Client Assessment

CLIENT ASSESSMENT

HOST COUNTY ____________________________ COUNTY OF ORIGIN ______________________________
Mental Health Plan Mental Health Plan

Client Name:	**DOB:**	**Age Today:**
Sex: Male / Female	SSN: _______ - _____ - ___________	Identification Number: _____________ ________
Ethnicity (How does the client identify):		
Program:	Date of First Billed Service:	

Primary Caregiver:	Relationship:	Phone:
Address:		
City/State/Zip:		
Legal Guardian:	Relationship:	Phone:
Address:	City/State:	Zip:
How long in current placement:		

Parents:

☐ Mother: ________________________________ Address (if known): ____

Phone number _____________________________ ____

☐ Father: ________________________________ Address (if known): ____

Phone Number _____________________________ ____

☐ Same as caregiver/legal guardian above

☐ Unknown

Restrictions on parental rights: ____

____

Parental rights held: ____

____

Client Name: **Record/Identification Number:**

Siblings:

_________________________________ At home Foster placement Unknown/neither Other _____________

_________________________________ At home Foster placement Unknown/neither Other _____________

Additional siblings/notes (include birth order if known):

____

____

____

Comments:

Language spoken at assessment: Interpreter: Yes/No (If yes, then who?)

STRENGTHS AND RESOURCES

Check and describe all known client strengths and resources in achieving Client Plan goals.

SKILLS, INTERESTS & DESIRES OF CHILD/YOUTH

☐ Interpersonal:

☐ Creative:

☐ Academic:

☐ Athletic:

☐ Other:

FAMILY

☐ Availability:

☐ Involvement:

☐ Skills:

☐ Interests:

☐ Financial resources:

☐ Other:

Client Name: **Record/Identification Number:**

COMMUNITY AND SOCIAL SUPPORTS FOR CHILD/YOUTH
☐ Positive peer and adult relationships:
☐ School:
☐ Job or volunteer activities:
☐ Access to leisure activities:
☐ Cultural activities:
☐ Spiritual activities:
☐ Other:
COMMUNITY AND SOCIAL SUPPORTS FOR FAMILY
☐ Supportive relationships:
☐ School:
☐ Job or volunteer activities:
☐ Access to leisure activities:
☐ Cultural activities:
☐ Spiritual activities:
☐ Other:
Comments:

Presenting Problems/Target Symptoms: Use client's/caregiver's words when possible.

Client Name: **Record/Identification Number:**

SYMPTOM CHECKLIST

Check the "Ever" box if symptom was ever present.
Also check the "6 months" box if symptom was present in the past 6 months.

Category	Ever	6 months	Symptom	Ever	6 months	Symptom
MOOD ☐ None	☐	☐	Depressed mood	☐	☐	Suicidal behavior
	☐	☐	Tearful	☐	☐	Irritable, easily annoyed
	☐	☐	Loss of interest of pleasure	☐	☐	Often feels angry
	☐	☐	Isolative or withdrawn	☐	☐	Homicidal ideation
	☐	☐	Hopeless and/or helpless	☐	☐	Over-reactive (quick to anger)
	☐	☐	Fatigue	☐	☐	Excessively happy or silly
	☐	☐	Worthlessness, shame or guilt	☐	☐	Labile (sudden mood shifts)
	☐	☐	Bored	☐	☐	Distinct mood cycles
	☐	☐	Thoughts of non-suicidal self-harm	☐	☐	Episodes of excess energy, insomnia, and euphoria or rage
	☐	☐	Non-suicidal self-harm (behavioral)			
	☐	☐	Suicidal thoughts	☐	☐	Other (describe below)
ANXIETY ☐ None	☐	☐	Anxious mood	☐	☐	Avoids talk or reminders of trauma
	☐	☐	Separation anxiety or clingy	☐	☐	Hypervigilance or excessive startle
	☐	☐	Feels tense or stressed	☐	☐	Panic attacks
	☐	☐	Excessive worry	☐	☐	Agoraphobia
	☐	☐	Fears or phobias	☐	☐	Dissociation
	☐	☐	Intrusive memories	☐	☐	Obsessions or compulsions
	☐	☐	Flashbacks (trauma re-experience)	☐	☐	Other (describe below)
SLEEP, APPETITE AND ELIMINATION ☐ None	☐	☐	Initial insomnia	☐	☐	Poor appetite
	☐	☐	Middle insomnia	☐	☐	Rapid weight gain
	☐	☐	Late insomnia	☐	☐	Weight loss (unintentional)
	☐	☐	Sleeps excessively	☐	☐	Excessive weight loss (intentional)
	☐	☐	Nighttime fears	☐	☐	Bedwetting
	☐	☐	Frequent nightmares	☐	☐	Daytime enuresis
	☐	☐	Night terrors	☐	☐	Encopresis
	☐	☐	Excessive appetite	☐	☐	Other (describe below)
THOUGHT AND PERCEPTION ☐ None	☐	☐	Difficulty concentrating	☐	☐	Visual hallucinations
	☐	☐	Disorganized thought process	☐	☐	Other hallucinations
	☐	☐	Delusions	☐	☐	Perceptual distortions other than hallucinations
	☐	☐	Auditory hallucinations	☐	☐	Bizarre behavior
	☐	☐	Irrational or odd but not delusional thoughts (e.g., of persecution)	☐	☐	Other (describe below)
ACTIVITY, ATTENTION & IMPULSE ☐ None	☐	☐	Overactive or fidgety	☐	☐	Difficulty completing tasks
	☐	☐	Slowed or lethargic	☐	☐	Talks excessively
	☐	☐	Short attention span	☐	☐	Impulsive (act without thinking)
	☐	☐	Easily distracted	☐	☐	Other (describe below)

Client Name: **Record/Identification Number:**

	Ever	6 months		Ever	6 months	
CONDUCT ☐ None	☐	☐	Defiant, uncooperative, oppositional	☐	☐	Threatens, bullies, or intimidates
	☐	☐	Frequent lying	☐	☐	Runaways
	☐	☐	Blames others for own misbehavior	☐	☐	Cruel to animals
	☐	☐	Controlling, bossy, or manipulative	☐	☐	Truancy
	☐	☐	Breaks rules	☐	☐	Breaking into car or building
	☐	☐	Provokes	☐	☐	Stealing
	☐	☐	Property destruction	☐	☐	Vandalism, tagging/graffiti
	☐	☐	Physical aggression toward others	☐	☐	Gang involvement
	☐	☐	Impulsive, reactive aggression	☐	☐	Fire-setting
	☐	☐	Planned, premeditated aggression	☐	☐	Other (describe below)
ATTACHMENT ☐ None	☐	☐	Poor eye contact	☐	☐	Physically intrusive
	☐	☐	Disinterest in relationships	☐	☐	Resistant to being touched
	☐	☐	Difficulty making relationships	☐	☐	Overly attached to objects
	☐	☐	Clingy	☐	☐	Other (describe below)
SEXUALITY AND GENDER ☐ None	☐	☐	Sexualized behavior	☐	☐	Gender preference conflict
	☐	☐	Inappropriate or high-risk sexual behavior	☐	☐	Gender identity conflict
	☐	☐	Forced sexual contact – Victim	☐	☐	Inappropriate sexual comments
	☐	☐	Forced sexual contact – Perpetrator	☐	☐	Other (describe below)
NEURO-COGNITIVE ☐ None	☐	☐	Low intellectual functioning	☐	☐	Motor delay
	☐	☐	Learning disorder	☐	☐	Head injury
	☐	☐	Speech or language delay/disorder	☐	☐	Other (describe below)

Comment on the most prominent checked symptoms that need additional information.

RISK ASSESSMENT

Document special situations that present a risk to the child or others identified in the "Symptom Checklist".

Client Name: **Record/Identification Number:**

SUBSTANCE USE/ABUSE

Answer the following questions about all current drug and alcohol use.
List applicable drug(s) for items marked "Yes".

TYPE OF SUBSTANCE	PRENATAL EXPOSURE	AGE AT FIRST USE	CURRENT SUBSTANCE USE					
☐ **Not applicable (comments required)**	None/ Unknown		None/ Denies	Current Use	Current Abuse	Current Dependence	In Recovery	Client-perceived Problem
☐ Alcohol	☐		☐	☐	☐	☐	☐	☐ Y ☐ N
☐ Amphetamines (Speed/Uppers, Crank, Ritalin)	☐		☐	☐	☐	☐	☐	☐ Y ☐ N
☐ Cocaine/Crack	☐		☐	☐	☐	☐	☐	☐ Y ☐ N
☐ Opiates (Heroin, Opium, Methadone)	☐		☐	☐	☐	☐	☐	☐ Y ☐ N
☐ Hallucinogens (LSD, Mushrooms, Peyote, Ecstasy)	☐		☐	☐	☐	☐	☐	☐ Y ☐ N
☐ Sleeping Pills, Pain Killers, Valium, or Similar	☐		☐	☐	☐	☐	☐	☐ Y ☐ N
☐ PCP (Phencyclidine) or Designer Drugs (GHB)	☐		☐	☐	☐	☐	☐	☐ Y ☐ N
☐ Inhalants (Paint, Gas, Glue, Aerosols)	☐		☐	☐	☐	☐	☐	☐ Y ☐ N
☐ Marijuana/Hashish	☐		☐	☐	☐	☐	☐	☐ Y ☐ N
☐ Methamphetamines	☐		☐	☐	☐	☐	☐	☐ Y ☐ N
☐ Tobacco/Nicotine	☐		☐	☐	☐	☐	☐	☐ Y ☐ N
☐ Caffeine (Energy drinks, Sodas, Coffee, Etc.)	☐		☐	☐	☐	☐	☐	☐ Y ☐ N
☐ Over the Counter: specify in comments below	☐		☐	☐	☐	☐	☐	☐ Y ☐ N
☐ Other Substance(s): specify in comments below	☐		☐	☐	☐	☐	☐	☐ Y ☐ N

Does the child report receiving any alcohol and drug services: ☐ Yes, from this program ☐ Yes, from a different program ☐ No

Comment on any co-occurring substance abuse/use as they relate to mental health symptoms and behaviors.

Client Name: **Record/Identification Number:**

<table>
<tr><td colspan="5">MENTAL STATUS EXAMINATION
Note cultural and age factors for descriptors when applicable.</td></tr>
<tr><td>APPEARANCE</td><td>☐ Older than stated age
☐ Younger than stated age
☐ Appropriate grooming/dress for age/culture</td><td>☐ Meticulous
☐ Eccentric
☐ Poor hygiene</td><td>☐ Seductive
☐ Unique features</td><td>Describe:</td></tr>
<tr><td>EYE CONTACT</td><td>☐ Good</td><td>☐ Fair</td><td>☐ Poor</td><td>Describe:</td></tr>
<tr><td>SPEECH</td><td>☐ Normal for age/situation
☐ Loud
☐ Soft
☐ Overly talkative
☐ Brief responses</td><td>☐ Non-verbal
☐ Rapid
☐ Pressured
☐ Rambling
☐ Monotone</td><td>☐ Excessive profanity
☐ Slurred
☐ Stammer/stutter
☐ Vocal tic
☐ Other speech difficulty</td><td>Describe:</td></tr>
<tr><td>ATTITUDE</td><td>☐ Responsive
☐ Engaging
☐ Cooperative
☐ Uncooperative</td><td>☐ Superficial
☐ Guarded/distant
☐ Provocative/limit testing
☐ Manipulative/deceitful</td><td>☐ Angry/hostile
☐ Shy/timid
☐ Dramatic
☐ Demanding/insistent</td><td>Describe:</td></tr>
<tr><td>BEHAVIOR/ MOTOR ACTIVITY</td><td>☐ Normal for age/situation
☐ Slowed
☐ Overactive/restless</td><td>☐ Impulsive
☐ Agitated
☐ Unusual mannerism</td><td>☐ Tremor
☐ Motor tic
☐ Other involuntary movement</td><td>Describe:</td></tr>
<tr><td>MOOD</td><td>☐ Happy
☐ Sad</td><td>☐ Irritable or angry
☐ Bored</td><td>☐ Anxious
☐ Fearful</td><td>Describe:</td></tr>
<tr><td>AFFECT</td><td>☐ Euthymic (normal)
☐ Sad
☐ Tearful
☐ Overly Happy
☐ Irritable</td><td>☐ Angry
☐ Silly
☐ Anxious
☐ Fearful
☐ Bored</td><td>☐ Labile (rapidly shifting)
☐ Flat, blunted, constricted
☐ Incongruent with topic or thoughts</td><td>Describe:</td></tr>
<tr><td>PERCEPTIONS</td><td>☐ Normal</td><td>☐ Hallucinations
☐ Auditory
☐ Visual
☐ Other</td><td>☐ Other perceptual distortion</td><td>Describe:</td></tr>
<tr><td>THOUGHT FORM/PROCESS</td><td>☐ Linear and rational
☐ Racing</td><td>☐ Disorganized or loose associations</td><td>☐ Pervasive</td><td>Describe:</td></tr>
<tr><td>THOUGHT CONTENT</td><td>☐ Normal
☐ Delusions
☐ Obsessions</td><td>☐ Excessive preoccupation</td><td>☐ Unusual, non-delusional Ideations (suspicious, etc)
☐ Other</td><td>Describe:</td></tr>
<tr><td>THOUGHTS OF HARMING SELF OR OTHERS</td><td>☐ None
☐ Suicidal ideation
☐ Suicidal intent</td><td>☐ Thoughts or intent of non-lethal self-injury</td><td>☐ Thoughts or intent of harming another person</td><td>Describe:</td></tr>
<tr><td>SENSORIUM</td><td>Oriented to:
☐ Person
☐ Place
☐ Time
☐ Situation

Memory intact for:
☐ Immediate
☐ Recent
☐ Remote</td><td>Alertness:
☐ Alert
☐ Clouded/confused
☐ Other

Attention:
☐ Good
☐ Fair
☐ Poor</td><td>Intellectual functioning:
☐ Average or higher
☐ Below average

Insight/judgment:
☐ Good
☐ Fair
☐ Poor</td><td>Describe:</td></tr>
</table>

Client Name: **Record/Identification Number:**

FUNCTIONAL IMPAIRMENT Assess the impact of the client's impairment in the following areas.
Home:
School:
Community:
Work:
Family relationships:
Peer relationships:

CULTURAL FACTORS
Explain how the client's cultural factors, including those previously described, impact current functioning and the treatment plan. Include immigration, acculturation, sexual orientation, and other significant factors in your explanation.

SOCIAL FACTORS
Explain how the client's social factors, including those previously described, impact current functioning and the treatment plan. Include living situation, daily activities, and other significant factors in your explanation.

Client Name: **Record/Identification Number:**

DEVELOPMENTAL STATUS			
Categories	**Within Normal Limits**	**Unknown**	**Concerns/Issues (describe the specific concern or issue)**
Parental Risk Factors: i.e.- Developmental delay, mental health issues, substance/physical abuse	☐	☐	
Cognitive Functioning: i.e.- Developmental delay, learning disability, making academic progress	☐	☐	
Sensory Functioning: i.e.- Visual or auditory deficits, other sensory Deficits	☐	☐	
Fine and gross motor skills: i.e.- Motor deficits, delay in acquiring skills	☐	☐	
Early Childhood: i.e.- Prenatal care, delivery complications, neglect or abuse, separation anxiety	☐	☐	
Middle Childhood: i.e.- Problems with peers and/or siblings, age appropriate behavior, problems at school	☐	☐	
Adolescence: i.e.- Sexuality/gender issues, truancy, illegal behavior, substance/alcohol use (including nicotine)	☐	☐	
Other:			

CLIENT'S MENTAL HEALTH HISTORY		
☐ Yes	☐ No	Previous outpatient mental health services? When/Where? ____ Transfer ☐
☐ Yes	☐ No	Previous crisis contact? Number of crisis unit visits without hospitalization in past 6 months: ☐ 0 ☐ 1 ☐ 2 or more Most recent date:
☐ Yes	☐ No	Previous psychiatric hospitalization? Number of psychiatric hospitalizations in past 6 months: ☐ 0 ☐ 1 ☐ 2 or more Most recent date:
☐ Yes	☐ No	Previous diagnosis (if yes, list in comments):
☐ Yes	☐ No	Use of traditional or alternative healing practices (describe, with results):
☐ Yes	☐ No	Lab consultation/reports Date if known: Examiner if known:
☐ Yes	☐ No	Neurological Testing Date if known: Examiner if known:
☐ Yes	☐ No	Psychological Testing Date if known: Examiner if known:

Comments: Include earliest symptoms, age at onset, other support/stressors at time of onset, family understanding of problem, response to treatment, other potential contributing factors, relevant family history and any **family mental health illness history**.

Client Name: **Record/Identification Number:**

CURRENT MEDICATIONS If known, include drug names, dosages, when prescribed, and who prescribed them. Document any experienced side effects and/or compliance issues.
Current medications, including psychiatric, if known.
Past medications, including psychiatric, if known.
Additional comments:

MEDICAL HISTORY

☐ **Unknown**	☐ **Not Available**	**Current Primary Medical Care Provider:**	**Phone:**

Last Physical Exam:	☐ Within Past 12 months	☐ More than 12 months	☐ Unknown	☐ No Explain:
Last Dental Exam:	☐ Within Past 12 months	☐ More than 12 months	☐ Unknown	☐ No Explain:
Are there any health concerns (medical illness, medical symptoms)?		☐ Unknown/None Reported	☐ No	☐ Yes Explain:
Non-Medication Allergies (Food, Pollen, Bee sting, etc)		☐ Unknown/None Reported	☐ No	☐ Yes Explain:
Medication Allergies (list type)		☐ Unknown/None Reported	☐ No	☐ Yes Explain:

Has the child or caregiver reported any of the following problems/experiences? (Check all that apply)

☐ Asthma	☐ Heart Problems	☐ Surgery of any kind Explain:
☐ Broken Bones	☐ High or Low Blood Pressure	☐ Thyroid Problem
☐ Convulsion or Seizure	☐ Immune System Problems	☐ Tuberculosis (TB)
☐ Diabetes	☐ Liver Problems or Hepatitis	☐ Obesity
☐ Exposure to Toxic Lead Levels	☐ Motor or Movement Problems	☐ Weight Gain or Loss Explain:
☐ Respiratory Problems	☐ Urinary Tract or Kidney Problems	☐ Eating Disorder
☐ Cancer	☐ Serious Rash or Other Skin Problem	☐ Appetite Changes
☐ Head Injury	☐ Pregnancy	☐ Speech or Language Problems Explain:
☐ Hearing Problems	☐ Miscarriage	☐ Other
☐ Vision Problems	☐ Sexually Transmitted Disease (STD)	☐ Unknown
☐ Enuresis	☐ Encopresis	☐ None/None Reported

Comments:

Client Name: **Record/Identification Number:**

Additional clarifying formulation information, as needed. Please document any additional comments or information.

DIAGNOSING LPHA:	Lic/Reg:	Date:
DSM IV CODE:		
Axis I Primary (ICD Code, if different):		
Axis I Secondary:		
Axis II (Code and descriptor):		
Axis III:		
Axis IV (Primary):		
Axis IV (Secondary):		
Axis V:		

Notice of Privacy Practices Offered to Client/Primary Caregiver?	☐ Yes ☐ No
LPHA Printed Name:	Date:
LPHA Signature:	Lic/Reg:
LPHA Co-Signature Printed Name (if required):	Date:
LPHA Co-Signature (if required):	Lic/Reg:

Enclosure 3
(2 of 6)

Client Plan

CLIENT PLAN

HOST COUNTY ________________________ COUNTY OF ORIGIN ___________________________
Mental Health Plan Mental Health Plan

Child's Name:	**DOB/Age:**	**CIN or SSN:**

Other coordinated services/agencies involved (with contacts if known): ☐ None Known

1. ____ Contact: ____
2. ____ Contact: ____
3. ____ Contact: ____

TREATMENT GOALS		
Specific observable and/or quantifiable goals (include the current Baseline)	**Modalities and Interventions**	**Within what timeframe (Duration)**

I participated in the development of this plan and was offered a copy.

____________________________________ __________ ____________________________________ __________
Child/Youth Signature* Date Caregiver Signature Date

____________________________________ __________ ____________________________________ __________
Provider Signature (Lic/Reg) Date LPHA (Lic/Reg) Co-Signature (if required) Date

____________________________________ ____________________________________
Provider Phone Number LPHA Co-Signature Phone Number

*Child/Youth refuses or is unavailable to sign. Please explain the refusal or unavailability here.

<u>**Enclosure 3**</u>
(3 of 6)

Service Authorization Request

SB 785 Service Authorization Request
MHXXX (rev. 3/09)

SERVICE AUTHORIZATION REQUEST

For out-of-county organizational providers only.

Client's Name:	DOB/Age:	CIN or SSN:
Requesting Agency:	**Contact Person:**	
Contact Phone Number:	**Contact Fax Number:**	
Submitted to (MHP):	**Date Submitted:**	

- ☐ **Initial Authorization for "Client Assessment" only.**
- ☐ **Initial Authorization (Required documents: "Client Assessment" and "Client Plan")**
- ☐ **Re-Authorization (Submit "Client Assessment" and "Client Plan" consistent with authorizing MHP's frequency requirements)**
- ☐ **Annual Re-Authorization (Submit "Client Assessment" and "Client Plan" consistent with authorizing MHP's frequency requirements)**

Please note: The MHP may request clarifying information/documentation to process your request for any of the above.

Specialty Mental Health Service Requested	Frequency of Service	Total Units Requested	Start Date	End Date	MHP Authorization (initial approved service)
☐ Day Treatment Intensive	_____ Days/week ☐ Half Day ☐ Full Day	3 months			
☐ Day Rehabilitation	_____ Days/week ☐ Half Day ☐ Full Day	6 months			

Explain why is this level of service necessary; if requesting more than 5 days per week, include your explanation for this level of care:

____

____

____

<u>Service Necessity:</u>

Child/youth requires day rehabilitation, a structured program of rehabilitation and therapy, to:

1. ☐Improve personal independence and functioning.
2. ☐Maintain personal independence and functioning.
3. ☐Restore personal independence and functioning.

Child/youth requires day treatment intensive, a structured, multi-disciplinary program of therapy, which may be:

1. ☐An alternative to hospitalization.
2. ☐To avoid placement in a more restrictive environment.
3. ☐To maintain in a community setting.
4. ☐Other (list): ____

Client Name: **Record/Identification Number:**

Specialty Mental Health Service(s) Requested	Frequency of Service(s) (Indicate how many AND circle the frequency)	Total Minutes Requested	Start Date	End Date	MHP Authorization (initial approved service)
☐ Assessment	_____ per Week Month authorization				
☐ Plan Development	_____ per Week Month authorization				
☐ Individual Therapy	_____ per Week Month authorization				
☐ Group Therapy	_____ per Week Month authorization				
☐ Family Therapy	_____ per Week Month authorization				
☐ Collateral Services	_____ per Week Month authorization				
☐ Targeted Case Mgmt	_____ per Week Month authorization				
☐ Medication Support	_____ per Week Month authorization				
☐ Other: ______________	_____ per Week Month authorization				

Explain why this service level is necessary. If the above services are in addition to day treatment intensive/day rehabilitation services, explain why additional services are needed:

____

____

____

____

DIAGNOSIS

List Primary Diagnosis first.

Axis I: P: ____

____

____

Axis II: P: ____

____

Axis III: P: ____

____

Axis IV: P: ____

____

Axis V: Current GAF ______ Past Year GAF (if available) _____

Client Name: **Record/Identification Number:**

Impairment criteria (Must have one of the following impairments as a result of the DSM diagnosis):

1. ☐A significant impairment in an important area of life functioning.
2. ☐A probability of significant deterioration in an important area of life functioning.
3. ☐A probability that the client will not progress developmentally as individually appropriate.
4. ☐For EPSDT beneficiaries, a condition as a result of a mental disorder that specialty mental health services can correct or ameliorate.

Intervention criteria (Must have 5, 6, and 7 <u>or</u> 7 and 8):

5. ☐The focus of treatment is to address the condition identified in the impairment criteria.
6. ☐The proposed intervention will significantly diminish the impairment or prevent significant deterioration in an important area of life functioning or allow the client to progress developmentally as individually appropriate.
7. ☐The condition would not be responsive to physical health care based treatment.
8. ☐For EPSDT beneficiaries, a condition as a result of a mental disorder that specialty mental health services can correct or ameliorate.

Authorized by (Printed Name/License):____ **Date:**__________________

Signature:____ **Authorizer's Phone Number:**______________________________

Enclosure 3
(4 of 6)

Client Assessment Update

CLIENT ASSESSMENT UPDATE

HOST COUNTY _________________________ COUNTY OF ORIGIN ____________________________
Mental Health Plan Mental Health Plan

Date of this Assessment Update ______________

Child's Name:	**DOB/Age:**	**CIN or SSN:**

Please describe any changes to the following areas since the most recent Client Assessment dated: ____________________

Primary Caregiver:	Phone:	Relationship:
Address:	City/State:	Zip:
Resources (interests, family, community, school and peers, etc):	☐ No Change	
Presenting Problems:	☐ No Change	
Symptoms (mood, anxiety, thought, perception, attention, sexuality, gender, etc):	☐ No Change	
Substance Abuse:	☐ No Change	
Mental Status Exam (appearance, eye contact, speech, behavior, mood, affect, etc):	☐ No Change	
Functional Impairment (home, school/education, community, work, family/peer relationships):	☐ No Change	
Relevant Physical Health Conditions:	☐ No Change	

Client Name: **Record/Identification Number:**

Cultural Factors:	☐ No Change
Social Factors:	☐ No Change
Developmental Status:	☐ No Change
Medications:	☐ No Change
Coordinated Services/Agencies:	☐ No Change

Diagnosis: ☐ No Change

I: ____

____

____

II: ____

____

III: ____

____

IV: ____

____

V: GAF: Past Year ___________ Current Year __________

Additional comments (Optional):

LPHA Printed Name:	Date:
LPHA Signature:	Lic/Reg:
LPHA Co-Signature Printed Nate (if required):	Date:
LPHA Co-Signature (if required):	Lic/Reg:

Enclosure 3
(5 of 6)

Day Treatment Intensive Services

PROGRESS NOTES

Day Treatment Intensive Services

Client Name:	**Record/Identification Number:**	
County MHP:	**MHP Contact:**	**Phone:**

WEEK OF: ________________________________
(MM/DD to MM/DD/YY)

Attendance	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**
A = Absent -50% **P** = Present +50%							
Community Meetings							
Daily Community Meetings							
Therapeutic Milieu							
Psychotherapy							
Skill Building							
Adjunctive Therapy							
Collateral Services							
Crisis Services							
*Other:							
*Other:							
*Other:							

*List "Other" service, describe if not in program description.

MONDAY Describe client participation in program activities:
____
____
Staff Signature & Title: Date:

TUESDAY Describe client participation in program activities:
____
____
Staff Signature & Title: Date:

WEDNESDAY Describe client participation in program activities:
____
____
Staff Signature & Title: Date:

THURSDAY Describe client participation in program activities:
____
____
Staff Signature & Title: Date:

FRIDAY Describe client participation in program activities:
____
____
Staff Signature & Title: Date:

Client Name: **Record/Identification Number:**

SATURDAY Describe client participation in program activities:

____

____

Staff Signature & Title: Date:

SUNDAY Describe client participation in program activities:

____

____

Staff Signature & Title: Date:

WEEKLY CLINICAL SUMMARY

Include client behaviors, clinical decisions, staff interventions, client responses, and progress toward each of the client plan goals.

____

____

____

____

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*Provider Signature (Lic/Reg) Date *LPHA (Lic/Reg) Co-Signature (if required) Date

Provider Phone Number LPHA Co-Signature Phone Number

* I have reviewed and concur with the Progress Notes and Weekly Summary for this week.

Enclosure 3
(6 of 6)

Day Rehabilitation Services

PROGRESS NOTES

Day Rehabilitation Services

Child's Name:		**Identification Number:**
County MHP:	**MHP Contact:**	**Phone:**

WEEK OF: ______________________________
(MM/DD to MM/DD/YY)

Attendance	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**
A = Absent -50%; **P** = Present +50%							
Community Meetings							
Daily Community Meetings							
Therapeutic Milieu							
Process Group							
Skill Building							
Adjunctive Therapy							
*Other:							
*Other:							
*Other:							

*List "Other" service, describe if not in program description.

WEEKLY SUMMARY
Include client behaviors, clinical decisions, staff interventions, client responses, and progress toward the client plan goals.

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Provider Signature (Lic/Reg) Date Co-Signature (if required) Date

Provider Phone Number Co-Signature Phone Number