

1 - Office	4 - Home	8 - Correctional Facility	11 - Faith-based	14 - Client's Job Site	17 - Non-Traditional	20 - Telehealth
2 - Field	5 - School	9 - Inpatient	12 - Health Care	15 - Adult Residential	18 - Other	21 - Unknown
3 - Phone	6 - Satellite Clinic	10 - Homeless	13 - Age-Specific	16 - Mobile Service	19 - Children's Residential	

DATE: _____	BILLING TIME: _____	LOCATION: _____	SERVICE TYPE: _____	PREFERRED LANGUAGE: _____
DATE: _____	BILLING TIME: _____	LOCATION: _____	SERVICE TYPE: _____	PREFERRED LANGUAGE: _____
DATE: _____	BILLING TIME: _____	LOCATION: _____	SERVICE TYPE: _____	PREFERRED LANGUAGE: _____

Gender:  M  F    Marital Status:  Single  Married  Divorced  Widowed  Separated  Lives In/With: \_\_\_\_\_  
Age:  Under 6 Y/O<sup>1</sup>     Over 15 Y/O<sup>2</sup>

**NOTE:** Shaded items with superscripts trigger CANS-SB Module. Completion of triggered CANS-SB Modules are required.

Person giving treatment consent:  Parent(s)  Guardian  CFS  Court  Self: \_\_\_\_\_  
Referral source:  Person(s) child is living with  School  CFS  Court  Probation  Access Unit  Health Plan  Self  
Other agencies/providers client is involved with:  None  
Sources of information:  Minor  Caregiver  Other: (name, role) \_\_\_\_\_

**PRESENTING PROBLEM / HISTORY OF CURRENT PROBLEMS**  
Include significant problems with regard to daily living, such as with responsibilities, social relations, living arrangement, mental health and physical health. Include cultural explanations if these are important to the client.

Motives for services / What does client really want from services?

What do caregivers really want from services?

Why is client coming for help now?

**REFER TO CANS-SB MANUAL FOR DETAILED SCORING INFORMATION**

**KEY**  
0 = NO EVIDENCE TO BELIEVE ITEM REQUIRES ANY ACTION  
1 = NEEDS WATCHFUL WAITING, MONITORING OR POSSIBLY PREVENTIVE ACTION  
2 = NEEDS ACTION. STRATEGY NEEDED TO ADDRESS PROBLEM/NEED  
3 = NEEDS IMMEDIATE/INTENSIVE ACTION. IMMEDIATE SAFETY CONCERN/PRIORITY FOR INTERVENTION

**CHILD BEHAVIORAL/EMOTIONAL NEEDS**

	n/a	0	1	2	3		n/a	0	1	2	3
Psychosis	<input type="checkbox"/>	Anger Control	<input type="checkbox"/>								
Impulsivity/Hyperactivity	<input type="checkbox"/>	Eating Disturbances*	<input type="checkbox"/>								
Depression	<input type="checkbox"/>	Affect Dysregulation*	<input type="checkbox"/>								
Anxiety	<input type="checkbox"/>	Behavioral Regressions*	<input type="checkbox"/>								
Oppositional	<input type="checkbox"/>	Somatization*	<input type="checkbox"/>								
Conduct	<input type="checkbox"/>	Substance Use <sup>9</sup>	<input type="checkbox"/>								
Adjustment to Trauma <sup>8</sup>	<input type="checkbox"/>										

Dysfunction requiring treatment (consider work, school, home, peer, family, parenting, self-care, etc.):  None

**LIFE DOMAIN FUNCTIONING**

	n/a	0	1	2	3		n/a	0	1	2	3
Family <sup>3</sup>	<input type="checkbox"/>	Medical	<input type="checkbox"/>								
Living Situation	<input type="checkbox"/>	Physical	<input type="checkbox"/>								
Social Functioning	<input type="checkbox"/>	Sexuality <sup>5</sup>	<input type="checkbox"/>								
Recreational	<input type="checkbox"/>	Sleep	<input type="checkbox"/>								
Developmental <sup>4</sup>	<input type="checkbox"/>	School Behavior <sup>6</sup>	<input type="checkbox"/>								
Job Functioning	<input type="checkbox"/>	School Achievement <sup>6</sup>	<input type="checkbox"/>								

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**County of San Bernardino**  
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**Confidential Patient Information**  
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**PROGRAM:** \_\_\_\_\_

Legal

School Attendance<sup>6</sup>

**MENTAL HEALTH HISTORY**

Type of Treatment (e.g., inpatient, outpatient)	Provider	Therapeutic Modality (e.g., therapy, medication)	Date(s)	Response to Treatment

**ASSESSMENT OF RISK**

**CLINICAL MASTERS LEVEL OR ABOVE ONLY**

Danger to Self:  None  Ideation  Plan  Intent w/o means  Intent w/means  
 Danger to Others:  None  Ideation  Plan  Intent w/o means  Intent w/means  
 Identifiable victim(s) (Tarasoff) See note dated: \_\_\_\_\_  
 Please describe actions taken: \_\_\_\_\_

Grave Disability:  No  Yes As evidenced by: \_\_\_\_\_

Suicide Hx:  No  Yes Describe if yes: \_\_\_\_\_

Homicide Hx:  No  Yes Describe if yes: \_\_\_\_\_

Abuse Hx:  No  Yes Describe if yes: \_\_\_\_\_

Risk for Abuse and/or Victimization:  No  Yes Describe if yes: \_\_\_\_\_

**CHILD RISK BEHAVIORS**

	n/a	0	1	2	3		n/a	0	1	2	3
Suicide Risk	<input type="checkbox"/>	Delinquency <sup>13</sup>	<input type="checkbox"/>								
Self-Mutilation	<input type="checkbox"/>	Judgment	<input type="checkbox"/>								
Other Self Harm	<input type="checkbox"/>	Fire Setting <sup>14</sup>	<input type="checkbox"/>								
Danger to Others <sup>10</sup>	<input type="checkbox"/>	Social Behavior - Sanction Seeking	<input type="checkbox"/>								
Sexual Aggression <sup>11</sup>	<input type="checkbox"/>										
Runaway <sup>12</sup>	<input type="checkbox"/>										

**MEDICAL HISTORY**

Current health problems:  None

Current health conditions placing client at special risk:  None

Currently pregnant?  Yes  No

Allergies to medicine or other substances:  None

Medications: (for medical and mental health conditions)

Medication/Herbal Tx	Dosage/Frequency	Duration	Response/Side Effects

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**SUBSTANCE EXPOSURE/SUBSTANCE USE (PAST AND PRESENT)**

No issue noted (If none, proceed to next section)

SUBSTANCE	EVER USED?	CURRENTLY USING?	AGE WHEN FIRST USED	TIME OF LAST USE	FREQUENCY & QUANTITY OF USE	PROBLEMS ASSOCIATED W/USE (I.E., LEGAL, INTERPERSONAL)	WITHDRAWAL AND/OR TOLERANCE?	EFFORTS TO STOP OR CUT DOWN AND TX
Tobacco	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y					<input type="checkbox"/> W <input type="checkbox"/> T	
Alcohol	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y					<input type="checkbox"/> W <input type="checkbox"/> T	
Caffeine	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y					<input type="checkbox"/> W <input type="checkbox"/> T	
Marijuana	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y					<input type="checkbox"/> W <input type="checkbox"/> T	
Complementary / Alt. Medications:	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y					<input type="checkbox"/> W <input type="checkbox"/> T	
OTC Medications:	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y					<input type="checkbox"/> W <input type="checkbox"/> T	
Illicit Drugs: (include IV drug use)	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y					<input type="checkbox"/> W <input type="checkbox"/> T	
Other:	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y					<input type="checkbox"/> W <input type="checkbox"/> T	

Additional information:

**DEVELOPMENTAL HISTORY**

Pregnancy Planned  YES  NO \_\_\_\_\_ Complications?  YES  NO \_\_\_\_\_  
 Drug/Alcohol Impact  YES  NO \_\_\_\_\_ Premature Birth?  YES  NO \_\_\_\_\_  
 Birth Complications  YES  NO \_\_\_\_\_  
 Age When: Crawled? \_\_\_\_\_ Walked? \_\_\_\_\_ Spoke Single Words? \_\_\_\_\_ Spoke Sentences? \_\_\_\_\_ Toilet Trained? \_\_\_\_\_  
 Age-appropriate Self-Care:  WNL  
 Current Developmental Delays and Problems:  None

**FAMILY HISTORY**

Birth order: \_\_\_\_\_ of \_\_\_\_\_ Raised by:  Birth Parents \_\_\_\_\_ Age at parents' divorce:  N/A \_\_\_\_\_  
 Out of home placements:  None  
 Parents are:  Married  Living Together  Separated  Divorced  No Longer Connected:  
 Problems with parents:  None  
 Cultural or acculturation-related parenting issues:  None  
 Siblings:  None  
 Problems with siblings:  None  
 Support system support/involvement of family in client's life:  None  
 Desire of client for involvement of family or others in treatment:  None

**CAREGIVER STRENGTHS/NEEDS**

Caregiver section does not apply at this time

	n/a	0	1	2	3		n/a	0	1	2	3
Supervision	<input type="checkbox"/>	Physical	<input type="checkbox"/>								
Involvement	<input type="checkbox"/>	Mental Health	<input type="checkbox"/>								
Knowledge	<input type="checkbox"/>	Substance Use	<input type="checkbox"/>								
Organization	<input type="checkbox"/>	Developmental	<input type="checkbox"/>								

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**PROGRAM:** \_\_\_\_\_

Social Resources  
Residential Stability  
Caregiver name: \_\_\_\_\_

Safety

Caregiver role: \_\_\_\_\_

**PROBLEM HISTORY**

Behavior problems:  None

Temper/Violence/Harm to Animals/Property:  None

Past and current arrests and legal problems:  None

Sexually active:  Yes  No \_\_\_\_\_ Sexual problems:  Yes  No \_\_\_\_\_

Sexual orientation issues:  None

Sleep problems:  None

Eating problems:  Normal  Binge  Purge  Underweight  Obese  Compulsive Eating  Distorted Body Image

Other:

Past and present employment:  Never employed

**SCHOOL/PEER RELATIONS**

School history: School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Current problems with:  Teachers  Grades  Peers  Suspensions/expulsions  Truancy  
 Resists going to school  Problems separating from home/parents  
 Recent drop in grades  Receiving special services Grades usually receives: \_\_\_\_\_

Explanation:

Peer issues:  None  Isolates  Cries a lot  Shy  Few friends  Usually a follower  
 Bullies  Provokes/teases  Fights  Frequently loses friends  Makes friends easily  
 Usually a leader  Frequently teased about: \_\_\_\_\_

Explanation:

**CULTURE/DIVERSITY**

Assess unique aspects of the client, including culture, background, and sexual orientation, that are important for understanding and engaging the client and for care planning.

Preferred language for receiving our services:  English  Other: \_\_\_\_\_ (If not English, complete all items in this section)

Nature of services and staff assigned will need to be significantly culturally-related:  No  Yes (How?)

(If "yes" complete all items in this section)

If the answers to the abovementioned items are "English" and "No," respectively, the remainder of this section is optional.

Mother's country of origin: \_\_\_\_\_ Father's country of origin: \_\_\_\_\_

Number of years client and parents have been in this country: Client:  All his/her life \_\_\_\_\_ Parents:  All their lives \_\_\_\_\_

Culture client most identifies with:

Problems client has had because of his/her cultural background:  None

Culture-related healing practices used:  None

Additional cultural/diversity assessment: (optional)  None

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Importance of religion/spirituality for client:  Not Important

**ACCULTURATION**

	0	1	2	3		0	1	2	3
Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ritual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Identity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cultural Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**CLIENT STRENGTHS**

Client strengths:

**CHILD STRENGTHS**

	n/a	0	1	2	3		n/a	0	1	2	3
Family		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spiritual/Religious		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpersonal		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Community Life		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Optimism		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Relationship Permanence <sup>7</sup>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Educational		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Well-being*		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vocational	<input type="checkbox"/>	Resiliency		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Talents/Interests		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Resourcefulness		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**MENTAL STATUS (CLINICAL MASTERS LEVEL OR ABOVE ONLY)**

Please check one or more of the following boxes below

**APPEARANCE:**  Clean  Groomed  Dirty  Disheveled (Describe)

**SPEECH:**  Organized  Coherent  Pressured  Rapid  Slow  Mumbling (Describe)

**ORIENTATION:**  Person  Place  Time  Situation (Describe)

**AFFECT:**  Appropriate  Blunted/Flat  Restricted  Labile  Tearful (Describe)

**INSIGHT:**  Good  Average  Poor  None (Describe)

**JUDGMENT:**  Good  Average  Poor (Describe)

**MOOD:**  Stable  Depressed  Irritable  Anxious  Manic  Elevated (Describe)

**PERCEPTION:**  Normal  Auditory Hallucinations  Visual Hallucinations  Other: \_\_\_\_\_ (Describe)

**THOUGHT CONTENT:**  Normal  Delusional  Grandiose  Paranoid  Phobic  Other: \_\_\_\_\_ (Describe)

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**THOUGHT PROCESS:**  Organized  Poor Concentration  Obsessive  Flight of Ideas  Thought Blocking (*Describe*)

**MEMORY:** Intact for:  Immediate  Recent  Remote (*Describe*)

**INTELLECTUAL FX ESTIMATE:**  Above Average  Average  Below Average  Intellectual Disability (*Describe*)

**CANS-SB MODULES**

No Modules Triggered (*no information to be completed in this section*)

**Early Development (ED) Module 0-5<sup>1</sup>**

Not Applicable

	0	1	2	3		0	1	2	3
Motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance Exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Parent or Sibling Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Maternal Availability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Failure to Thrive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Curiosity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Regulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Playfulness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Birth Weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PICA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Adaptability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prenatal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Labor and Delivery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Empathy for Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Transitional Age Youth (TAY) Module<sup>2</sup>**

Not Applicable

	0	1	2	3		0	1	2	3
Independent Living Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gender Identity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Orientation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parenting Roles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medication Compliance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personality Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Educational Attainment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intimate Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Victimization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Family Difficulties (FAM) Module<sup>3</sup>**

Not Applicable

	0	1	2	3		0	1	2	3
Relationship with Bio-Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Parental/Caregiver Collaboration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship with Bio-Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship with Primary Caregiver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family Role Approp/Boundaries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship among Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family Conflict	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Developmental Needs (DD) Module<sup>4</sup>**

Not Applicable

	0	1	2	3		0	1	2	3
Cognitive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Developmental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Self-care/Daily Living Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Sexuality Module<sup>5</sup>**

Not Applicable

	0	1	2	3		0	1	2	3
Promiscuity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Knowledge of Sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Masturbation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Choice of Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reactive Sexual Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Exploitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**School Module<sup>6</sup>**

Not Applicable

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	0	1	2	3		0	1	2	3
Attention-Concentration in School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression in School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensory Integration Difficulties in School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peer Relations in School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Affect Dysregulation in School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oppositional in School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety in School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Conduct in School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Permanency Module<sup>7</sup>**

Not Applicable

	0	1	2	3		0	1	2	3
Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Living Situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biological/Adoptive Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Grief and Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biological/Adoptive Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family Identity and Belonging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Significant Adults	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family Finding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Trauma Module<sup>8</sup>**

Not Applicable

**Characteristics of the Trauma Experience**

	0	1	2	3		0	1	2	3
Sexual Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Witness to Family Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Witness to Community Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Witness/Victim - Criminal Acts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neglect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Marital/Partner Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Natural Disaster	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

**Sexual Abuse Expansion - Complete if Sexually Abused**

	0	1	2	3		0	1	2	3
Emotional Closeness to Perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Duration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Force	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Reaction to Disclosure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Adjustment to Sexual Abuse Expansion - Complete if Sexually Abused**

	0	1	2	3		0	1	2	3
Affect Regulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dissociation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intrusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Caregiver Post-Traumatic Reaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

**Substance Use Disorder (SUD) Module<sup>9</sup>**

Not Applicable

	0	1	2	3		0	1	2	3
Severity of Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peer Influences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Duration of Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Parental Influences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stage of Recovery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Environmental Influences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Violence Module<sup>10</sup>**

Not Applicable

**Historical risk factors**

	0	1	2	3		0	1	2	3
History of Physical Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Witness to Environmental Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Witness to Domestic Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

**Emotional/Behavioral risks**

	0	1	2	3		0	1	2	3
Bullying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paranoid Thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frustration Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Secondary Gains from Anger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hostility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Violent Thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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**Resiliency factors**

	0	1	2	3		0	1	2	3
Aware of Violence Potential	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Commitment to Self-Control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Response to Consequences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Treatment Involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Sexually Aggressive Bx (SAB) Module<sup>11</sup>**

Not Applicable

	0	1	2	3		0	1	2	3
Relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Response to Accusation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Force/Threat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Temporal Consistency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of Sexual Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Age Differential	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severity of Sexual Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type of Sex Act	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prior Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Runaway Module<sup>12</sup>**

Not Applicable

	0	1	2	3		0	1	2	3
Frequency of Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Likelihood of Return on Own	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consistency of Destination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Involvement with Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safety of Destination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Realistic Expectations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Involvement in Illegal Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Juvenile Justice (JJ) Module<sup>13</sup>**

Not Applicable

	0	1	2	3		0	1	2	3
Seriousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peer Influences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Parental Criminal Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Environmental Influences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

**Fire Setting (FS) Module<sup>14</sup>**

Not Applicable

	0	1	2	3		0	1	2	3
Seriousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Community Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Response to Accusation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Remorse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of Accelerants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Likelihood of Future Fire	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intention to Harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

**DISPOSITION**

**Diagnosis:**  See diagnosis sheet for full diagnosis

**Case Status:**  Case Open     NOA Issued     Rationale for NOA: (Medi-Cal Only)

**Disposition:** List actions taken, recommendations, and referrals made (*mental health tx, drug/alcohol tx, community resources, medical care, etc.*). Include preferred language for services and provider gender and ethnicity if these are important to the client.

(All staff participating sign below)

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Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

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ASSESSMENT UPDATE

Update entries may be made here of important background information or other assessment information about changes in the client's circumstances discovered during the course of services. All entries will be dated and signed as a regular chart note. If an interview takes place, it may be charted here and billed by adding the MHS-Assess heading, the billing time, and the location code.

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