**San Diego County Mental Health Services**

**BEHAVIORAL HEALTH ASSESSMENT – 0-5 CHILDREN**

**Client Name**:       **Case #:**

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

**BHA CHILDREN TAB**

**PATHWAYS TO WELL-BEING/KTA**

Client is involved with Child Welfare Services (CWS) – *(this section is only completed when client is involved with CWS.)*  [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

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)* Name:

[ ] Licensed Group Home *(LGH)* Name:

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

Name:

* + 1. [ ]  Level 12
		2. [ ]  Level 14
1. Petition True Finding based on Welfare and Institution Code, Section 300, as adjudicated by Juvenile Court *(may be multiple)*:

[ ] 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)*:

[ ] Member of Class

[ ] Member of Sub-Class

[ ] 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

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 [ ] Other:

**SOURCE OF INFORMATION**

 *(Select from Source of Information Table located in the Instructions sheet):*

 If a source other than listed on the “Source of Information” Table, specify:

 Reports Reviewed:

 \*Referral Source: (*Select from Referral Source Table*) Choose an item.

If Other, specify:

**PRESENTING PROBLEMS/NEEDS** *(Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and history of present illness. Summary of request for services including client’s most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behaviors; include experiences of stigma and prejudice, if any):*

**PAST PSYCHIATRIC HISTORY** *(History of symptoms and/or mental health and behavioral treatments. Describe in chronological order - where, when, and length of time. Include dates and providers related to any prior psychiatric treatment, history, traumatic and/or significant events, and/or trauma related to treatment. Include the most recent periods of stability and the characteristics of those periods.)*

**CHILD CARE/EARLY INTERVENTION/SCHOOL SERVICES:**

Current childcare/early intervention/school involvement:

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

[ ]  Early intervention/support services [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

[ ]  Educational program/preschool [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

[ ]  Site visit/observation conducted [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

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

Please describe:

Previous childcare/early intervention/school involvement:

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

[ ]  Early intervention/support services [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

[ ]  Educational program/preschool [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

[ ]  Site visit/observation conducted [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

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

Describe:

**FAMILY HISTORY**:

\*Living Arrangement: *(Select from Living Arrangement table listed in the Instructions Sheet):*

 Those living in the home with client:

Genogram completed: [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Ecomap completed: [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Have any relatives ever had any of the following conditions:

*(Select from Relatives table listed in the Instructions Sheet):* 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

Include relevant family information impacting the client:

Family strengths:

**CULTURAL INFORMATION**: *(Considerations could include language of client/family, primary language spoken at home, religious, spiritual beliefs, family structures, customs, morals/legal systems, life-style changes, socio-economic background, ethnicity, race, immigration history/experience, age, 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).*

Experience of stigma, prejudice, or barriers to

accessing services: [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Describe:

**HISTORY OF SELF-INJURY/SUICIDE/VIOLENCE**:

History of abuse: [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

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

Experience of traumatic event/s: [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

A YES or REFUSE/CANNOT assess response to any of the above requires detailed documentation:

**HIGH RISK ASSESSMENT TAB**

**ASSESSMENT OF IMMEDIATE RISK FACTORS:** Any “Yes” response triggers enhanced suicide/violence/homicide precautions and/or efforts to transfer to higher level of care. For all unlicensed staff, documentation of a consultation is required. For trainees specifically, review with supervisor is required prior to end of session.

Direct (past 2 weeks) discharge from 24 hour program [ ] No [ ] Yes [ ] Refuse/Cannot Assess

***due to suicidal or homicidal crisis*** (hospital, IMD, START,

residential treatment, etc.)

Current serious thoughts/impulses of hurting/killing [ ] No [ ] Yes [ ] Refuse/Cannot Assess

self or others: (*Note if access to firearms (guns) or other lethal means:)*

Pre-death behavior/committed to dying [ ] No [ ] Yes [ ] Refuse/Cannot Assess

(e.g. giving away possessions)and/or current hopelessness/sees

no options

Preoccupied with incapacitating or life threatening [ ] No [ ] Yes [ ] Refuse/Cannot Assess

illness and/or chronic intractable pain and/or catastrophic

social loss

Current command hallucinations, intense paranoid delusions [ ] No [ ] Yes [ ] Refuse/Cannot Assess

and/or command override symptoms (belief that others

control thoughts/actions)

Current behavioral dyscontrol with intense anger/humiliation, [ ] No [ ] Yes [ ] Refuse/Cannot Assess recklessness, risk taking, self-injury and/or physical aggression,

and violence.

**Additional Youth Risk Factors:**

Current extreme social alienation, isolation and/or victim of

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

A YES or Refuse/Cannot Assess response to any of the above requires detailed documentation:

**PROTECTIVE FACTORS:** (Self-regulation, strong attachment/responsibility to others, strong religious, cultural, or inherent values against harming self/others, strong social support system, positive planning for future, engagement in treatment, and valued care giving role (people or pets).)

**SELF-INJURY/SUICIDE/VIOLENCE MANAGEMENT PLAN:** (Document enhanced suicide/violence/homicide precautions and/or efforts to transfer to higher level of care. For all unlicensed staff, documentation of a consultation is required. For trainees specifically, review with supervisor is required prior to end of session.)

**TARASOFF ASSESSMENT:**

Current Violent Impulses and/or Homicidal ideation [ ] No [ ] Yes [ ] Refuse/Cannot Assess

toward a reasonably identified victim?

Tarasoff Warning Indicated? [ ] No [ ] Yes

*If yes, include victim(s) name and contact information (Tarasoff Warning Details):*

Reported To:       Date:

**CURRENT DOMESTIC VIOLENCE?** [ ] No [ ] Yes [ ] Refuse/Cannot Assess

*If yes, detailed documentation and child/adult protective services question mandatory.* Describe situation:

Child/Adult Protective Services Notification Indicated? [ ]  No [ ] Yes

Reported To:       Date:

**MENTAL STATUS EXAM TAB (SEPARATE TAB)**

[ ]  Unable to assess at this time.

**Appearance:** *(Check all that apply)*

 [ ]  Well-groomed [ ]  Dysmorphic features [ ]  Birthmark

 [ ]  Disheveled [ ]  Small-for-age [ ]  Immature-for-age [ ]  Small Head

 [ ]  Inappropriate Dress [ ]  Large-for-age [ ]  Mature-for-age [ ]  Large Head

 [ ]  Cuts, scrapes, or bruises:

[ ]  Other:

**Reaction to Situation**: Location & with whom: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­

 **Initial Reaction to setting & stranger (examiner):** *(Check* ***one*** *only)*

[ ]  Appropriately Cautious [ ]  Highly Fearful [ ]  Highly Resistant [ ]  Inappropriately Friendly [ ]  Indifferent

 Describe:

 **Behaviors:** *(Check* ***all*** *that apply)*

 [ ]  Freezes [ ]  Cries [ ]  Hides (face or body) [ ]  Tantrums [ ]  Curious [ ]  Excited [ ]  Apathetic

 [ ]  Other: ­­­­­­­­­­­­­­­­­

**Exploration** *(consistent with developmental level)*: *(Check* ***all*** *that apply)*

[ ]  Explores faces [ ]  Explores toys [ ]  Explores strangers [ ]  References caregiver while exploring

 **Transitions** *(consistent with developmental level)*: *(Check* ***all*** *that apply)*

Plays with examiner: [ ]  Easily w/ referencing [ ]  Easily w/o referencing [ ]  Slow to warm up [ ]  Resists

Request to pick up toys: [ ]  Complies [ ] Resists initially but complies w/ structure [ ]  Refuses or Tantrums

Transitions from playroom: [ ]  Easily [ ] Resists initially but complies w/ structure [ ]  Refuses or Tantrums

Expand Description of Reactions *(optional)*:

**Regulation:** *(Check* ***all*** *that apply)* *(WNL = Within Normal Limits for age)*

 **States Observed:** [ ]  Deep sleep [ ]  Quiet Alert [ ] Active Alert [ ]  Fussy [ ]  Distressed

 [ ]  Disoriented

**Sensory Responsive to:**  [ ]  Smells [ ] Light touch [ ]  Firm touch [ ] Visual stimuli [ ]  Sounds

[ ]  Other:

**Quality of Sensory Responsiveness:** [ ]  WNL [ ]  Hyperresponsive ­­­­­­­­­­­­­­­ [ ]  Hyporesponsive ­ [ ]  Other:

**Transitions & Regulation:** [ ]  Smooth Transition [ ]  Abrupt Transitions

[ ] Seeks Stimulation Excessively [ ]  Able to Sooth Self [ ]  Able to be Soothed [ ]  Difficult to calm

[ ]  Low Frustration Tolerance [ ]  Calm, quiet [ ]  Active *(climbing, exploring)* [ ]  Overcontrolled

[ ]  Restless *(squirming, constantly moving)*

**Attention Span: [ ]** WNL for age[ ]  Short for age [ ]  Long for age [ ]  Variable, situational

 Infants: [ ]  Visual fixing & following *(1 mo)* [ ]  Tracking *(2-3 mo)* [ ]  Attends to own hands

 [ ]  Attends to faces

 Toddles/Preschoolers: Longest sustained attention:       Average sustained attention:

Task Persistence: [ ]  Persistence WNL [ ]  Sustained persistence [ ]  Gives up easily

 [ ]  Easily frustrated [ ]  Other

**Expand Description of Regulation Documented Above**:

**Unusual Behaviors:** *(Check* ***all*** *that apply)*

 [ ]  Mouthing after 1 year [ ]  Head banging [ ]  Smelling objects [ ]  Finger flicking

[ ]  Hand flapping [ ]  Spinning/twirling [ ]  Rocking [ ]  Hair pulling

[ ]  Ruminating [ ]  Toe walking [ ]  Perseverative Speech

[ ]  Breath holding [ ]  Staring at lights [ ]  Spinning objects [ ]  Bizarre verbalizations

 [ ]  Bizarre behaviors

 **Expand Description of Unusual Behaviors Documented Above:**

**Motor:** *(Check* ***all*** *that apply)*

 **Muscle Tone, Strength: [ ]** WNL for age [ ]  Hypotonic [ ]  Hypertonic

 [ ]  Drooling [ ]  Swallowing problems [ ]  Feeding problems

 [ ]  Oral motor problems *(language)*

 [ ]  Abnormal gaze:

**Gross Motor Coordination:** **[ ]** WNL for age **[ ]** Advanced for age **[ ]** Delayed for age

Check areas of concern below:

Infants: [ ]  Pushing up [ ]  Head control [ ]  Rolling [ ]  Sitting [ ]  Standing [ ] Cruising

Toddlers: [ ]  Walking [ ]  Running [ ]  Climbing [ ]  Jumping [ ]  Hopping

[ ]  Kicking ball [ ]  Throwing ball

Preschoolers: [ ]  Riding tricycle [ ]  Catching ball

 **Fine Motor Coordination:** **[ ]** WNL for age **[ ]** Advanced for age **[ ]** Delayed for age

Check areas of concern below:

Infants: **[ ]** Grasping/Releasing [ ]  Transferring between hands [ ]  Banging [ ]  Using Pincer grasp

Toddlers/Preschoolers: **[ ]** Stacking blocks (#     )

 [ ]  Cutting

 [ ]  Solving puzzles (# pieces      )

 Drawing: [ ]  Scribbling [ ]  Circles [ ]  Big Head People

 [ ]  Tadpole People [ ]  Complete People

 **Unusual Motor Patterns or Tics**: **[ ]  No [ ]  Yes:**

 **Expand Description of Motor** *(optional)*:

**Speech and Language:**

 **Speech**: **[ ]** WNL for age [ ]  Articulation unclear [ ]  Dysrhythmic [ ]  Stuttering

 [ ]  Unusual quality, intonation [ ]  Other concerns

**Receptive Language: [ ]** WNL for age **[ ]** Points in response to “Where is\_\_\_\_?

[ ]  Understands requests [ ]  Understands pronouns

 [ ]  Understands prepositions

 **[ ]** Gets confused by more than 1-word commands [ ]  Other

 [ ]  Doesn’t seem to understand [ ]  Dysrhythmic

**Expressive Language: [ ]** WNL for age [ ]  Advanced for age [ ]  Delayed for age

[ ]  Vocalizing [ ]  Babbling [ ]  Imitates sounds [ ]  Jargon [ ]  Gestures

 [ ]  Single Words (#     ) [ ]  Sentences

 [ ]  Caregiver understands communication

 [ ]  Others Understand Communication

**Expand Description of Speech/Language Documented Above**:

**Affect and Mood:**

 **Modes of Expression:** [ ]  Facial [ ]  Verbal [ ]  Body Tone [ ]  Body Posture

 **Predominant Mood:** [ ]  Cheerful [ ]  Euthymic [ ]  Tired/Sleepy [ ]  Shy/Timid [ ]  Angry [ ]  Depressed [ ]  Anxious/worried [ ]  Irritable [ ]  Bored/Apathetic

[ ]  Other:

 **Affect Range & Lability: [ ]** WNL *(Congruent/Responsive)* [ ]  Flat [ ]  Blunted

 [ ]  Restricted [ ]  Labile

**Expand Description of Affect (Optional)**:

**Thought Processes**  *(\*WNL = Within Normal Limits for Age)*

**Estimated Cognitive Developmental Level:** [ ]  Sensorimotor [ ]  Pre-operational

**Within Normal Limits for Age**: [ ]  Yes [ ]  No, functioning is: [ ]  Precocious [ ]  Delayed

**Describe**:

**Stranger Fears:** [ ]  No [ ]  Yes

 **Separation Fears:** [ ]  No [ ]  Yes

 **Specific Fears:** [ ]  No [ ]  Yes

 **Nightmares:** [ ]  No [ ]  Yes

 **Trauma Symptoms:** [ ]  No [ ]  Yes, Type: [ ]  Nightmares [ ]  Flashbacks

 [ ]  Alexithymia

 [ ]  Reenactment Behaviors and/or play

 [ ]  Dissociative Phenomena

 [ ]  Other:

**If Yes to any of the Above, requires detailed documentation:**

 **Hallucinations:** [ ]  No [ ]  Yes,

If yes, Type: [ ] Visual [ ]  Tactile [ ]  Other:

Describe:

**Unusual Thought Processes for age:** [ ]  No [ ]  Yes, Type: [ ]  Bizarre Ideation

 [ ]  Perseveration

 [ ]  Loose Association

 [ ]  Jargon or echolalia

 [ ]  Other:

**If Yes to any of the above requires detailed documentation:**

**Play Behavior**

 **Estimated Developmental Level of Play:** [ ]  WNL for Age [ ]  Precocious [ ]  Delayed

 **Structure of Play:** [ ]  **Sensori-motor play** *(0-12 months)* [ ]  **Functional play** *(12-18 months)*

[ ]  **Early symbolic play** *(18+ months)*

 [ ]  **Complex Symbolic Play** *(30+ months)*

 [ ]  **Imitation, turn taking & problem solving as part of play**

**Content of Play:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DYADIC SYSTEM**

**Primary Caregiver (s) in Past**: *(Describe quality of relationship, past, present, significant disruptions, availability)*

**Significant Disruptions in Primary Relationships?** [ ]  No [ ]  Yes:

Current Primary Caregiver(s) #1:

**Subjective Experience of Caregiver(s) #1:**

 **Self Concept:**

 **View of Child:**

 **View of Responsibility:**

Current Primary Caregiver(s) #2:

**Subjective Experience of Caregiver(s) #2:**

 **Self Concept:**

 **View of Child:**

 **View of Responsibility:**

**Expand Description of Dyadic System (optional):**

**Observation of Development of Parent-Child Attachment:**

Pre-attachment (4-6 weeks)

Attachment in the Making (1-8 months)

Discriminated Attachment (7-14 months)

Goal Directed Partnership (12-36 months)

Check all that are appropriate:

[ ]  Orients to people, social smile

[ ]  Signals for help

[ ]  4-6 weeks – recognizes sound and feel

[ ]  4 months – visual discrimination of caregivers

[ ]  5-6 months – reaches, actively prefers through actions

[ ]  Object Constancy

[ ]  Protests Separations, responds to internal needs

[ ]  Normal Stranger Anxiety

[ ]  Normal Separation Anxiety

[ ]  Attachment sequences with modulation of affect

[ ]  Two-way communication of feelings

[ ]  Intentional communication of needs & goals

[ ]  Demonstrates problem solving skills integrated with affect

[ ]  Able to remain organized in challenging situations

**Development of Attachment Behaviors Within Normal Limits for Age:** [ ]  Yes [ ]  No

Describe:

**Observations of Child-Caretaker Interactions:**

**MEDICAL TAB**

\***ALLERGIES AND ADVERSE MEDICATION REACTIONS**:

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

If yes, specify:

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

\*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:

Immunizations current? [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

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

Physical Health issues: [ ]  None at this time [ ]  Yes

 If yes, specify:

Is condition followed by Primary Care Physician? [ ]  No [ ]  Yes [ ]  N/A

Physical health problems affecting mental health functioning:

Chronic Ear Infections: [ ]  No [ ]  Yes, Describe:

Serious Illness: [ ]  No [ ]  Yes, Describe:

Chronic Illness: [ ]  No [ ]  Yes, Describe:

Head injuries: [ ]  No [ ]  Yes, Describe:

Head injuries with Loss of Consciousness: [ ]  No [ ]  Yes, Describe:

Other Medical Problems: [ ]  No [ ]  Yes, Describe:

Hospitalizations: [ ]  No [ ]  Yes, Describe:

Child’s Reactions to Medical Separations or Traumatic Medical Procedures:

Eating Pattern:

Sleeping Pattern:

Growth Curves:

 Height:       [ ]  WNL [ ]  Below 15%ile [ ]  Above 85%ile

 Weight:       [ ]  WNL [ ]  Below 15%ile [ ]  Above 85%ile

Family History of Medical Problems:

Medical and/or adaptive devices:

Healing and Health: *(Alternative healing practices and beliefs. 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**

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

Describe:

Prenatal care: [ ] None [ ] Intermittent [ ] Regular Other:

During pregnancy, did the mother:

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

Experience family violence? [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

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

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

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

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

Stressors/Complications/discomfort with the pregnancy [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Describe:

Describe support system during pregnancy:

Was the pregnancy or delivery unusual or difficult in any way? [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Was birth premature? [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

If yes, number of weeks gestation:

Type of Birth: [ ]  Natural [ ]  Induced [ ]  C-Section [ ]  Forceps [ ]  Vacuum

Type Anesthesia used?

Who was present at delivery?

Was mother 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 at birth? [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

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

APGAR:

Passed Newborn Screening? [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Postpartum Psychiatric Problems? [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Provide detailed documentation to any of the above responses:

**DEVELOPMENTAL MILESTONES:**

Age at which child first:

Slept through the night:

Rolled over:

Sat up alone:

Crawled:

Walked alone:

Weaned:

Fed self:

Bladder trained:

Bowel trained:

Babbled:

First words:

Spoke in complete sentences:

[ ]  All within normal limits [ ] unknown

Assessments/Screens: [ ] ASQ-3 [ ]  ASQ-SE [ ] CBCL [ ]  Other

Describe results:

**DEVELOPMENTAL FUNCTIONING**

Cognitive functioning: [ ]  no concern [ ]  attention span [ ]  age appropriate play/exploration [ ]  problem-solving [ ]  representational abilities.

Language/Communication: [ ]  no concern [ ]  expressive [ ]  receptive [ ]  articulation

 [ ]  processing

Motor functioning: [ ]  no concern [ ] fine motor skills [ ]  gross motor skills

Adaptive functioning: [ ] no concern [ ] self-help skills [ ]  toileting [ ]  hoarding

Regulatory Functioning: [ ]  no concern [ ]  Feeding [ ]  Sleeping

 [ ]  Eliminating (urine/bowel movement)

Sensory processing: [ ]  no concern [ ]  hyper-sensitive [ ]  hypo-sensitive [ ]  sensory seeking

 [ ]  sensory avoidant

Social-emotional functioning: [ ]  no concern [ ]  attachment [ ]  peer relationships

 [ ]  social awareness and responsiveness

 [ ]  regulation of affect and behavior

Describe strengths and/or concerns:

**GENDER IDENTITY AND GENDER ROLE BEHAVIOR**

Gender identity divergent from biologic gender: [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Gender role behavior divergent from socio-cultural norms: [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Client experiences divergence as problematic: [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Others experience divergence as problematic: [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Describe:

**DC: 0-3R DIAGNOSIS**

 **I. Primary Diagnosis**:

**II. Relationship Classification**: **Caregiver #1:**

 **PIR-GAS W Caregiver 1:**       **Caregiver:**

**Relationship Quality Problems Checklist-RPCL**

 **Over Involved** [ ]  No evidence [ ]  Some evidence [ ]  Substantial evidence

 **Under Involved** [ ]  No evidence [ ]  Some evidence [ ]  Substantial evidence

 **Anxious/Tense** [ ]  No evidence [ ]  Some evidence [ ]  Substantial evidence

 **Angry/Hostile** [ ]  No evidence [ ]  Some evidence [ ]  Substantial evidence

 **Verbally Abusive** [ ]  No evidence [ ]  Some evidence [ ]  Substantial evidence

 **Physically Abusive** [ ]  No evidence [ ]  Some evidence [ ]  Substantial evidence

 **Sexually Abusive** [ ]  No evidence [ ]  Some evidence [ ]  Substantial evidence

**Describe:**

 **Relationship Classification**: **Caregiver #2:**

 **PIR-GAS W Caregiver 2:**       **Caregiver:**

**Relationship Quality Problems Checklist-RPCL**

 **Over Involved** [ ]  No evidence [ ]  Some evidence [ ]  Substantial evidence

 **Under Involved** [ ]  No evidence [ ]  Some evidence [ ]  Substantial evidence

 **Anxious/Tense** [ ]  No evidence [ ]  Some evidence [ ]  Substantial evidence

 **Angry/Hostile** [ ]  No evidence [ ]  Some evidence [ ]  Substantial evidence

 **Verbally Abusive** [ ]  No evidence [ ]  Some evidence [ ]  Substantial evidence

 **Physically Abusive** [ ]  No evidence [ ]  Some evidence [ ]  Substantial evidence

 **Sexually Abusive** [ ]  No evidence [ ]  Some evidence [ ]  Substantial evidence

**Describe:**

**III: Medical & Dev. D/O**:

Only a doctor can document a diagnosis in the field below:

**IV: Psychosocial Stressors**:

 List Sources of Stress:

Effects: [ ]  Mild [ ]  Moderate [ ]  Severe

Duration:      Age of onset:

[ ]  Acute [ ]  Enduring

Describe *(effects, duration, age of onset, severity, etc.)*

**V: Functional Emotional Developmental Level:**

 1 = Age-appropriate under all conditions and full range of affect

 2 = Age-appropriate but vulnerable to stress and/or constricted range of affect

 3 = Has capacity bit not at age appropriate level

 4 = Inconsistent/needs support and structure to function at this capacity

 5 = Barely evidences capacity even with support

 6 = Has not reached this level

 N/A = Not applicable

 **Caregiver 1:**

Emotional and Social Functioning Rating Scale:

 Attention and Regulation *(0-3 mos)*:

 Forming relationships/mutual engagement *(3-6 mos)*:

 Intentional two-way communication *(4-10 mos)*:

 Complex gestures and problem solving *(10-18 mos)*:

 Use of symbols to express thoughts and feelings *(18-30 mos)*:

 Connecting symbols logically and abstract thinking *(30-48 mos)*:

**Caregiver 2:**

Emotional and Social Functioning Rating Scale:

 Attention and Regulation *(0-3 mos)*:

 Forming relationships/mutual engagement *(3-6 mos)*:

 Intentional two-way communication *(4-10 mos)*:

 Complex gestures and problem solving *(10-18 mos)*:

 Use of symbols to express thoughts and feelings *(18-30 mos)*:

 Connecting symbols logically and abstract thinking *(30-48 mos)*:

**Therapist:**

Emotional and Social Functioning Rating Scale:

 Attention and Regulation (0-3 mos):

 Forming relationships/mutual engagement *(3-6 mos)*:

 Intentional two-way communication *(4-10 mos)*:

 Complex gestures and problem solving *(10-18 mos)*:

 Use of symbols to express thoughts and feelings *(18-30 mos)*:

 Connecting symbols logically and abstract thinking *(30-48 mos)*:

**BHA SIGNATURE PAGE TAB**

**CLINICAL FORMULATION**: *(Summarize clearly and with specific details (i.e. AEB, client statements or examples), how scoring in the high-risk range on a trauma screening tool, involvement with CWS, the Juvenile justice or homelessness results in a high risk for a mental health disorder OR with clear details state significant impairment(s) or the reasonable probability of significant deterioration in an important area(s) of life functioning or the interference(s) with appropriate developmental progress. Justify MH ICD-10 diagnosis or suspected diagnosis if not yet determined or based on the assessment of a Licensed MH professional, if at risk of a future mental health condition due to significant trauma. Document proposed service(s) to meet client’s needs and if applicable, address both MH and SUD issues from an integrated perspective.)*

**MEDICAL NECESSITY MET**:  [ ]  No [ ]  Yes

When “No,” note date NOA-A 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 or parent/guardian at intake or change of address:**

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

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

Signature

Printed Name       CCBH ID number:

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

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

Signature

Printed Name       CCBH ID number:

**Signature of Staff Entering Information (if different from above):**

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

Signature

Printed Name       CCBH ID number: