Unable to Assess

 **or insurmountable?**

**Does the client have any historic stressors? (select all that apply)**

 [ ]  Family/primary support group

 [ ]  Social environment

 [ ]  Economic/occupational/educational problems

 [ ]  Housing problems

 [ ]  Health problems

 [ ]  Legal problems

 [ ]  Other

**\*If yes, are these stressors experienced as “catastrophic”** [ ] Yes [ ] No [ ] Unable to Assess

 **or insurmountable?**

**DOMAIN #6 CONCURRENT CLINICAL FACTORS:**

Active severe mental illness or serious emotional [ ] Yes [ ] No [ ] Unable to Assess

disturbance not yet stabilized or in remission?

Active self-destructive and/or impulsive personality [ ] Yes [ ] No [ ] Unable to Assess

traits such as that found in borderline, histrionic and/or

antisocial personality disorder?

Active moderate or severe substance use disorder [ ] Yes [ ] No [ ] Unable to Assess

and/or recent relapse?

Active physical illness which causes severe pain, [ ] Yes [ ] No [ ] Unable to Assess

immobility, life dysfunction or risk of death?

**\***Currently experiencing hopelessness, excessive [ ] Yes [ ] No [ ] Unable to Assess

guilt/responsibility/family burden, isolation, extreme

psychological pain and suffering, extreme

bullying/victimization or making pre-death arrangements?

**\***Currently experiencing extreme confusion, paranoia, [ ] Yes [ ] No [ ] Unable to Assess

command auditory hallucinations, restlessness/agitation,

anxiety/panic or severe sleep disturbance?

**DOMAIN #6 PROTECTIVE FACTORS:** *(strong religious, cultural, or inherent values against harming self/others, strong social support system and availability of resources and opportunities, positive planning for future, engagement in treatment, valued care giving role (people or pets) and strong attachment/responsibility to others or activities (routines/social hobbies) or family/ community/professional systems)*

**DOMAIN #6 OVERALL RISK AND SAFETY PLANNING:**

Based on the above analysis, along with the completed comprehensive assessment, summarize concerns with respect to client’s risk for suicide, self-injury, and violence, and situations/triggers that may induce risky behaviors. Describe what will be done to manage or mitigate these risks in the safety plan. In addition, be sure to address any Yes or Yes**\*** response in the overall safety plan. and include specific details of the plan that can be self-initiated or initiated by a trusted person (e.g. family member, teacher, foster parent):

If applicable, enter name and credential of licensed staff with which any yes response to an asterisk question was identified and the safety plan was created/reviewed prior to end of the session with the client:

**DOMAIN #1 MENTAL STATUS EXAM TAB:**

**(should be completed in full or if unable to assess, use comment section to document reason)**

[ ]  Unable to assess at this time.

Level of Consciousness

 [ ]  Alert [ ]  Lethargic [ ]  Stuporous

Orientation

 [ ]  Person [ ]  Place [ ]  Day [ ]  Month [ ]  Year [ ]  Current Situation

 [ ]  All Normal [ ]  None

Appearance

 [ ]  Good Hygiene [ ]  Poor Hygiene [ ]  Malodorous [ ]  Disheveled

 [ ]  Reddened Eyes [ ]  Normal Weight [ ]  Overweight [ ]  Underweight

Speech

 [ ]  Normal [ ]  Slurred [ ]  Loud [ ]  Soft [ ]  Pressured

 [ ]  Slow [ ]  Mute

Thought Process

 [ ]  Coherent [ ]  Tangential [ ]  Circumstantial [ ]  Incoherent [ ]  Loose Association

Behavior

 [ ]  Cooperative [ ]  Evasive [ ]  Uncooperative [ ]  Threatening [ ]  Agitated [ ]  Combative

Affect

[ ]  Appropriate [ ]  Restricted [ ]  Blunted [ ]  Flat [ ]  Labile [ ]  Other

Intellect

 [ ]  Average [ ]  Below Average [ ]  Above Average [ ]  Poor Vocabulary

 [ ]  Poor Abstraction [ ]  Paucity of Knowledge [ ]  Unable to Rate

Mood

 [ ]  Euthymic [ ]  Elevated [ ]  Euphoric [ ]  Irritable [ ]  Depressed [ ]  Anxious

Memory

 [ ]  Normal [ ]  Poor Recent [ ]  Poor Remote [ ]  Inability to Concentrate

 [ ]  Confabulation [ ]  Amnesia

Motor

 [ ]  Age Appropriate/Normal [ ]  Slowed/Decreased [ ]  Psychomotor Retardation

[ ]  Hyperactive [ ]  Agitated [ ]  Tremors [ ]  Tics [ ]  Repetitive Motions

 Judgment

 [ ]  Age Appropriate/Normal [ ]  Poor [ ]  Unrealistic

 [ ]  Fair [ ]  Limited [ ]  Unable to Rate

Insight

 [ ]  Age Appropriate/Normal [ ]  Poor [ ]  Fair [ ]  Limited [ ]  Adequate [ ]  Marginal

Command Hallucinations

[ ]  No [ ]  Yes, specify:

Auditory Hallucinations

[ ]  No [ ]  Yes, specify:

Visual Hallucinations

[ ]  No [ ]  Yes, specify:

Tactile Hallucinations

[ ]  No [ ]  Yes, specify:

Olfactory Hallucinations

[ ]  No [ ]  Yes, specify:

Delusions

[ ]  No [ ]  Yes, specify:

Other observations/comments when applicable :

**DOMAIN #4 MEDICAL TAB**

**DOMAIN #4 ALLERGIES AND ADVERSE MEDICATION REACTIONS**:

*(Share this allergy information with your medical staff.)*

 [ ]  No [ ]  Yes [ ]  Unknown/Not Reported

If yes, specify:

**DOMAIN #4 DOES CLIENT HAVE A PRIMARY CARE PHYSICIAN?**  [ ]  No [ ]  Yes [ ]  Unknown

If No, has client been advised to seek primary care? [ ]  No [ ]  Yes

Primary Care Physician:

Phone Number:

Seen within the last: [ ]  6 months [ ]  12 months [ ]  Other:

Address of primary care physician (required if client is residing in a STRTP):       [ ] N/A

Hospital of choice *(physical health)*:

Been seen for the following:

Date of last dental exam:

Hearing seems to be normal: [ ]  No [ ]  Yes

Hearing has been tested: [ ]  No [ ]  Yes

If yes, when?       Where?       Results?

Vision seems normal: [ ]  No [ ]  Yes

Vision has been tested: [ ]  No [ ]  Yes

If yes, when?       Where?       Results?

Wears glasses: [ ]  No [ ]  Yes

**DOMAIN #4 PHYSICAL HEALTH ISSUES:** [ ]  None at this time [ ]  Yes

**If yes, specify:**

**DOMAIN #4 IS CONDITION FOLLOWED BY PRIMARY CARE PHYSICIAN?** [ ]  No [ ]  Yes [ ]  N/A

**DOMAIN #4 PHYSICAL HEALTH PROBLEMS AFFECTING MENTAL HEALTH FUNCTIONING:** *(describe relevant current or past physical health conditions, history of medical treatments and responses)*

Head injuries: [ ]  No [ ]  Yes

If Yes, specify:

Medical and/or adaptive devices:

Healing and Health: *(Alternative healing practices and beliefs. Complementary and alternative medications. Apart from mental health professionals, who or what helps client deal with disability/illness and/or to address substance use issues? Describe.)*

PREGNANCY/BIRTH HISTORY

During pregnancy, did the mother:

 Have any medical problems or injuries? [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

 Take any medications? [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

 Use any drugs or alcohol? [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

 Use tobacco? [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Was the pregnancy or delivery unusual or difficult

in any way? [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Mother was unable to take the baby home with her

when she left the hospital? [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Did the child have any medical problems in infancy? [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Baby’s birth weight: \_\_\_\_ lbs \_\_\_\_\_oz

A YES response to any of the above requires detailed documentation:

DEVELOPMENTAL MILESTONES:

Age at which child first:

Crawled:

Sat up alone:

Walked alone:

Weaned:

Fed self:

Bladder control:

Bowel trained:

First words:

Spoke in complete sentences:

[ ] all within normal limits [ ] unknown

Significant Developmental Information *(when applicable)*:

MEDICAL CHECKLIST:

Has the child ever had any of the following:

Speech problems [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Head banging [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Day time wetting [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Nighttime wetting [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Poor bowel control [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Sleep problems [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Eating problems [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

More interested in things than people [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Ear infections [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

High fevers [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

TB [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Seizures or loss of consciousness [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Medical hospitalizations [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Operations [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Serious illness [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Child menstruating [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Pregnancies [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Venereal diseases [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Do you know child’s HIV status [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

A YES response to any of the above requires detailed documentation:

**BHA SIGNATURE PAGE TAB**

**DOMAIN #7 CLINICAL FORMULATION**: **(*Summary of clinical and diagnostic impressions, level of care, medical necessity determination, and service recommendations for treatment episode)***

**DOMAIN #7 MEDICAL NECESSITY MET**:  [ ]  No [ ]  Yes

**When “No,” note date NOABD issued [Medi-Cal clients only]:**

**CLIENT HAS BEEN INFORMED OF HIS/HER FREEDOM OF CHOICE?** [ ] Yes Date:

Local mental health program shall inform Clients receiving mental health services, including parents or guardians of children / adolescents, verbally or in writing that:

[ ]  Acceptance and participation in the mental health system is voluntary and shall not be considered a prerequisite for access to other community services.

[ ]  They retain the right to access other Medi-Cal or Short Doyle/Medi-Cal reimbursable services and have the right to request a change of provider, staff person, therapist, and/or case manager.

[ ]  **Guide to Medi-Cal Mental Health Services was explained and offered on:**

**[ ]  Grievance and Appeal Process explained and Brochure with form fill and envelope offered on:**

**[ ]  Provider List explained and offered on:**

**[ ]  Mental Health Plan’s Notice of Privacy Practices (NPP) was offered on:**

**[ ]  Language/Interpretation services availability reviewed and offered when applicable on:**

**[ ]  Advanced Directive brochure was offered on:**

**[ ]  Voter registration material offered to client at intake or change of address:**

**Signature of Clinician Requiring Co-signature**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Signature

Printed Name       Cerner ID number:

**\*Signature of Clinician Completing/Accepting the Assessment:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Signature

Printed Name       Cerner ID number:

Appendix A:

*Sexual Orientation: The type of sexual, romantic, and/or physical attraction someone feels towards others. Who a person is primarily attracted to physically, romantically, and/or emotionally, for example, males, females, both, neither, enduring emotional, romantic, or sexual attraction to other people. One’s sexual behavior affects the choices one makes in responding to sexual orientation. It is the attraction that shapes one’s orientation.*

*Another sexual orientation: Not attracted to either female or male; can refer to a person who is asexual and does not have a sexual attraction or desire to any group of people. Asexuality is not the same as celibacy.*

*Bisexual: Is romantic attraction, sexual attraction, or sexual behavior toward both males and females or romantic or sexual attraction to people of any sex or gender identity. A person who is “bi” may not have had an equal amount of sexual experiences with people of the same sex.*

*Decline to state: Client may be unsure or unwilling to disclose.*

*Gay: Emotionally, romantically, and/or physically attracted to people of the same sex; although it can be used for any sex (e.g., gay man, gay woman, gay person), “lesbian” is sometimes the preferred term for women who are attracted to women; a gay person may not have had any sexual experience; it is the attraction that shapes sexual orientation.*

*Heterosexual/straight: Emotionally, romantically, and/or physically attracted to people of the opposite gender.*

*Lesbian: A woman who is emotionally, romantically, and/or physically attracted to other women; women may also use the term gay to describe themselves; a gay or lesbian woman may not have had any sexual experience.*

*Queer: Think of queer as an umbrella term. It includes anyone who: a) wants to identify as queer and b) who feels somehow outside the societal norm in regard to gender or sexuality. This therefore, could include the person who highly values queer theory concepts and would rather not identify with any particular label, the gender fluid bisexual, the gender fluid heterosexual, the questioning LGBT person, and the person who just doesn’t feel like they quite fit in to societal norms and wants to bond with a community over that. Originally pejorative for gay; this term has been reclaimed by some gay men, lesbians, bisexuals and transgendered persons as a self-affirming umbrella term. It is a fluid label as opposed to a solid label.*

*Questioning/Unsure: Exploring sexual orientation, gender identity, gender expression.*

*Gender Identity: The sense of “being” male, female, genderqueer, agender, etc. For some people, gender identity is in accord with physical anatomy. For transgender people, gender identity may differ from physical anatomy or expected societal roles. It is important to note that gender identity, biological sex, and sexual orientation are separate and that you cannot assume how someone identifies in one category based on how they identify in another category.*

*Another Gender Identity: Some of both male and female or neither; refer to genderqueer for more information.*

*Genderqueer: Most commonly used to describe a person who feels that his/her gender identity does not fit into the socially constructed "norms" associated with his/her biological sex. Genderqueer identities can include one or more of the following: both man and woman, neither man or woman [genderless], moving between genders [gender fluid], third gender or other gender, those who do not or cannot place a name to their gender, and having an overlap of, or blurred lines between gender identity and sexual orientation.*

*Transgender: It is frequently used as an umbrella term to refer to people who do not identify with their assigned gender at birth. This includes transsexuals, cross-dressers, genderqueer, drag kings, two spirit people and others. Some transgender people feel like they exist not within one of the two standard gender categories, but rather somewhere in between, beyond, or outside of those two genders.*

*Questioning/unsure: Exploring sexual orientation, gender identity, gender expression.*