CONTRA COSTA BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

Initial Clinical Assessment for Children

Name/MRN

Billing Information

Program Name: _____ RU: _____ Date: _____

Staff #: _____ Hours: _____ Min(s): _____ Code Activity ☐ 331 Assessment ☐ 580 Lockout

Is Client Pregnant? ☐ **Yes** ☐ **No** *Travel Time To/From included in above (if applicable) Hrs* _____ *Mins* _____

Location of Services: (Please check one)

☐1 Office	☐5 School	☐11 Faith-Based	☐15 LicCommCarefac (adult)	☐19 Res Tx Ctr (child)
☐2 Field	☐8 Cor Fac	☐12 Healthcare	☐16 Mobile Service	☐20 TeleHealth
☐3 Phone	☐9 Inpatient	☐13 Age-spec Com ctr	☐17 Non Trad Svc Loc	☐21 Unknown
☐4 Home	☐10 Homeless/shelter	☐14 Client's job site	☐18 Other	

Service Strategies: (Check up to three, if applicable)

☐50 Peer/Fam DelivSvcs	☐53 Supportive Education	☐56 Ptnrshp:Soc Svcs	☐59 Integrated Svcs: MH-Dvlp Disabled	
☐51 Psych Education	☐54 Prtnrshp:Law Enfcmt	☐57 Ptnrshp:Subs Abuse	☐60 Ethnic Specific Service Strategy	
☐52 Family Support	☐55 Ptnrshp:Health Care	☐58 IntSvcs:MH/Aging	☐61 Age-Spec Svc Strategy	☐99 Unknown

Language:

Primary Language:_____ Other Languages spoken in home:_____

☐ **Interpreter** Name of Interpreter: _____

Language service provided in other than English: ☐ Spanish ☐ Other _____

Identifying Information

Name: _____ ☐ Male ☐ Female DOB: _____

Address: _____ Phone: _____

Referred by: _____

Client Information:

Lives with: ☐ Immed. Family ☐ Extend. Family ☐ Unrel. Foster Family ☐ Jail/Juvenile Hall
☐ Acute Hospital ☐ Group Home ☐ Emergency Foster Care ☐ Residential ☐ Other_____

Residential Contact (Name & Phone):_____

Others in Home/Ages/Relationship to Child: _____

_____

_____

Compostion of Family of Origin (if different from above):_____

_____

_____

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Current Legal Status:

☐ Independent Adult ☐ Child in custody of biological Parent(s), Adpotive parent(s) ☐ Emancipated Minor
☐ Juvenile Dependent of Court ☐ Juvenile Ward of the Court (Probation 602) ☐ Other _____

Agencies/Other MH Providers Involved: (check all that apply, including contact names & phone numbers as appropriate)

☐ CC Mental Health Clinic_____ ☐ CFS_____

☐ CBO_____ ☐ Network Provider_____

☐ Regional Center_____ ☐ Probation_____

☐ Other_____

Presenting Problem: (What is the primary reason for current referral? Describe current precipitating event, primary stressors, primary symptoms and functional impairment.)

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Developmental History: ☐ Birth and Developmental History is not available.

Birth was: ☐ On-Time ☐ Early (< 36 weeks) ☐ Late

While Pregnant, did mother have any injuries, illnesses, physical trauma or use alcohol/drugs? ☐ No ☐ Yes

Were there any complications at time of birth? ☐ No ☐ Yes

Did the child experience any traumas during first 5 years? ☐ No ☐ Yes

Did the child have any sleep, eating, or social problems the first 5 years? ☐ No ☐ Yes

If "yes" to any of the above, please describe: _____

_____

_____

Developmental Milestones: ☐ Early ☐ On-Time ☐ Delayed (If delayed, please describe): _____

_____

_____

Family/Social History: (Summarize relevant data regarding significant interpersonal relationships (i.e. parents, siblings, etc.), living situations, family history or mental illness or substance abuse, and/or relevant traumatic events/losses)

_____

_____

_____

_____

_____

_____

Medical History ☐ Not available

Current Primary Medical Provider: _____ ☐ None ☐ Unknown

Last Physical Exam: ☐ Within Past 12 months ☐ Not Within past 12 months ☐ Unknown

Last Dental Exam: ☐ Within Past 12 Months ☐ Not Within past 12 months ☐ Unknown

Are there any health concerns (medical illness, medical symptoms) regarding this child? ☐ No ☐ Yes (if so, please describe):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Has the child had any allergic/serious reactions to medication(s)? ☐ No ☐ Yes (if so, please describe):

_____

_____

_____

_____

Has the child had any NON medication allergies (food, pollen, bee stings, etc.)? ☐ No ☐ Yes (if so, please describe):

_____

_____

_____

_____

Is the child taking any medications? If yes, List name of any medication(s) child is taking at this time: (list all current medications including OTC, herbal, psychiatric, and homeopathic. Include start date/dose/frequency) ☐ None

_____

_____

_____

_____

Medication compliance issues? ☐ N/A ☐ No ☐ Yes (if yes, please describe)

_____

_____

_____

_____

☐ Referral to Health Care Provider for further Evaluation/Assessment

Treatment History: ☐ None ☐ Unknown

☐ Psych Hospitalization ☐ Psych Medication ☐ Residential Treatment ☐ Day Treatment

☐ Substance Abuse Program ☐ Psychotherapy ☐ Testing- Psychological/Neurological/Educational

☐ Previous Crisis Contact ☐ Use of Non Traditional or Alternative Healing Practices

Comments on above history: _____

_____

Criminal Justice History: ☐ None ☐ Unknown

☐ **Probation** ☐ **Parole**

Probation/Parole Officer Contact: _____ ☐ Obtain Release (ROI)

Offense History (include jail/juvenile hall facility): _____

_____

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Substance Use History: ☐ No Current or Past Substance Abuse ☐ Unknown

☐ Actively Using Substances ☐ Currently Clean & Sober for: ☐ < 6 months ☐ > 6 months ☐ > 1 year

Please check all substances used in the past 6 months:

Past	Present		Frequency
☐	☐	Alcohol	_____
☐	☐	Amphetamine	_____
☐	☐	Caffeine	_____
☐	☐	Cocaine/Crack	_____
☐	☐	Designer Drugs (GHB, PCP, Ecstasy)	_____
☐	☐	Hallucinogens (LSD, Mushrooms)	_____
☐	☐	Inhalants (Paint, Gas, Aerosols)	_____
☐	☐	Marijuana	_____
☐	☐	Opiates (Heroin, Opium, Methadone)	_____
☐	☐	Over the Counter_____	_____
☐	☐	Pain Killers (Oxy, Norco, Vicodin)	_____
☐	☐	Other_____	_____

Comments: _____
_____

Education History: ☐ N/A Child is under 5 years old

Current School: _____ Grade: _____ Contact: _____

School Performance – In and Out of Classroom

Usual Grades: ☐ Exceptional ☐ Above Average ☐ Average ☐ Below Average ☐ Failing

Academic Strengths: _____

Academic Challenges: _____

Names of Previous Schools: _____

_____

Has child been held back a grade? ☐ No ☐ Yes If yes, year(s) _____

Has child ever been expelled from school? ☐ No ☐ Yes, If yes, year(s) _____

If child was ever held back or expelled, please explain: _____

_____

_____

Has child ever been considered for Special Education? ☐ No ☐ Yes

Has child ever qualified for Special Education? ☐ No ☐ Yes If yes, grade _____

Is child receiving Special Education services now? ☐ No ☐ Yes If yes, please describe_____

School Attendance Current (or most recent) School year:

Absent due to illness:	☐Never	☐Seldom	☐ Frequently
Absent due to truancy:	☐Never	☐Seldom	☐ Frequently
Absent due to suspension:	☐Never	☐Seldom	☐ Frequently
Has child been referred to SARB?	☐No	☐Yes	

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Behavior and Social Relationships:

Has child had problems with peers? ☐No ☐ Yes
Has child had problems with teachers/authorities? ☐No ☐ Yes
If yes, please describe: _____
_____
_____
Extracurricular interests/activities: (e.g. work, clubs, church groups, arts, music, sports, exercise) _____
_____

Child & Family Strengths

_____
_____
_____
_____

Risk Assessment ☐ None Identified

Danger to self (intent, plan means): _____

Past: _____

Danger to others (intent, plan, means): _____

Past: _____

Grave Disability (unable to make use of available resources): _____

☐ 5150 Initiated ☐ CPS Referral/Involvement ☐ Tarasoff ☐ Weapons Confiscated

Additional Risk Factors: (check all that apply, and document details in comments)

☐ Family History of Suicide
☐ History of Domestic Violence
☐ Sexual Abuse
☐ Adverse Childhood
☐ Trauma or Loss in Family
☐ Physical Abuse/Emotional Abuse
☐ Inappropriate Sexualized Behavior
☐ Impulsivity/Threatening Behavior
☐ Other_____
☐ Animal Cruelty
☐ Fire Setting
☐ Emotional/Physical Neglect
☐ Substance Abuse
☐ Self-Injurious Behavior
☐ Access to Firearms (family, friends)
☐ Behavior Influences by Delusions or Hallucinations
☐ Severe Hopelessness

Comments: _____
_____
_____
_____

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Mental Status Exam:

General (appearance, attitude, behavior, speech):_____

Orientation:_____

Mood/Affect: _____

Thought Process: _____

Memory/Thought Content: _____

Insight/Judgment/Impulsivity: _____

Additional Observation(s): _____

Diagnostic Impression: DSM 5 Diagnosis and Narrative, ICD 10 Code

DSM-5 Diagnosis: _____(Primary) **AND** ICD-10 Code: _____
DSM-5
Diagnosis Title/Narrative:_____

DSM-5 Diagnosis: _____ (Secondary) **AND** ICD-10 Code: _____
DSM-5
Diagnosis Title/Narrative: _____

DSM-5 Diagnosis by: _____
(Name of Diagnosing Clinician/Licensure)

Functional Impairment:

	None	Mild	Mod	Severe		None	Mild	Mod	Severe
Family Relations	☐	☐	☐	☐	Peer Relations	☐	☐	☐	☐
School Performance	☐	☐	☐	☐	Physical Health	☐	☐	☐	☐
Self Care	☐	☐	☐	☐	Substance Abuse	☐	☐	☐	☐

Targeted Symptoms:

	None	Mild	Mod	Severe		None	Mild	Mod	Severe
Cognition/Memory/Thought	☐	☐	☐	☐	Perceptual Disturbance	☐	☐	☐	☐
Attention/Impulsivity	☐	☐	☐	☐	Oppositional/Conduct	☐	☐	☐	☐
Socialization/Communication	☐	☐	☐	☐	Destructive/Assaultive	☐	☐	☐	☐
Depressive Symptoms	☐	☐	☐	☐	Mania/Agitation/Lability	☐	☐	☐	☐
Anxiety/Phobia/Panic Attack	☐	☐	☐	☐	Somatic Disturbance	☐	☐	☐	☐
Affect Regulation	☐	☐	☐	☐	Other_____	☐	☐	☐	☐

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Initial Treatment Plan:

Additional Comments:

Clinician Signature/Licensure | Printed Name | Date

Co-Signature of Licensed Clinician | Printed Name | Date

Data Entry Clerk Initials