

|            |                      |                           |                   |                        |                            |                 |
|------------|----------------------|---------------------------|-------------------|------------------------|----------------------------|-----------------|
| 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 - Childrens Residential |                 |

**DATE:** \_\_\_\_\_ **SERVICE TIME:** \_\_\_\_\_ **LOCATION:** \_\_\_\_\_ **SERVICE TYPE:** ASSESSMENT

ALL ITEMS BELOW MUST BE COMPLETED (EVEN WITH N/A OR "NOT AVAILABLE"). THE ASSESSMENT SHOULD ILLUSTRATE ALL MEDICAL NECESSITY PRESENT AND PROVIDE THE BASIS FOR THE DSM-4 DIAGNOSIS.

**IDENTIFYING DATA** Age: \_\_\_\_\_ Gender:  M  F Marital Status:  S  M  D  W  Sep Education (yrs.): \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Lives In/With: \_\_\_\_\_  
 Ethnic Background: \_\_\_\_\_ Preferred Language for Tx: \_\_\_\_\_ Primary Care MD: \_\_\_\_\_ M.D. Phone: \_\_\_\_\_  
 Person Giving Tx Consent:  Self  Parent  Fam. Caregiver  Foster Parent  Guard.  Conserv.  DCS  Other: \_\_\_\_\_  
 Referral Source:  Self  School  Probation  DCS  APS  Parent/Guard/Conserv/Family  Other: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**REFERRAL INFORMATION**

SELPA: \_\_\_\_\_ Date of IEP Requesting Services: \_\_\_\_\_ Date Referral Received: \_\_\_\_\_  
 Date Assessment Plan Signed: \_\_\_\_\_ Date Assessment Completed: \_\_\_\_\_

**PRESENTING PROBLEM/HISTORY OF CURRENT PROBLEMS** (Include significant problems with regard to daily living, such as with responsibilities, social relations, living arrangement, and health. For children, include child education status (school, teacher, suspensions, expulsions):

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**RECORDS REVIEWED** (List all separate mental health episodes, school, and other records reviewed):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

**SCHOOL RECORDS**

School Attending: \_\_\_\_\_ Grade Level: \_\_\_\_\_ Level of Special Education Placement: \_\_\_\_\_  
 History of School Interventions

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**CLINICAL ASSESSMENT**  
**AB2726 Counseling**

**Confidential Patient Information**  
**See W&I Code 5328**

**NAME:**  
**CHART NO:**  
**DOB:**  
**PROGRAM:**

**SUMMARY OF INTERVIEWS**

Parent Interview

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Child Interview

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Teacher Interview

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**SUMMARY OF TESTING**

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PSYCHIATRIC HISTORY Sources of Information: ( reliability uncertain) \_\_\_\_\_

History of Mental Illness in Family:  None \_\_\_\_\_

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Previous INPT and OUTPT MENTAL HEALTH TX (include dates, providers, dx., results): [ ] No previous inpt tx [ ] No previous outpt tx \_\_\_\_\_

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Current and Past Medications (psychotropic & other, including over-the-counter) (include dosage if known)

Past:  None \_\_\_\_\_  
Current:  None \_\_\_\_\_

Previous Suicide / Homicide History Suicide Attempts:  None \_\_\_\_\_

Homicide:  None \_\_\_\_\_

MEDICAL HISTORY Current Health Problems:  None \_\_\_\_\_

Medical Referral Needed?  Yes  No

Sleep:  No problems  Current sleep problem elaborate): \_\_\_\_\_

Appetite:  No problems  Weight Gain  Weight Loss  Current appetite problem (elaborate): \_\_\_\_\_

Physical, Developmental, Cognitive, and other Handicaps:  None \_\_\_\_\_

Head Injuries, Unconsciousness, Seizures:  No history  History of head injuries, unconsciousness, seizures (elaborate): \_\_\_\_\_

**SUBSTANCE PROBLEMS** (describe use)

|   |   |
|---|---|
| Nicotine <input type="checkbox"/> None _____    | <input type="checkbox"/> Not a current problem <input type="checkbox"/> Hx of problem |
| Alcohol <input type="checkbox"/> None _____     | <input type="checkbox"/> Not a current problem <input type="checkbox"/> Hx of problem |
| Drugs <input type="checkbox"/> None _____       | <input type="checkbox"/> Not a current problem <input type="checkbox"/> Hx of problem |
| Medications <input type="checkbox"/> None _____ | <input type="checkbox"/> Not a current problem <input type="checkbox"/> Hx of problem |
| Caffeine <input type="checkbox"/> None _____    | <input type="checkbox"/> Not a current problem <input type="checkbox"/> Hx of problem |
| Other _____                                     | <input type="checkbox"/> Not a current problem <input type="checkbox"/> Hx of problem |

**DEVELOP. HISTORY/ MILESTONES** (optional for adults) [ ] No unusual prenatal events [ ] Perinatal dev. within usual limits \_\_\_\_\_

**EMPLOYMENT**

|  |   |
|--|---|
| <input type="checkbox"/> Full-time employment (as _____) | <input type="checkbox"/> Part-time employment (as _____)  |
| <input type="checkbox"/> Job training (to be _____)      | <input type="checkbox"/> Unemployed (has worked as _____) |
| <input type="checkbox"/> Disabled (due to _____)         | <input type="checkbox"/> Retired (from _____)             |
| <input type="checkbox"/> Homemaker                       | <input type="checkbox"/> Other _____                      |

CURRENT INCOME AND SOURCES \_\_\_\_\_

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**LEGAL HISTORY**

ARRESTS  None \_\_\_\_\_  
CURRENT LEGAL PROBLEMS  None \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SEXUAL ORIENTATION/CULTURAL/FAMILY/SPIRITUAL ISSUES  None \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**RISK ASSESSMENT**

Current Health Conditions Placing Client At Special Risk:  None \_\_\_\_\_  
Allergies and Adverse Reactions to Medications:  No allergies/adverse reactions to medicines or other substances  
 Allergies/adverse reactions to medicines reported (explain): \_\_\_\_\_  
 Allergies/adverse reactions to other substances reported (explain): \_\_\_\_\_

Risk For Abuse and/or Victimization:  Non-significant \_\_\_\_\_  
Current Suicide Risk:  None noted  Ideation  Plan  Means (Explanation required): \_\_\_\_\_

Current Homicide Risk and Other Risks Posed to Other People by Client:  None noted  Ideation  Plan  Means  
 Person(s) at risk \_\_\_\_\_ (Explanation required): \_\_\_\_\_

CLIENT STRENGTHS \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

OTHER COMMENTS \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DYSFUNCTION RATING (use DBH definitions):  Less than mild  Mild  Moderate  Severe Behavior supporting rating: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

OTHER AGENCIES/PROVIDERS WITH WHOM THE CLIENT IS INVOLVED \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DISPOSITION List actions taken, recommendations, and referrals made: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FORMULATION/EXPLANATION OF PROBLEMS (optional): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**AB2726 CONCLUSION**

**AB2726 ELIGIBILITY SUMMARY:**

Service recommendation below is based on the following: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- No mental health services recommended under AB2726 Program
- Mental health services are recommended, but not under AB2726 Program
- Client is approved for AB2726 mental health services

**SUMMARY OF TARGET PROBLEMS FOR AMELIORATION: (Correlate with MHS Service Plan)**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**RECOMMENDATIONS**

The attached Service Plan is submitted to the Referring I.E.P. Team. These recommendations may be accepted and incorporated into the I.E.P. Team Meeting Report as a whole and without modification and without D.B.H. representation at the Expanded I.E.P. Meeting. These recommendations and services will have up to a twelve (12) month duration if approved by the I.E.P. Team and so documented on the I.E.P. Team Meeting Report. Any modification made to the recommended services will require Behavioral Health staff presence and signature of agreement on the I.E.P. Team Report prior to D.B.H. acceptance of responsibility to provide the services as modified.

SIGNATURE \_\_\_\_\_ PRINTED NAME: \_\_\_\_\_ DATE \_\_\_\_\_

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