1915(c) INDEPENDENT BEHAVIORAL HEALTH ASSESSMENT

Authorization No:

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? □ Yes □ 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's/caretaker's own words/quoted*.)

II. PRESENTING PROBLEM/RELEVANT HISTORY (Including client/caretaker/guardian reason for seeking services, precipitating factors, symptoms, behavioral and functioning impacts, onset/course of issues, *current behavioral health providers,* 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: □ No; □ Yes;
Detail:

Psychiatric Hospitalizations: □ No; □ Yes;
Detail:

Prior Residential/Out of Home Placement: □ No; □ Yes;
Detail:

Additional History/Comments:

IV. SUBSTANCE ABUSE/DEPENDENCE (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:

□ Alcohol Use; □ Illegal Drug Use; □ Injected Drug Use ; □ Tobacco Product Use; □ Prescription Drugs Abuse; □ Non-Prescription (OTC) abuse; □ Alcohol and/or Drug Overdose; □ Alcohol and/or Drug Withdrawal; □ Problems caused by gambling; □ Trouble stopping any substance □ Other/Describe:

Substance Abuse Treatment History: □ None; □ Outpatient; □ Intensive Outpatient; □ Residential/Inpatient:; □ Detox; □ Other/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
						□ Oral; □ Nasal; □ Smoking; □ Non-IV Injxn; □ IV
						□ Oral; □ Nasal; □ Smoking; □ Non-IV Injxn; □ IV
						□ Oral; □ Nasal; □ Smoking; □ Non-IV Injxn; □ IV

PHYSICAL

V. CURRENT MEDICAL CONDITIONS (Check all that apply)

□ Pregnant	Due date:		Prenatal care:		
□ None Reported	□ Congestive Heart Failure	□ Asthma	□ Seizure	□ Cancer	□ Underweight
□ High Blood Pressure	□ Stroke	□ Emphysema	□ Cirrhosis	□ Chronic Pain	□ Overweight
□ Heart Disease	□ Diabetes	□ Epilepsy	□ Digestive Problems	□ Thyroid Disease	□ Sexually Transmitted Dz.
□ Other/Describe:					

VI. CURRENT & PAST MEDICATIONS(Including non-psychotropic medications)

Medication Name	**Dose**	**Freq.**	**Route**	**Current**	**COMMENTS** (Reason Prescribed/Response, etc.)
				□ Yes; □ No	
				□ Yes; □ No	
				□ Yes; □ No	

VII. ALLERGIES □ No Reported Drug or Food Allergies; □ Other/Describe:

VIII. PRIMARY CARE PHYSICIAN	**NAME**	**PHONE**	**FAX**

IX. ADDITIONAL SIGNIFICANT MEDICAL HISTORY (Diagnosis, Hospitalizations, Surgery, labs values, status of conditions, etc.)

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SOCIAL

X. LEGAL STATUS

Current Legal Status: □ None; □ Probation; □ Charges Pending; □ DCFS; □ OJJ; □ Other
Comment/Detail:

Past Legal Status: □ None; □ DCFS; □ OJJ; □ Other
Comment/Detail:

XI. FAMILY HISTORY (relationship status with relatives, family involvement in treatment, and living status of significant relatives):

Custodial Status: □ Independent Adult; □ Biologic Father; □ Biologic Mother; □ Joint Biologic Parents; □ Gov't/Judicial; □ Other:

Adverse Circumstances in Family of Origin: □ N/A; □ Poverty; □ Criminal Behavioral; □ Mental Illness; □ Substance Use; □ Abuse; □ Neglect; □ Domestic Violence; □ Violence; □ Trauma; □ Other/Describe:

Summarize significant CANS results:

XII. TRAUMA HISTORY

History of Trauma: □ None; □ Experienced; □ Witnessed; □ Abuse; □ Neglect; □ Violence; □ Sexual Assault; □ Other/Describe:

XIII. LIVING SITUATION (Current status and functioning)

a. **Primary Residence:** □ Parent/Guardian Home; □ Relative's Home; □ Out of Home placement; □ Homeless; □ Other/Describe:
How long at current residence?
Family/Household Composition:

b. **Summarize significant CANS results:**

XIV. EDUCATIONAL/EMPLOYMENT STATUS

a. **Current Educational Placement/Employer:**
Current or Highest Grade Completed/Degree:
Difficulties with Reading/Writing: □ No; □ Yes; **Estimated Literacy Level:**

b. **Summarize significant CANS results:**
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XV. SOCIAL HISTORY AND COMMUNITY INTEGRATION

a. **Current status and functioning** (Involvement in the community, social supports and activities, social barriers)
Does Client feel supported by friends or family? □ Yes; □ No;
Recreational Activities:
Self-Help Activities:

b. **Summarize significant CANS results:**

CURRENT STATUS

XVI. MENTAL STATUS EXAMINATION *(Circle or Check all that apply.)*

a. **GENERAL APPEARANCE** □ Healthy; □As stated Age; □ Older Than Stated Age; □ Young-looking; □ Tattoos; □ Disheveled; □ Unkempt; □ Malodorous; □ Thin; □ Overweight; □Obese; □ Other/Describe:

b. **BEHAVIOR & PSYCHOMOTOR ACTIVITY** □ Normal; □ Overactive; □ Hypoactive; □ Catatonia; □ Tremor; □ Tics; □ Combative; □ Other/Describe:

c. **ATTITUDE** □ Optimal; □ Constructive; □ Motivated; □ Obstructive; □ Adversarial; □ Inaccessible; □ Cooperative; □ Seductive; □ Defensive; □ Hostile; □ Guarded; □ Apathetic; □ Evasive; □ Other/Explain:

d. **SPEECH** □ Normal; □ Spontaneous; □ Slow; □ Impoverished; □ Hesitant; □ Monotonous; □ Soft/Whispered; □ Mumbled; □ Rapid; □ Pressured; □ Verbose; □ Loud; □ Slurred; □ Impediment; □ Other/Describe:

e. **MOOD:** □ Dysphoric; □ Euthymic; □ Expansive; □ Irritable; □ Labile; □ Elevated; □ Euphoric; □ Ecstatic; □ Depressed; □ Grief/mourning; □ Alexithymic; □ Elated; □ Hypomanic; □ Manic; □ Anxious; □ Tense; □ Other/Describe:

c. **AFFECT** □ Appropriate; □ Inappropriate; □ Blunted; □ Restricted; □ Flat; □ Labile; □ Tearful; □ Intense; □ Other/Describe:

g. **PERCEPTUAL DISTURBANCES** □ None; Hallucinations: □ Auditory; □ Visual; □ Olfactory; □ Tactile; □ Other/Describe:

h. **THOUGHT PROCESS** □ Logical/Coherent; □ Incomprehensible; □ Incoherent; □ Flight of Ideas; □ Loose Associations; □ Tangential; □ Circumstantial; □ Rambling; □ Evasive; □ Racing Thoughts; □ Perseveration; □ Thought Blocking; □ Concrete; □ Other/Describe:

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i. THOUGHT CONTENT □ Preoccupations; □ Obsessions; □ Compulsions; □ Phobias; □ Delusions; □ Thought Broadcasting; □ Thought Insertion; □ Thought Withdrawal; □ Ideas of Reference; □ Ideas of Influence; □ Delusions; □ Other/Describe:

j. SUICIDAL/HOMICIDAL IDEATION □ Suicidal Thoughts; □ Suicidal Attempts; □ Suicidal Intent; □ Suicidal Plans; □ History of Self-Injurious Behavior □ Homicidal Thoughts; □ Homicidal Attempts; □ Homicidal Intent; □ Homicidal Plans; □ Other/Describe:

k. SENSORIUM/COGNITION □ Alert; □ Lethargic; □ Somnolent; □ Stuporous; **Oriented to:** □ Person; □ Place; □ Time; □ Situation; □ Normal Concentration; □ Impaired Concentration; □ Other/Describe:

l. MEMORY **Remote Memory:** □ Normal; □ Impaired; **Recent Memory:** □ Normal; □ Impaired; **Immediate Recall:** □ Normal; □ Impaired □ Other/Describe:

m. INTELLECTUAL FUNCTIONING (Estimate) □ Above Avg.; □ Normal/Avg.; □ Borderline; Mental Retardation: □ Mild; □ Moderate; □ Severe □ Other/Describe:

n. JUDGEMENT □ Critical Judgment Intact; □ Impaired Judgment; □ Other/Describe:

o. INSIGHT □ True Emotional Insight; □ Intellectual Insight; □ Some Awareness of Illness/symptoms; □ Impaired Insight; □ Denial; □ Other/Describe:

p. IMPULSE CONTROL □ Able to Resist Impulses; □ Recent Impulsive Behavior; □ Impaired Impulse Control; □ Compulsions; □ 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: □ Prior Suicide Attempt; □ Stated Plan/Intent; □ Access to means (weapons, pills, etc.); □ Recent Loss; □ Presence of Behavioral Cues (isolation, giving away possessions, rapid mood swings, etc.); □ Family History of Suicide; □ Terminal Illness; □ Substance Abuse; □ Marked lack of support; □ Psychosis; □ Suicide of friend/acquaintance; □ Other/Describe:

b. Risk of Harm to Others: □ Prior acts of violence; □ Destruction of property; □ Arrests for violence; □ Access to means (weapons); □ Substance use; □ Physically abused as child; □ Was physically abusive as a child; □ Harms animals; □ Fire setting; □ Angry mood/agitation; □ Prior hospitalizations for danger to others; □ Psychosis/command hallucinations; □ Other/Describe:

d. Client Safety & Other Risk Factors: □ Feels unsafe in current living environment; □ Feels currently being harmed/hurt/abused/threatened by someone; □ Engages in dangerous sexual behavior; □ Past involvement with Child or Adult Protective Services; □ Relapse/decompensation triggers; □ Other/Describe:

e. 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:

XIX. PRINCIPAL DIAGNOSES

AXIS I	
AXIS II	
AXIS III	
AXIS IV	
AXIS V	Current: Highest Past Year:

XX. INTERPRETATIVE SUMMARY *Briefly describe client's global preferences/hopes for recovery, recommended treatments/assessments, level of care, duration.*

a. CSoC Plan of Care Services Options for Child & Family Team consideration: (Check all that apply.) □ Family Therapy; □ Individual Therapy; □ Group Therapy; □ Alcohol/Drug Assessment; □ Alcohol/ Drug Individual Therapy; □ Parent Support/Training; □ Youth Support/Training; □ Crisis Stabilization; □ Respite; □ Independent Living/Skill Building; □ PSR; □ CPST; □ Other/Describe:

b. Other Services/Linkages Needed: □ Vocational Services; □ Social Services; □ Educational Services; □ Medical Services/PCP; □ Self help Groups; □ Other/Describe:

c. Additional Comments:

SIGNATURE

PRINTED NAME OF ASSESSOR	SIGNATURE	LMHP STATUS	DATE

NOTE: Please include completed CANS Comprehensive with this document.