

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 Widow Separated Lives In/With: _____
 Age: Under 6 Y/O¹ Over 15 Y/O²

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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anger Control		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impulsivity/Hyperactivity		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disturbances*		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Affect Dysregulation*		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Behavioral Regressions*		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oppositional		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Somatization*		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conduct		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance Use ⁹		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adjustment to Trauma ⁸		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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 ³		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medical		<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"/>	Physical		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Functioning		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexuality ⁵		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreational		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developmental ⁴		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Social Behavior ⁶	<input type="checkbox"/>				

CHILD/ADOL CLINICAL ASSESSMENT County of San Bernardino DEPARTMENT OF BEHAVIORAL HEALTH Confidential Patient Information See W&I Code 5328	NAME: _____ CHART NO.: _____ DOB: _____ PROGRAM: _____
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Job Functioning
Legal

School Achievement⁶
School Attendance⁶

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 ¹³	<input type="checkbox"/>								
Self-Mutilation	<input type="checkbox"/>	Judgment	<input type="checkbox"/>								
Other Self Harm	<input type="checkbox"/>	Fire Setting ¹⁴	<input type="checkbox"/>								
Danger to Others ¹⁰	<input type="checkbox"/>	Social Behavior - Sanction Seeking	<input type="checkbox"/>								
Sexual Aggression ¹¹	<input type="checkbox"/>										
Runaway ¹²	<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

SUBSTANCE EXPOSURE/SUBSTANCE USE (PAST AND PRESENT)

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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"/>								
Social Resources	<input type="checkbox"/>	Safety	<input type="checkbox"/>								
Residential Stability	<input type="checkbox"/>										

Caregiver name: _____ Caregiver role: _____

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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
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"/>

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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"/>				
Interpersonal		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Community Life	<input type="checkbox"/>				
Optimism		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Relationship Performance ⁷	<input type="checkbox"/>				
Educational		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Well-being*	<input type="checkbox"/>				
Vocational	<input type="checkbox"/>	Resiliency	<input type="checkbox"/>								
Talents/Interests		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Resourcefulness	<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)*

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

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

Early Development (ED) Module 0-5¹

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) Module²

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) Module³

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) Module⁴

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 Module⁵

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 Module⁶

Not Applicable

	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 Module⁷

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"/>

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Trauma Module⁸

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"/>

Substance Use Disorder (SUD) Module⁹

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 Module¹⁰

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"/>

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) Module¹¹

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 Module¹²

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"/>

CHILD/ADOL CLINICAL ASSESSMENT
County of San Bernardino
DEPARTMENT OF BEHAVIORAL HEALTH

Confidential Patient Information
See W&I Code 5328

NAME: _____

CHART NO.: _____

DOB: _____

PROGRAM: _____

Consistency of Destination
Safety of Destination
Involvement in Illegal Activity

Involvement with Others
Realistic Expectations
Planning

Juvenile Justice (JJ) Module¹³

Not Applicable

Seriousness
History
Planning
Community Safety

0 1 2 3

Peer Influences
Parental Criminal Behavior
Environmental Influences

0 1 2 3

Fire Setting (FS) Module¹⁴

Not Applicable

Seriousness
History
Planning
Use of Accelerants
Intention to Harm

0 1 2 3

Community Safety
Response to Accusation
Remorse
Likelihood of Future Fire

0 1 2 3

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)

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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