

1915(c) INDEPENDENT BEHAVIORAL HEALTH ASSESSMENT

DEMOGRAPHIC INFORMATION

Child/Youth Name: (first, middle, last)					Assessment Date:
Age:	DOB:	Ethnicity:	Gender:	Gender Expression:	SSN:
Parent/Primary Caretaker Name: (first, middle, last)				Is this person, the legal guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No (if not, enter information below)	
Legal Guardian Name: (first, middle, last)			Title/Department:		Phone Number:

BEHAVIORAL HEALTH HISTORY

I. CHIEF COMPLAINT (Major symptoms, difficulties, and/or Issues as they relate to behavioral health –in client/members’/caretaker’s own words/quoted.)						
II. PRESENTING PROBLEM/RELEVANT HISTORY (Including client/member/caretaker/guardian reason for seeking services, precipitating factors, symptoms, behavioral and functioning impacts, onset/course of issues, <i>current behavioral health providers</i> , services sought and expectations.)						
CURRENT BEHAVIORAL HEALTH PROVIDER NAME:				PHONE NUMBER:		
III. PAST PSYCHIATRIC/PLACEMENT HISTORY (First onset of illness, past diagnostic and treatment history, medications, hospitalizations):						
Prior Outpatient Mental Health Treatment: <input type="checkbox"/> No; <input type="checkbox"/> Yes; Detail:			Psychiatric Hospitalizations: <input type="checkbox"/> No; <input type="checkbox"/> Yes; Detail:			
Prior Residential/Out of Home Placement: <input type="checkbox"/> No; <input type="checkbox"/> Yes; Detail:						
Additional History/Comments:						
IV. SUBSTANCE USE HISTORY (Past use of primary, secondary & tertiary current substance, incl. type, freq, method & age of 1st use.)						
Check any/all that apply in past 12 months:						
<input type="checkbox"/> Alcohol Use; <input type="checkbox"/> Illegal Drug Use; <input type="checkbox"/> Injected Drug Use ; <input type="checkbox"/> Tobacco Product Use; <input type="checkbox"/> Prescription Drug Misuse; <input type="checkbox"/> Non-Prescription Drug (OTC) Misuse <input type="checkbox"/> Alcohol and/or Drug Overdose; <input type="checkbox"/> Alcohol and/or Drug Withdrawal; <input type="checkbox"/> Problems caused by gambling; <input type="checkbox"/> Trouble stopping any substance <input type="checkbox"/> Other/Describe:						
Substance Use Treatment History: <input type="checkbox"/> None; <input type="checkbox"/> Outpatient; <input type="checkbox"/> Intensive Outpatient; <input type="checkbox"/> Residential/Inpatient; <input type="checkbox"/> Detox; <input type="checkbox"/> Other/Describe: Hx of Drugs Used/Describe ♂						
SUBSTANCE TYPE Include all use in last 30 days.	AGE OF 1ST USE	YEARS IN LIFETIME	DAYS IN PAST 30	DAYS SINCE LAST USE	AMOUNT	ROUTE OF ADMINISTRATION
						<input type="checkbox"/> Oral; <input type="checkbox"/> Nasal; <input type="checkbox"/> Smoking; <input type="checkbox"/> Non-IV Injxn; <input type="checkbox"/> IV
						<input type="checkbox"/> Oral; <input type="checkbox"/> Nasal; <input type="checkbox"/> Smoking; <input type="checkbox"/> Non-IV Injxn; <input type="checkbox"/> IV
						<input type="checkbox"/> Oral; <input type="checkbox"/> Nasal; <input type="checkbox"/> Smoking; <input type="checkbox"/> Non-IV Injxn; <input type="checkbox"/> IV

PHYSICAL

V. CURRENT MEDICAL CONDITIONS (Check all that apply)						
<input type="checkbox"/> Pregnant	Due date:			Prenatal care:		
<input type="checkbox"/> None Reported	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Seizure	<input type="checkbox"/> Cancer	<input type="checkbox"/> Underweight	
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Overweight	
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Digestive Problems	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Sexually Transmitted Dz.	
<input type="checkbox"/> Other/Describe:						
VI. CURRENT & PAST MEDICATIONS (Including non-psychotropic medications)						
Medication Name	Dose	Freq.	Route	Current	COMMENTS (Reason Prescribed/Response, etc.)	
				<input type="checkbox"/> Yes; <input type="checkbox"/> No		
				<input type="checkbox"/> Yes; <input type="checkbox"/> No		
				<input type="checkbox"/> Yes; <input type="checkbox"/> No		
				<input type="checkbox"/> Yes; <input type="checkbox"/> No		
VII. ALLERGIES			<input type="checkbox"/> No Reported Drug or Food Allergies; <input type="checkbox"/> Other/Describe:			

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VIII. PRIMARY CARE PHYSICIAN	NAME	PHONE	FAX
IX. ADDITIONAL SIGNIFICANT MEDICAL HISTORY (Diagnosis, Hospitalizations, Surgery, labs values, status of conditions, etc.)			

SOCIAL

X. LEGAL STATUS	
Current Legal Status: <input type="checkbox"/> None; <input type="checkbox"/> Probation; <input type="checkbox"/> Charges Pending; <input type="checkbox"/> DCFS; <input type="checkbox"/> OJJ; <input type="checkbox"/> Other Comment/Detail:	Past Legal Status: <input type="checkbox"/> None; <input type="checkbox"/> DCFS; <input type="checkbox"/> OJJ; <input type="checkbox"/> Other Comment/Detail:

XI. FAMILY HISTORY (relationship status with relatives, family involvement in treatment, and living status of significant relatives):	
Custodial Status: <input type="checkbox"/> Independent Adult; <input type="checkbox"/> Biologic Father; <input type="checkbox"/> Biologic Mother; <input type="checkbox"/> Joint Biologic Parents; <input type="checkbox"/> Gov't/Judicial; <input type="checkbox"/> Other:	
Adverse Circumstances in Family of Origin: <input type="checkbox"/> N/A; <input type="checkbox"/> Poverty; <input type="checkbox"/> Criminal Behavioral; <input type="checkbox"/> Mental Illness; <input type="checkbox"/> Substance Use; <input type="checkbox"/> Abuse; <input type="checkbox"/> Neglect; <input type="checkbox"/> Domestic Violence; <input type="checkbox"/> Violence; <input type="checkbox"/> Trauma; <input type="checkbox"/> Other/Describe:	
Summarize <u>family history and child-rearing practices</u> :	

XII. TRAUMA HISTORY	
History of Trauma: <input type="checkbox"/> None; <input type="checkbox"/> Experienced; <input type="checkbox"/> Witnessed; <input type="checkbox"/> Abuse; <input type="checkbox"/> Neglect; <input type="checkbox"/> Violence; <input type="checkbox"/> Sexual Assault; <input type="checkbox"/> Other/Describe:	
Summarize <u>trauma history</u> :	

XIII. LIVING SITUATION (Current status and functioning)	
a. Primary Residence: <input type="checkbox"/> Parent/Guardian Home; <input type="checkbox"/> Relative's Home; <input type="checkbox"/> Out of Home placement; <input type="checkbox"/> Homeless; <input type="checkbox"/> Other/Describe: How long at current residence? Family/Household Composition:	
b. Summarize <u>current living situation</u>:	

XIV. EDUCATIONAL/EMPLOYMENT STATUS	
a. Current Educational Placement/Employer: Current or Highest Grade Completed/Degree: Difficulties with Reading/Writing: <input type="checkbox"/> No; <input type="checkbox"/> Yes; Estimated Literacy Level:	
b. Summarize <u>educational history and status</u>:	

XV. SOCIAL HISTORY AND COMMUNITY INTEGRATION	
a. <u>Current status and functioning</u> (Involvement in the community, social supports and activities, social barriers) Does Client/Member feel supported by friends or family? <input type="checkbox"/> Yes; <input type="checkbox"/> No; Recreational Activities: Self-Help Activities:	
b. Summarize <u>social and community involvement</u>:	

CURRENT STATUS

XVI. MENTAL STATUS EXAMINATION (Circle or Check all that apply.)	
a. GENERAL APPEARANCE <input type="checkbox"/> Healthy; <input type="checkbox"/> As stated Age; <input type="checkbox"/> Older Than Stated Age; <input type="checkbox"/> Young-looking; <input type="checkbox"/> Tattoos; <input type="checkbox"/> Disheveled; <input type="checkbox"/> Unkempt; <input type="checkbox"/> Malodorous; <input type="checkbox"/> Thin; <input type="checkbox"/> Overweight; <input type="checkbox"/> Obese; <input type="checkbox"/> Other/Describe:	
b. BEHAVIOR & PSYCHOMOTOR ACTIVITY <input type="checkbox"/> Normal; <input type="checkbox"/> Overactive; <input type="checkbox"/> Hypoactive; <input type="checkbox"/> Catatonia; <input type="checkbox"/> Tremor; <input type="checkbox"/> Tics; <input type="checkbox"/> Combative; <input type="checkbox"/> Other/Describe:	
c. ATTITUDE <input type="checkbox"/> Optimal; <input type="checkbox"/> Constructive; <input type="checkbox"/> Motivated; <input type="checkbox"/> Obstructive; <input type="checkbox"/> Adversarial; <input type="checkbox"/> Inaccessible; <input type="checkbox"/> Cooperative; <input type="checkbox"/> Seductive; <input type="checkbox"/> Defensive;	

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<input type="checkbox"/> Hostile; <input type="checkbox"/> Guarded; <input type="checkbox"/> Apathetic; <input type="checkbox"/> Evasive; <input type="checkbox"/> Other/Explain:
d. SPEECH <input type="checkbox"/> Normal; <input type="checkbox"/> Spontaneous; <input type="checkbox"/> Slow; <input type="checkbox"/> Impoverished; <input type="checkbox"/> Hesitant; <input type="checkbox"/> Monotonous; <input type="checkbox"/> Soft/Whispered; <input type="checkbox"/> Mumbled; <input type="checkbox"/> Rapid; <input type="checkbox"/> Pressured; <input type="checkbox"/> Verbose; <input type="checkbox"/> Loud; <input type="checkbox"/> Slurred; <input type="checkbox"/> Impediment; <input type="checkbox"/> Other/Describe:
e. MOOD: <input type="checkbox"/> Dysphoric; <input type="checkbox"/> Euthymic; <input type="checkbox"/> Expansive; <input type="checkbox"/> Irritable; <input type="checkbox"/> Labile; <input type="checkbox"/> Elevated; <input type="checkbox"/> Euphoric; <input type="checkbox"/> Ecstatic; <input type="checkbox"/> Depressed; <input type="checkbox"/> Grief/mourning; <input type="checkbox"/> Alexithymic; <input type="checkbox"/> Elated; <input type="checkbox"/> Hypomanic; <input type="checkbox"/> Manic; <input type="checkbox"/> Anxious; <input type="checkbox"/> Tense; <input type="checkbox"/> Other/Describe:
f. AFFECT <input type="checkbox"/> Appropriate; <input type="checkbox"/> Inappropriate; <input type="checkbox"/> Blunted; <input type="checkbox"/> Restricted; <input type="checkbox"/> Flat; <input type="checkbox"/> Labile; <input type="checkbox"/> Tearful; <input type="checkbox"/> Intense; <input type="checkbox"/> Other/Describe:
g. PERCEPTUAL DISTURBANCES <input type="checkbox"/> None; <u>Hallucinations:</u> <input type="checkbox"/> Auditory; <input type="checkbox"/> Visual; <input type="checkbox"/> Olfactory; <input type="checkbox"/> Tactile; <input type="checkbox"/> Other/Describe:
h. THOUGHT PROCESS <input type="checkbox"/> Logical/Coherent; <input type="checkbox"/> Incomprehensible; <input type="checkbox"/> Incoherent; <input type="checkbox"/> Flight of Ideas; <input type="checkbox"/> Loose Associations; <input type="checkbox"/> Tangential; <input type="checkbox"/> Circumstantial; <input type="checkbox"/> Rambling; <input type="checkbox"/> Evasive; <input type="checkbox"/> Racing Thoughts; <input type="checkbox"/> Perseveration; <input type="checkbox"/> Thought Blocking; <input type="checkbox"/> Concrete; <input type="checkbox"/> Other/Describe:
i. THOUGHT CONTENT <input type="checkbox"/> Preoccupations; <input type="checkbox"/> Obsessions; <input type="checkbox"/> Compulsions; <input type="checkbox"/> Phobias; <input type="checkbox"/> Delusions; <input type="checkbox"/> Thought Broadcasting; <input type="checkbox"/> Thought Insertion; <input type="checkbox"/> Thought Withdrawal; <input type="checkbox"/> Ideas of Reference; <input type="checkbox"/> Ideas of Influence; <input type="checkbox"/> Delusions; <input type="checkbox"/> Other/Describe:
j. SUICIDAL/HOMICIDAL IDEATION <input type="checkbox"/> Suicidal Thoughts; <input type="checkbox"/> Suicidal Attempts; <input type="checkbox"/> Suicidal Intent; <input type="checkbox"/> Suicidal Plans; <input type="checkbox"/> History of Self-Injurious Behavior <input type="checkbox"/> Homicidal Thoughts; <input type="checkbox"/> Homicidal Attempts; <input type="checkbox"/> Homicidal Intent; <input type="checkbox"/> Homicidal Plans; <input type="checkbox"/> Other/Describe:
k. SENSORIUM/COGNITION <input type="checkbox"/> Alert; <input type="checkbox"/> Lethargic; <input type="checkbox"/> Somnolent; <input type="checkbox"/> Stuporous; <u>Oriented to:</u> <input type="checkbox"/> Person; <input type="checkbox"/> Place; <input type="checkbox"/> Time; <input type="checkbox"/> Situation; <input type="checkbox"/> Normal Concentration; <input type="checkbox"/> Impaired Concentration; <input type="checkbox"/> Other/Describe:
l. MEMORY <u>Remote Memory:</u> <input type="checkbox"/> Normal; <input type="checkbox"/> Impaired; <u>Recent Memory:</u> <input type="checkbox"/> Normal; <input type="checkbox"/> Impaired; <u>Immediate Recall:</u> <input type="checkbox"/> Normal; <input type="checkbox"/> Impaired <input type="checkbox"/> Other/Describe:
m. INTELLECTUAL FUNCTIONING (Estimate) <input type="checkbox"/> Above Avg.; <input type="checkbox"/> Normal/Avg.; <input type="checkbox"/> Borderline; <u>Mental Retardation:</u> <input type="checkbox"/> Mild; <input type="checkbox"/> Moderate; <input type="checkbox"/> Severe <input type="checkbox"/> Other/Describe:
n. JUDGMENT <input type="checkbox"/> Critical Judgment Intact; <input type="checkbox"/> Impaired Judgment; <input type="checkbox"/> Other/Describe:
o. INSIGHT <input type="checkbox"/> True Emotional Insight; <input type="checkbox"/> Intellectual Insight; <input type="checkbox"/> Some Awareness of Illness/symptoms; <input type="checkbox"/> Impaired Insight; <input type="checkbox"/> Denial; <input type="checkbox"/> Other/Describe:
p. IMPULSE CONTROL <input type="checkbox"/> Able to Resist Impulses; <input type="checkbox"/> Recent Impulsive Behavior; <input type="checkbox"/> Impaired Impulse Control; <input type="checkbox"/> Compulsions; <input type="checkbox"/> Other/Describe:
XVII. RISK ASSESSMENT: Assess potential risk of harm to self or others, including patterns of risk behavior and/or risk due to personality factors, substance use, criminogenic factors, exposure to elements, exploitation, abuse, neglect, suicidal or homicidal history, self-injury, psychosis, impulsiveness, etc.
a. Risk of Harm to Self: <input type="checkbox"/> Prior Suicide Attempt; <input type="checkbox"/> Stated Plan/Intent; <input type="checkbox"/> Access to means (weapons, pills, etc.); <input type="checkbox"/> Recent Loss; <input type="checkbox"/> Presence of Behavioral Cues (isolation, giving away possessions, rapid mood swings, etc.); <input type="checkbox"/> Family History of Suicide; <input type="checkbox"/> Terminal Illness; <input type="checkbox"/> Substance Abuse; <input type="checkbox"/> Marked lack of support; <input type="checkbox"/> Psychosis; <input type="checkbox"/> Suicide of friend/acquaintance; <input type="checkbox"/> Other/Describe:
b. Risk of Harm to Others: <input type="checkbox"/> Prior acts of violence; <input type="checkbox"/> Destruction of property; <input type="checkbox"/> Arrests for violence; <input type="checkbox"/> Access to means (weapons); <input type="checkbox"/> Substance use; <input type="checkbox"/> Physically abused as child; <input type="checkbox"/> Was physically abusive as a child; <input type="checkbox"/> Harms animals; <input type="checkbox"/> Fire setting; <input type="checkbox"/> Angry mood/agitation; <input type="checkbox"/> Prior hospitalizations for danger to others; <input type="checkbox"/> Psychosis/command hallucinations; <input type="checkbox"/> Other/Describe:
c. Client/Member Safety & Other Risk Factors: <input type="checkbox"/> Feels unsafe in current living environment; <input type="checkbox"/> Feels currently being harmed/hurt/abused/threatened by someone; <input type="checkbox"/> Engages in dangerous sexual behavior; <input type="checkbox"/> Past involvement with Child or Adult Protective Services; <input type="checkbox"/> Relapse/decompensation triggers; <input type="checkbox"/> Other/Describe:
d. Inappropriate sexual behaviors <input type="checkbox"/> Sex offender status <input type="checkbox"/> Pending sex offense charge <input type="checkbox"/> Report or Investigation <input type="checkbox"/> Other: _
e. Additional Risk Factors
f. Describe recipient's preferences and desires for addressing risk factors, including any Mental Health Advance Directives or plan of response to periods of decompensation/relapse (Ex. Resources recipient feels comfortable reaching out to for assistance in a crisis.):
XVIII. CULTURAL AND LANGUAGE PREFERENCES (Language, Customs/Values/Preferences)
a. Spiritual Beliefs/Preferences:
b. Cultural Beliefs/Preferences:

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XIX. PRINCIPAL DIAGNOSES			
AXIS I			
AXIS II			
AXIS III			
AXIS IV			
AXIS V	Current: _____ Highest Past Year: _____		
XX.	INTERPRETIVE SUMMARY: <i>Briefly describe client/member's global preferences/hopes for recovery, your clinical summary, and recommended treatments/assessments, level of care, duration.</i>		
<p>a. Recommended Services: (Check all that apply.) <input type="checkbox"/> Family Therapy; <input type="checkbox"/> Individual Therapy; <input type="checkbox"/> Group Therapy; <input type="checkbox"/> Alcohol/Drug Assessment; <input type="checkbox"/> Alcohol/ Drug Individual Therapy; <input type="checkbox"/> PSR; <input type="checkbox"/> CPST; <input type="checkbox"/> Other/Describe:</p> <p>b. Other Services/Linkages Needed: <input type="checkbox"/> Vocational Services; <input type="checkbox"/> Social Services; <input type="checkbox"/> Educational Services; <input type="checkbox"/> Medical Services/PCP; <input type="checkbox"/> Self help Groups; <input type="checkbox"/> Other/Describe:</p> <p>c. Additional Comments:</p>			
SIGNATURE			
PRINTED NAME OF ASSESSOR	SIGNATURE	LMHP STATUS	DATE