|  |  |  |
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| Person’s Name (First MI Last):       | Record #:       | Date of Admission:       |
| Organization/Program Name:       | DOB:       | **Gender:** [ ]  Male [ ]  Female[ ]  Transgender |
| Presenting Concerns (In Person’s Served/Family’s Own Words) |
| Referral Source and Reason for Referral:       |

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| **What Occurred to Cause the Person to Seek Services Now** (Note Precipitating Event, Symptoms, Behavioral and Functioning Needs)**:**       |

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| **Custody** (If more than one parent/guardian has custody, check all boxes that apply to indicate sole or joint legal and/or physical custody) |
| [ ]  Self: | [ ]  Person is 18 yrs. Or Older [ ]  Mature Minor (16 – 18 yrs. Old) |
| [ ]  Parent / [ ]  Guardian 1: | **Name:**       | [ ]  Legal Custody | [ ]  Physical Custody |
| [ ]  Parent / [ ]  Guardian 2: | **Name:**       | [ ]  Legal Custody | [ ]  Physical Custody |
| [ ]  DCF | **Caseworker Name:**       |
| [ ]  Other (Describe):       Is there a Rep Payee? [ ]  Yes [ ]  No; If yes, complete the Rep Payee section of the Legal Status AddendumIs a Conservatorship? [ ]  Yes [ ]  No; If yes, complete the Conservatorship section of the Legal Status Addendum**Is there a need for a Legal Guardian, Rep Payee or Conservatorship that has not been met?** [ ]  No [ ]  Yes / Explain:       |

**Instructions for Integration with CANS Assessment**

**Current Status is either captured below or in CANS Assessment. If CANS Assessment** has been completed check here [ ] . If you have completed the CANS you do not need to complete the **current** information for those areas noted with an \* if the current status is well documented in the CANS narrative. History of all areas must be described. If you have not completed the CANS complete all the following information. Comment should be included for any CANS score above a 1.

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| Living Situation |
| What is the person’s current living situation? (check one)[ ]  Rent [ ]  Own [ ]  Friend’s Home [ ]  Relative’s/Guardian’s Home [ ]  Foster Care Home [ ]  Respite Care [ ]  Jail/Prison [ ]  Homeless living with friend [ ]  Homeless in shelter/No residence [ ]  Other:        [ ]  Residential Care/Treatment Facility*:*  *[ ]  Hospital* *[ ]  Temporary Housing* *[ ]  Residential Program* *[ ]  Nursing/Rest Home* *[ ]  Supportive Housing* *[ ]  DYS Facility* *[ ]  Other:*      At Risk of Losing Current Housing [ ]  Yes [ ]  No Satisfied with Current Living Situation [ ]  Yes [ ]  No **Is Person 14 ½ years or older?** [ ]  **Yes** [ ]  **No If Yes, Complete Transition to Adulthood Addendum**  |

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| FAMILY |

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| ([ ]  Genogram Attached / [ ]  Ecomap Attached) |
| Household Members (Name) | Relationship to Person Served | Age |
|        |        |       |
|        |        |       |
|        |        |       |
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| Person’s Name (First MI Last):       | Record #:       |

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| Street Address (if different from the person’s served address listed on Personal Information Form):       |
| Relevant Family Members/Others not listed above | Relationship to Person Served | Age |
|        |        |       |
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| **\*Family Functioning/Parent and Child Interaction/Relationship Permanence: Include the child functioning within the context of his/her family and community.:** **Current Status**       **History**       |

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| **DEVELOPMENTAL INFORMATION** |
| **\*Developmental/Cognitive Delay and Functioning/Sensory/Motor/Sleep/Feeding Disorders: Include if child met developmental milestones and development/cognitive delay such as low IQ or developmental disability:** **Current Status**       **History**       |

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| **Learning Style (visual, auditory, verbal, written or learn by doing):**      **Current Status**       **History**       |

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| **\*Learning Disability/Communication, Comprehension and Expression: Include expressive and receptive language problems:** **Current Status**       **History**       |

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| **\*School: Preschool/Childcare/Behavior/Achievement/Attendance: Provide information based on age of child, if older than preschool include current grade:** **Current Status**       **History**       |

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| **\*Self Care: Include whether child can perform age appropriate activities of daily living, assistive technology and special communication needs and ability to self-preserve:** **Current Status**       **History**       |

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| **CULTURAL AND RELIGIOUS CONSIDERATIONS** |
| **\*Language (Primary Language and Secondary Language):** **Current Status**       **History**       |

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| **\*Cultural Differences Within a Family:** **Current Status**       **History**       |

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| Person’s Name (First MI Last):       | Record #:       |

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| **\*Cultural/Ethnic Identity:** **Current Status**       **History**       |

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| **\*Discrimination/Bias:** **Current Status**       **History**       |

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| **Religion/Spirituality:** **Current Status**       **History**       |

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| **\*Youth/Family Relationship to System:** **Current Status** **History**  |

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| **\*Agreement About Strengths and Needs:** **Current Status** **History**  |

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| **SOCIAL SUPPORT AND FUNCTIONING** |
| **\*Social Support, Social Functioning and Recreation/Play** (Friendship/Social/Peer, Support Relationships, Afterschool Programs/Clubs, Pets, Community Supports/Self Help Groups such as AA, NA, SMART, NAMI, Peer Support, etc.) Include difficulties with social skills and relationships with peers and adults and child’s ability to play appropriately with peers)**:** **Current Status**       **History**       |

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| **\*Community Functioning:** **Current Status**       **History**       |

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| **EMPLOYMENT** *(complete if 14 years of age or older)* |
| **Employment Income/Financial Support:** **[ ]** Not Applicable [ ]  Never Worked Currently Employed?[ ]  No [ ]  Yes; If yes, length of employment:       (If not currently employed) – Person served wants to work? [ ]  No [ ]  Yes [ ]  Uncertain / Comments:      Does the person want help to find employment or vocational training? [ ]  No [ ]  Yes / Comments:       **If yes, complete Employment Addendum****Income/Financial Support (sources of and adequacy of financial support; own and/or parents/family):**       |

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| **CAREGIVER RESOURCES AND NEEDS** |

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| **\*Medical/Physical/Mental Health and Substance Abuse:****Current Status**       **History**       |

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| **\*Developmental/Cognitive Delay: Current Status**       **History**       |

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| **\*Family Stress/Housing Stability/Financial Resources/Organizational Skills/Advocacy/Involvement:** **Current Status**       **History**       |
| Person’s Name (First MI Last):       | Record #:       |

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| **\*Child/Youth Supervision:** **Current Status**       **History**       |

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| **Legal Involvement History** |
| Does the person have a history of, or current involvement with the legal system (i.e., legal charges)? [ ]  No [ ]  Yes; **If yes, Please complete and attach the Legal Involvement and History Addendum** |

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| **Trauma History** |
| Does person report a history of trauma? [ ]  No [ ]  YesDoes person report history/current family/relevant other, household, and/or environmental violence, abuse or neglect or exploitation? [ ]  No [ ]  Yes **If the answer to either of the above questions is yes, complete the Trauma History Addendum** |

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| **Addictive Behavior and Substance Abuse History** |
| Does person report a history of, or current, substance use or other addictive behavior concerns (i.e., alcohol, tobacco, gambling, food)?[ ] No[ ] Yes **If yes completed the following based on the requirements of your program, funder, or organization:** Check other assessments completed: [ ]  GAIN [ ] CAGE [ ]  AUDIT or [ ]  Addictive Behavior/SA Addendum [ ]  ESM/BSAS [ ]  Other:  |

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| Mental Health and Addiction Treatment History  |

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| **Type of Service** | **Dates of Service** | **Reason** | **Name of Provider/ Agency:** | **Inpatient/ Outpatient** | **Completed** |
|       |      /      |       |       | [ ]  In [ ]  Out | [ ]  No[ ]  Yes |
|       |      /      |       |       | [ ]  In [ ]  Out | [ ]  No[ ]  Yes |
|       |      /      |       |       | [ ]  In [ ]  Out | [ ]  No[ ]  Yes |
|       |      /      |       |       | [ ]  In [ ]  Out | [ ]  No[ ]  Yes |
|       |      /      |       |       | [ ]  In [ ]  Out | [ ]  No[ ]  Yes |
|       |      /      |       |       | [ ]  In [ ]  Out | [ ]  No[ ]  Yes |
|       |      /      |       |       | [ ]  In [ ]  Out | [ ]  No[ ]  Yes |

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| **Efficacy of past and current treatment:**       |

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| **Psychiatric History (including past diagnoses and course of illness):**       |

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| **Source(s) of Information:**  [ ]  Person Served [ ]  Significant other/Family member(s) [ ]  Service Provider(s) [ ]  Case Manager [ ]  Written records [ ]  Other:       |

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| Person’s Name (First MI Last):       | Record #:       |

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| **Medical and Physical Health Summary** **OR** **[ ]  Refer to Attached Physical Health Assessment** |
| **Allergies:** **[ ]** No Known Allergies **[ ]  Yes, list below:** Food:  Medication Allergies and Medication Sensitivities (including OTC, herbal):  Environmental: **Medical and Physical Health Summary:** **Current:** **History** **(**Health history including immunization status, prenatal exposure to alcohol and drugs, chronic conditions, significant dental history, and current physical complaints that may interfere with the person’s served functioning, issues of language, speech, hearing, vision, intellectual, sensory and motor development) : Does the person use complimentary health approaches (e.g. natural products, mind-body practices, yoga)? [ ]  Yes [ ]  No If yes, please describe:      Does the person wish to consider using complimentary health approaches and want help finding a provider? [ ]  Yes [ ]  No [ ]  NAIf yes, please describe:      **Pain Screening:** Does the person experience pain currently? [ ]  Yes [ ]  No Has the person experienced pain in past few months? [ ]  Yes [ ]  NoDescribe the type, frequency, duration, intensity, identified cause, any limitations to functioning and what helps relieve the pain:     **Nutritional Screening:** (check all that are reported)[ ]  Special diet? (e.g. diabetic, celiac) Follows special diet? [ ]  Yes [ ]  No [ ]  Medications affecting nutritional status[ ]  Weight gain/loss of 10 pounds or more without specific diet [ ]  Change in appetite[ ]  Binging [ ]  Purging [ ]  Use of laxatives [ ]  Intense focus on weight, body size, calorie intake, exerciseBeliefs, perceptions, attitude, behaviors regarding food:      **\*Sexuality. Include concerns with sexual development, sexual behavioral and concerns with sexual identity:** **Current:** **History/Concerns:** **Physical Health Summary and Recommendations:**If person has not had physical exam in past year, or if person has reported pain without a determined cause, or if person has reported eating disordered behaviors that are not being medically followed:[ ]  Referral for physical exam [ ]  Referral for Nutritional Assessment[ ]  Person declined exam (reason):       [ ]  PCP contacted |

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| **Medication information and history of adverse reactions:** (Include what medications have worked well previously, any adverse side effects, why person doesn’t take meds as prescribed and/or which one(s) the person would like to avoid taking in the future): **If the person served is currently taking any medication, complete and attach the Medication Addendum.** |

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| **Primary Care Provider and Dentist Name and Credentials** | **Address** | **Tel Number** | **Fax** | **Date of Last Exam** |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
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| Person’s Name (First MI Last):       | Record #:       |

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| **Mental Status Exam –** (WNL = Within Normal Limits) (**\*\***) ***– If Checked, Risk Assessment is Required*** |

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| **Appearance/ Clothing:** | [ ]  WNL | [ ]  Neat and appropriate | [ ]  Physically unkempt | [ ]  Disheveled | [ ]  Out of the Ordinary |  |
| **Eye Contact:** | [ ]  WNL | [ ]  Avoidant | [ ]  Intense | [ ]  Intermittent |  |  |
| **Build:** | [ ]  WNL | [ ]  Thin  | [ ]  Overweight | [ ]  Short | [ ] Tall |  |
| **Posture:** | [ ]  WNL | [ ]  Slumped | [ ]  Rigid, Tense | [ ]  Atypical |  |  |
| **Body Movement:** | [ ]  WNL | [ ] Accelerated | [ ]  Slowed | [ ]  Peculiar | [ ]  Restless | [ ]  Agitated |
| **Behavior:** | [ ]  WNL | [ ]  Cooperative | [ ]  Uncooperative | [ ]  Overly Compliant | [ ]  Withdrawn | [ ]  Sleepy  |
|  | [ ]  Silly | [ ]  Avoidant/Guarded/ Suspicious | [ ]  Nervous/ Anxious | [ ]  Preoccupied | [ ]  Restless  | [ ]  Demanding |
|  | [ ]  Controlling | [ ]  Unable to perceive pleasure | [ ]  Provocative | [ ]  Hyperactive | [ ]  Impulsive | [ ]  Agitated |
|  | [ ]  Angry | [ ]  Assaultive | [ ]  Aggressive | [ ]  Compulsive [ ]  Relaxed |
| **Speech:** | [ ]  WNL | [ ]  Mute  | [ ]  Over-talkative | [ ]  Slowed | [ ]  Slurred | [ ]  Stammering |
|  | [ ]  Rapid | [ ]  Pressured | [ ]  Loud | [ ]  Soft | [ ]  Clear | [ ]  Repetitive |
| **Emotional State-Mood (in person’s words):** | [ ]  WNL | [ ]  Not feeling anything | [ ]  Irritated | [ ]  Happy | [ ]  Angry | [ ]  Hostile |
|  | [ ]  Depressed, sad | [ ]  Anxious | [ ]  Afraid, Apprehensive |  |  |  |
| **Emotional State- Affect** | [ ]  WNL | [ ]  Constricted | [ ]  Changeable | [ ]  Inappropriate | [ ]  Flat |  |
|  | [ ]  Full | [ ]  Blunted, unvarying |  |  |  |  |
| **Facial Expression** | [ ]  WNL | [ ]  Anxiety, fear, apprehension | [ ]  Sadness, depression | [ ]  Anger, hostility, irritability |  |  |
|  | [ ]  Elated | [ ]  Expressionless | [ ]  Inappropriate | [ ]  Unvarying |  |  |
| **Perception:** | [ ]  WNL |  |  |  |  |  |
| *Hallucinations-* | [ ]  Tactile | [ ]  Auditory | [ ]  Visual | [ ]  Olfactory | [ ]  Command **\*\*** |
| **Thought Content:** | [ ]  WNL |  |  |  |  |  |
| *Delusions-* | [ ]  None Reported | [ ]  Grandiose | [ ] Persecutory | [ ]  Somatic | [ ]  Illogical | [ ]  Chaotic |
|  | [ ]  Religious |  |  |  |  |  |
| *Other Content-* | [ ]  Preoccupied | [ ]  Obsessional | [ ]  Guarded | [ ]  Phobic | [ ]  Suspicious | [ ]  Guilty |
|  | [ ]  Thought broadcasting | [ ]  Thought insertion | [ ]  Ideas of reference |  |  |  |
| **Thought Process:** | [ ]  WNL | [ ]  Incoherent | [ ]  Decreased thought flow | [ ]  Blocked  | [ ]  Flight of ideas |  |
|  | [ ]  Loose | [ ]  Racing | [ ]  Chaotic | [ ]  Concrete  | [ ]  Tangential |  |
| **Intellectual Functioning:** | [ ]  WNL | [ ]  Lessened fund of common knowledge  | [ ]  Impaired concentration | [ ]  Impaired calculation ability |  |  |
| *Intelligence Estimate -* | [ ]  Develop. Disabled | [ ]  Borderline | [ ]  Average | [ ]  Above average  | [ ]  No formal testing |  |
| **Orientation**:  | [ ]  WNL | **Disoriented to**: | [ ]  Time | [ ]  Place | [ ]  Person |  |
| **Memory**:  | [ ]  WNL | **Impaired:**  | [ ]  Immediate recall  | [ ]  Recent memory  | [ ]  Remote memory | [ ]  Short Attention Span |
| **Insight**:  | [ ]  WNL  | [ ]  Difficulty acknowledging presence of psychological problems  | [ ]  Mostly blames other for problems  | [ ]  Thinks he/she has no problems |
| **Judgment**: | [ ]  WNL  | **Impaired Ability to Make** **Reasonable Decisions**:  | [ ]  Mild  | [ ]  Moderate  | [ ]  Severe\*\*  |
| **Past Attempts to Harm Self or Others:**  | [ ]  None Reported  |  [ ]  Self\*\*  | [ ]  Others\*\*  |  |  |  |
| **Self Abuse Thoughts:** | [ ]  None reported  | [ ]  Cutting\*\*  | [ ]  Burning\*\*  | [ ]  Other:       |
| **Suicidal Thoughts:** | [ ]  None reported  | [ ]  Passive SI\*\*  | [ ]  Intent\*\*  | [ ]  Plan\*\*  | [ ]  Means\*\*  |  |
| **Aggressive Thoughts:** | [ ]  None reported  | [ ]  Intent\*\*  | [ ]  Plan\*\*  | [ ]  Means\*\* |  |  |

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| **Comments:** |       |

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| Person’s Name (First MI Last):       | Record #:       |

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| **Person’s Served Strengths/Abilities/Resiliency** (Skills, talents, interests, aspirations, protective factors that help the client achieve his/her goals) **Comment on all areas** |

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| **Personal Qualities – Adaptable, Persistent, Curious, Playful, Creative, Confident, Optimistic, Resilient** |       |

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| **Living Situation, Family, and Interpersonal Relationships** |  |

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| **Financial/Employment/Education:**  |  |

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| --- | --- |
| **Health:**  |  |

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| --- | --- |
| **Leisure/Recreational/Community Involvement and Connections/Talents and Interests:**  |  |

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| --- | --- |
| **Spirituality/Culture/Religion** |  |

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| Assessed Needs Checklist Including Functional Domains |

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|  |  |  |  | **Activities of Daily Living****CN = Current Need Area****PFD = Person/Family Desires Change Now** |  |  |  |
| **CN** | **PFD** |  | **CN** | **PFD** |  | **CN** | **PFD** |  |
| [ ]  | [ ]  | **Housekeeping/Laundry** | [ ]  | [ ]  | **Money Management** | [ ]  | [ ]  | **Transportation** |
| [ ]  | [ ]  | **Housing Stability** | [ ]  | [ ]  | **Personal Care Skills (includes Grooming/ Dress)** | [ ]  | [ ]  | **Problem Solving Skills** |
| [ ]  | [ ]  | **Grocery Shopping/ Food Preparation** | [ ]  | [ ]  | **Exercise** | [ ]  | [ ]  | **Time Management** |
| [ ]  | [ ]  | **Medication Management** | [ ]  | [ ]  | **Other:**       |
| **Current Needs Selected Above as Evidenced By:**       |

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|  |  |  |  | **Family and Social Supports****CN = Current Need Area****PFD = Person/Family Desires Change Now** |  |  |  |
| **CN** | **PFD** |  | **CN** | **PFD** |  | **CN** | **PFD** |  |
| [ ]  | [ ]  | **Communication Skill** | [ ]  | [ ]  | **Family Education (Directed at the exclusive well being of the person served)** | [ ]  | [ ]  | **Peer/ Personal Support Network** |
| [ ]  | [ ]  | **Community Integration** | [ ]  | [ ]  | **Family Relationships** | [ ]  | [ ]  | **Social/ Interpersonal Skills** |
| [ ]  | [ ]  | **Caretaker Obligation Issues** | [ ]  | [ ]  | **Other:**       |
| **Current Needs Selected Above as Evidenced By:**       |

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| Person’s Name (First MI Last):       | Record #:       |

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|  |  |  |  | **Legal****CN = Current Need Area****PFD = Person/Family Desires Change Now** |  |  |  |
| **CN** | **PFD** |  | **CN** | **PFD** |  |  |  |  |
| [ ]  | [ ]  | **Legal Issues** | [ ]  | [ ]  | **Other:**       |
| **Current Needs Selected Above as Evidenced By:**       |

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | **Employment/ Education/ Finances****CN = Current Need Area****PFD = Person/Family Desires Change Now** |  |  |  |
| **CN** | **PFD** |  | **CN** | **PFD** |  | **CN** | **PFD** |  |
| [ ]  | [ ]  | **Education** | [ ]  | [ ]  | **Employment/ Volunteer Activities**  | [ ]  | [ ]  | **Meaningful Activities** |
| [ ]  | [ ]  | **Financial/Benefits** (include SSA, VA benefits) | [ ]  | [ ]  | **Other:**       |
| **Current Needs Selected Above as Evidenced By:**       |

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|  |  |  |  | **Addictive Behavior and Substance Use** **CN = Current Need Area****PFD = Person/Family Desires Change Now** |  |  |  |
| **CN** | **PFD** |  | **CN** | **PFD** |  |  |  |  |
| [ ]  | [ ]  | **Substance Use/ Addiction** (Tobacco, illicit & licit drugs) | [ ]  | [ ]  | **Other Addictive Behaviors** (food, gambling, exercise, sex etc.) |
| **Current Needs Selected Above as Evidenced By:**       |

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|  |  |  |  | **Mental Health/ Illness Management-Behavior Management****CN = Current Need Area****PFD = Person/Family Desires Change Now** |  |  |  |
| **CN** | **PFD** |  | **CN** | **PFD** |  | **CN** | **PFD** |  |
| [ ]  | [ ]  | **Attachment** | [ ]  | [ ]  | **Conduct** | [ ]  | [ ]  | **Hyperactivity** |
| [ ]  | [ ]  | **Atypical Behaviors** | [ ]  | [ ]  | **Depression/Sadness** | [ ]  | [ ]  | **Impulsivity** |
| [ ]  | [ ]  | **Attention** | [ ]  | [ ]  | **Dissociation** | [ ]  | [ ]  | **Mania** |
| [ ]  | [ ]  | **Anxiety** | [ ]  | [ ]  | **Disturbed Reality (Hallucinations)** | [ ]  | [ ]  | **Mood Swings** |
| [ ]  | [ ]  | **Anger/Aggression** | [ ]  | [ ]  | **Disturbed Reality****(Delusions)** | [ ]  | [ ]  | **Obsessions** |
| [ ]  | [ ]  | **Antisocial Behaviors** | [ ]  | [ ]  | **Emotional Control** | [ ]  | [ ]  | **Oppositional/ Defiance** |
| [ ]  | [ ]  | **Coping/Symptom Management Skills** | [ ]  | [ ]  | **Eating Disturbance** | [ ]  | [ ]  | **Somatic Problems** |
| [ ]  | [ ]  | **Cognitive Delay** | [ ]  | [ ]  | **Gender Identity** | [ ]  | [ ]  | **Stress Management** |

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| Person’s Name (First MI Last):       | Record #:       |

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| [ ]  | [ ]  | **Compulsive Behavior** | [ ]  | [ ]  | **Grief/Bereavement** | [ ]  | [ ]  | **Trauma** |
| [ ]  | [ ]  | **Other:**       |
| **Current Needs Selected Above as Evidenced By:**       |

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|  |  |  |  | **Physical Health****CN = Current Need Area****PFD = Person/Family Desires Change Now** |  |  |  |
| **CN** | **PFD** |  | **CN** | **PFD** |  | **CN** | **PFD** |  |
| [ ]  | [ ]  | **Health Practices** | [ ]  | [ ]  | **Pain Management** | [ ]  | [ ]  | **Sleep Problems** |
| [ ]  | [ ]  | **Diet/Nutrition** | [ ]  | [ ]  | **Sexual Health Issues** |
| [ ]  | [ ]  | **Other:**       |
| **Current Needs Selected Above as Evidenced By:**       |

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|  |  |  |  | **Risk****CN = Current Need Area****PFD = Person/Family Desires Change Now** |  |  |  |
| **CN** | **PFD** |  | **CN** | **PFD** |  | **CN** | **PFD** |  |
| [ ]  | [ ]  | **Bullying** | [ ]  | [ ]  | **Homicidal Ideation** | [ ]  | [ ]  | **Self-Mutilation** |
| [ ]  | [ ]  | **Danger to Others** | [ ]  | [ ]  | **Lack of Assertiveness** | [ ]  | [ ]  | **Self-Harm** |
| [ ]  | [ ]  | **Delinquent Behavior** | [ ]  | [ ]  | **Running Away** | [ ]  | [ ]  | **Sexual Aggression** |
| [ ]  | [ ]  | **Exploited** | [ ]  | [ ]  | **Poor Judgment** | [ ]  | [ ]  | **Sexual Promiscuity** |
| [ ]  | [ ]  | **Fire Setting Behavior** | [ ]  | [ ]  | **Safety/ Self-Preservation Skills** | [ ]  | [ ]  | **Sexualized Behaviors** |
| [ ]  | [ ]  | **Frustration Tolerance/ Tantrums** | [ ]  | [ ]  | **Sanction Seeking Behavior** | [ ]  | [ ]  | **Suicidal Ideation/ Risk** |
| [ ]  | [ ]  | **Other:**       |
| **Current Needs Selected Above as Evidenced By:**       |

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|  |  |  |  | **Other Need Areas****CN = Current Need Area****PD = Person/ Family Desires Change Now** |  |  |  |
| **CN** | **PFD** |  |  |  |  |  |
| [ ]  | [ ]  | **Other:**       |
| [ ]  | [ ]  | **Other:**       |

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| Person’s Name (First MI Last):       | Record #:       |

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| **Current Needs Selected Above as Evidenced By:**       |

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| Clinical Formulation – Interpretive Summary |
| **This Clinical Formulation is Based Upon Information Provided By** (Check all that apply): |
| [ ]  Person Served | [ ]  Parent(s) | [ ]  Guardian(s) | [ ]  Family/Friend(s)  [ ]  Physician [ ]  Records  |
| [ ]  Law Enforcement | [ ]  Service Provider | [ ]  School Personnel | [ ]  Other:  |
| **Interpretive Summary:** What in your clinical judgment are the need areas, the factors that led to the needs, symptoms that support your diagnosis, and your plan to address them?   |

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| **Diagnosis: [ ]**  DSM-IV Codes **[ ]**  DSM 5 Codes [ ]  ICD-9 Codes [ ]  ICD-10 Codes |
| **Check Primary/Billing Diagnosis**  | **Code** | **Narrative Description**  |
| [ ]  |  |  |
| [ ]  |  |  |
| [ ]  |  |  |
| [ ]  |  |  |
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| [ ]  |  |  |
|  **Further Evaluations Needed:** **[ ]** None Indicated **[ ]**  Psychiatric **[ ]**  Psychological **[ ]**  Neurological **[ ]**  Medical **[ ]**  Educational [ ] Vocational [ ]  Visual [ ]  Auditory [ ]  Nutritional [ ]  SA Assessment [ ]  Other:  |
| **Was Outcomes tool administered?** **[ ]  Yes** **[ ]  No If Yes, specify:**  |

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| **Prioritized Assessed Needs:** [ ]  No Additional Recommendations Clinically IndicatedAC-Active, PD-Person Declined, F/G-Family/Guardian declined, DF-Deferred, RE-Referred Out (If person or family/guardian declined/deferred/referred out, please provide rationale) |
|  | **AC** | **PD\*** | **F/G\*** | **DF\*** | **RE\*** |
| **1.**  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **2.**  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **3.**  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **4.**  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **5.**  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |

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| Person’s Name (First MI Last):       | Record #:       |

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| **Person or Family/Guardian Declined/Deferred/Referred Out Rationale(s)**(Explain why Person Family/Guardian Declined to work on Need Area; List rationale(s) for why Need Area(s) is/are Deferred/Referred Out below)**.**[ ]  **None** |
| **1.**       |
| **2.**       |
| **3.**       |
| **4.**       |
| **5.**       |

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| **Person’s Service Preferences, Level of Care/ Indicated Services Recommendation:**      |

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| **Will person’s family be involved with treatment** **[ ]  Yes** **[ ]  No. If yes, specify (include family’s response to recommendations, the involvement of family in the assessment process, state agency involvement and other supports).:**  |

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| **Person’s Signature** (Optional, if clinically appropriate) | **Date:** | **Parent/Guardian Signature** (If appropriate): | **Date:** |
| **Clinician/Provider - Print Name/Credential:** | **Date:** | **Supervisor - Print Name/Credential** (if needed): | **Date:** |
| **Clinician/Provider Signature:** | **Date:** | **Supervisor Signature** (if needed): | **Date:** |
| **Psychiatrist/MD/DO** (If required): | **Date:** | **Next Appointment:****Date:** **Time:** [ ]  **am** [ ]  **pm** |

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| Date of Service | Provider Number | Loc. Code | Prcdr. Code | Mod 1 | Mod2 | Mod3 | Mod4 | Start Time | Stop Time | Total Time | Diagnostic Code |
|       |       |       |       |     |     |     |     |       |       |       |       |