

NORTH COUNTRY COMMUNITY MENTAL HEALTH

Consumer Name	DOB	ID #	Date
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In order to help you best, we would like to know some things about you or your child. If you have any questions about anything we've asked, please ask for assistance. If you are uncomfortable providing answers to any of these questions, please draw a single line through the question and skip it.

1 LIVING ARRANGEMENTS-Check one

- 01 Homeless
 - 02 Living with natural or adoptive family member(s) in a private residence
 - 03 Private residence alone or w/ spouse or non-relative (not owned by CMHSP)
 - 05 Foster family home (Children's Foster Care)
 - 06 Specialized residential - Adult Foster Care
 - 08 General residential - Adult Foster Care
 - 10 Prison/jail/juvenile detention
 - 12 Nursing Care Facility
 - 13 Institutional setting
 - 16 Supported Independence Living Program
- If dependent, what was last independent address?**

FAMILY AND SOCIAL LIFE

2 Ethnic Background

- 01 Native American
- 02 Asian/Pacific Islander
- 03 African American/Black
- 04 White/Caucasian
- 05 Hispanic
- 06 Multi-Racial
- 08 Arab American
- 09 I refuse to provide this information

3 Primary Language Spoken

- CHI Chinese ENG English
- FRE French JPN Japanese
- POR Portuguese SGN Sign Language
- SPA Spanish

4 Marital Status

- 01 Never married 04 Separated
- 02 Married 05 Divorced
- 03 Widowed 06 Significant Other

5 Parental Status

Indicate if consumer (no matter what age) is the natural or adoptive parent of a minor child (under 18 years old)

01 Yes 02 No

6 List Household Members

Name	Relationship	Age
	SELF	

Next Of Kin:

Address:

Phone:

7 EMPLOYMENT-Check one

- 01 I work full-time over 30 hours
- 02 I work part-time under 30 hours
- 03 I am unemployed, looking for work and/or laid off
- 04 I am unemployed, not looking for work, in a day program, resident or inmate of an institution (including nursing home)
- 06 Retired
- 07 Sheltered Workshop
- 08 Not applicable (Child under 18)
- 09 In supported employment only
- 10 In supp. employment & competitive employment
- Unreported

8 Military Experience

- Yes No Are you a veteran?
- Yes No If yes, combat experience?
- Year drafted/enlisted Year discharged
- Type of discharge
- Highest rank obtained
- Any disciplinary action, Article 15?

9 EDUCATION-Check one

- 01 Completed less than high school
- 02 Completed high school, GED or Special Ed
- 03 In school K-12th grade
- 04 In training program
- 06 In Special Education
- 07 Attended or is attending undergraduate college
- 08 College graduate
- Unreported

10 LEGAL

Corrections Related Status (Indicate loc./jurisdiction)

- 01 In prison
- 02 In jail
- 03 Paroled from prison
- 04 Probation from jail
- 05 Juvenile detention center
- 06 Court supervision
- 07 **NOT UNDER ANY JURISDICTION OF CORRECTION OR LAW ENFORCEMENT**
- 08 Awaiting trial
- 09 Awaiting sentencing
- 10 Consumer refused to provide information
- 11 Minor (< age 18) referred by the court
- 12 Arrested and booked
- 13 Diverted from arrest or booking (Jail Diversion)

11 PROGRAMS – Check if YES

- Individual is enrolled in the State Medical Plan
- CHILD served by FIA for abuse and neglect
- CHILD served by another FIA program
- CHILD enrolled in the Early On program

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ADULT HEALTH SCREENING

Please fill in the information for the consumer named at the bottom of the page:

Primary Care Physician Name:							
Physician/Clinic Address:						Phone:	
City/State:						Zip:	
When did you last see your physician? For what reason?							
If female, are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No							
CHECK THE SPECIFIC CONDITION THAT CURRENTLY APPLIES							
<input type="checkbox"/> A disorder of eyes, ears, nose or throat							
<input type="checkbox"/> Dizziness, fainting, seizure, convulsions, paralysis, stroke, head trauma (with or without loss of consciousness) or other neurological disease							
<input type="checkbox"/> Persistent coughing, bronchitis, asthma, emphysema, tuberculosis, or other disorder of your lungs							
<input type="checkbox"/> High blood pressure, rheumatic fever, murmur, heart attack or other disorder of the heart or blood vessels							
<input type="checkbox"/> Intestinal bleeding, ulcer, hernia, colitis or other disorder of the stomach, intestines, liver (e.g. hepatitis) or gallbladder							
<input type="checkbox"/> Disorder of kidney, bladder, prostate or reproductive system including HIV or other sexually transmitted diseases							
<input type="checkbox"/> Diabetes, thyroid, or other endocrine disorders							
<input type="checkbox"/> Arthritis or other disorder of the muscles or bones, including the spine, back or joints							
<input type="checkbox"/> A tumor, cancer or disorder of skin or lymph glands							
<input type="checkbox"/> A contagious illness, as far as you are aware							
<input type="checkbox"/> If sexually active, use of a condom and/or means of birth control							
If you have had any of these conditions in the past, please explain:							
If you have had any of the following conditions, using a number scale of 1-10, 1=very mild, 10=extreme, rate the severity of the condition. Indicate how long it lasts and how often it occurs.							
	Severity	Duration	Freq.		Severity	Duration	Freq.
Headaches				Joint/muscle pain			
Hoarse throat				Menstrual pain			
Ear infections/pain				Abdominal/flank pain			
Fainting spells				Nausea/vomiting			
Balance problems				Unusual Bleeding			
Fevers				Easy bruising			
Chest Pain				Frequent/difficult/painful urination			
Breathing problems/cough							

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Have you been treated for any of the above conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Which conditions?	Who treated you?	When?

Do you have any disability restrictions because of these conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Condition	Restrictions

Height:	Weight:	Recent change? <input type="checkbox"/> No <input type="checkbox"/> Yes,	Up	lbs. In	months
			Down	lbs. In	months

Has there been a change in your appetite/eating habits? Yes No, Explain:

Do you have Food Preferences/Concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you on a Special Diet? <input type="checkbox"/> Yes <input type="checkbox"/> No
Explain:	

Do you have any chewing or swallowing problems? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you run out of food before the end of the month? <input type="checkbox"/> Yes <input type="checkbox"/> No
Explain:	

List Vitamins/Minerals/Supplements you take:

What are your sleep patterns (total sleep time, problems initiating or maintaining, nightmares, sleep disturbances)?

Are you currently taking any prescribed medication? Yes No **If yes, please list below**

Name of Medication	Dose	When Taken	For What Condition?	Prescribed By

Do you currently or have you ever had medication allergies? Yes No **Please list:**

Do you currently use	Yes	No	Type used	How long used?	How much used?	Frequency Used
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>				
Non-prescription drugs	<input type="checkbox"/>	<input type="checkbox"/>				
Herbal remedies	<input type="checkbox"/>	<input type="checkbox"/>				
Injected drugs	<input type="checkbox"/>	<input type="checkbox"/>				
Caffeine	<input type="checkbox"/>	<input type="checkbox"/>				

Immunization Status: Are your immunizations up to date? Yes No Unsure
If not, what shots or immunizations are needed?

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Is there anything else about your medical history or health and safety issues that you would like to tell us about?

Signatures:

Person Completing Form	Date	Relationship
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Reviewer	Date	Other	Date
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Comments:

- Referral to nurse for further assessment
- Referral To: Current Physician Release on File

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ADULT ASSESSMENT (18 AND ABOVE)

1 Worker:	Location of Interview:
Who is present at the interview?	
2 Identifying Data: (age, sex, education, living situation, marital status, occupation); Brief summary narrative about the consumer including behavior, mood, appearance, language, mobility, communication skills and style:	
3 Presenting Concerns: (consumer and/or significant other's statement of presenting problem, precipitating factors, current symptoms, duration); If referral, state reason:	
4 Psychiatric History: (previous treatment and medications, hospitalization/s, family psychiatric history, including suicide)	
5 Current Medications (prescribed and over-the-counter):	
6 Psychosocial History/Communication/ Family and Social Life/Education/Employment/Military (relationships, sexual history, marriage/divorce, behaviors, roles, patterns of interaction, strengths, values and beliefs; school/s attended, current grade; types of work, duration, abilities):	
7 Supports and Concerns: Basic Needs/Spiritual/Cultural/Leisure-Recreation/Interpersonal Relationships/Financial/Gambling (food, clothing, transportation, living arrangements):	
8 Legal (court involvement, guardianship, conservator, payee issues):	
9 Safety/Abuse-Neglect/Adaptive Equipment/Environmental Modifications/Mobility-Ambulation/Other Risk Factors (safety at home, community, work; abilities, needs, readiness; personal, mobility-ambulation):	

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MENTAL STATUS SUMMARY

APPEARANCE/GENERAL BEHAVIOR

Appearance				
<input type="checkbox"/> Chronological Age	<input type="checkbox"/> Overweight	<input type="checkbox"/> Remarkable Features	<input type="checkbox"/> Well-Dressed	<input type="checkbox"/> Disheveled
<input type="checkbox"/> Normal Weight	<input type="checkbox"/> Underweight	<input type="checkbox"/> Well-Groomed	<input type="checkbox"/> Unkempt	
Attitude				
<input type="checkbox"/> Cooperative	<input type="checkbox"/> Hostile	<input type="checkbox"/> Avoids Eye Contact	<input type="checkbox"/> Evasive	<input type="checkbox"/> Suspicious
<input type="checkbox"/> Relates Well	<input type="checkbox"/> Good Eye Contact	<input type="checkbox"/> Guarded	<input type="checkbox"/> Negative Attitude	<input type="checkbox"/> Uncooperative
<input type="checkbox"/> Accessible				
Observations:				

SPEECH/LANGUAGE

Speech				
<input type="checkbox"/> Normal Speech	<input type="checkbox"/> Rapid	<input type="checkbox"/> Monotonous	<input type="checkbox"/> Low	<input type="checkbox"/> Mumbled
<input type="checkbox"/> Slow	<input type="checkbox"/> Pressured	<input type="checkbox"/> Loud	<input type="checkbox"/> Delayed Reaction	<input type="checkbox"/> Halting
<input type="checkbox"/> Hesitant	<input type="checkbox"/> Slurred/Impaired Articulation			<input type="checkbox"/> Stuttering
Language				
<input type="checkbox"/> English-Speaking	<input type="checkbox"/> Bilingual	<input type="checkbox"/> Poor Grammar	<input type="checkbox"/> Interpreter Used	<input type="checkbox"/> Non-Verbal
<input type="checkbox"/> Spanish-Speaking	<input type="checkbox"/> Unusual Language	<input type="checkbox"/> Limited Vocabulary	<input type="checkbox"/> Sign Language	
<input type="checkbox"/> Other Language Spoken				
Observations:				

AFFECT/MOOD

Affect				
<input type="checkbox"/> Appropriate	<input type="checkbox"/> Blunted	<input type="checkbox"/> Flattened	<input type="checkbox"/> Inappropriate	<input type="checkbox"/> Labile
<input type="checkbox"/> Constricted				
Mood				
<input type="checkbox"/> Euthymic (Normal)	<input type="checkbox"/> Anxious	<input type="checkbox"/> Elated	<input type="checkbox"/> Irritable	<input type="checkbox"/> Angry
<input type="checkbox"/> Subdued	<input type="checkbox"/> Depressed			
Observations:				

PERCEPTUAL DISORDER

Form and Content				
<input type="checkbox"/> No Perceptual Distortions	<input type="checkbox"/> Illusions	<input type="checkbox"/> Visual Hallucinations	<input type="checkbox"/> Derealizations	<input type="checkbox"/> Other
	<input type="checkbox"/> Depersonalization	<input type="checkbox"/> Auditory Hallucinations		
Observations:				

THINKING

Abstract Thinking		
<input type="checkbox"/> Concrete	<input type="checkbox"/> Overly Abstract	<input type="checkbox"/> Adequate Abstracting Ability
Thought Process		

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<input type="checkbox"/> Relevant	<input type="checkbox"/> Derailment	<input type="checkbox"/> Circumstantial	<input type="checkbox"/> Blocking
<input type="checkbox"/> Rambling	<input type="checkbox"/> Illogical	<input type="checkbox"/> Loose Associations	<input type="checkbox"/> Perseverations
<input type="checkbox"/> Tangential			
<u>Productivity</u>			
<input type="checkbox"/> Spontaneous	<input type="checkbox"/> Impoverished	<input type="checkbox"/> Flight of Ideas	<input type="checkbox"/> Overabundance of Ideas
<u>Thought Content</u>			
<input type="checkbox"/> Preoccupations	<input type="checkbox"/> Ideas of Reference	<input type="checkbox"/> Ideas of Influence	<input type="checkbox"/> No Formal Thought Disorder
<input type="checkbox"/> Delusions			
Observations:			

COGNITION

<u>Orientation</u>			
<input type="checkbox"/> Fully Oriented	<input type="checkbox"/> Disoriented to Place	<input type="checkbox"/> Disoriented to Time	<input type="checkbox"/> Disoriented to Person
<u>Intellectual Functioning</u>			
<input type="checkbox"/> Below Average	<input type="checkbox"/> Average	<input type="checkbox"/> Above Average	
<u>Memory</u>			
<input type="checkbox"/> No Memory Impairment	<input type="checkbox"/> Recent Past Memory Impairment (past few days)	<input type="checkbox"/> Recent Past Memory Impairment (past few months)	<input type="checkbox"/> Remote Memory Impairment
<input type="checkbox"/> Immediate Retention and Recall Impairment			
<u>Concentration</u>			
<input type="checkbox"/> Adequate	<input type="checkbox"/> Mildly Impaired	<input type="checkbox"/> Moderately Impaired	<input type="checkbox"/> Severely Impaired
Observations:			

INSIGHT

<u>Insight/Awareness</u>				
<input type="checkbox"/> Acceptance of Illness	<input type="checkbox"/> Little to No Insight	<input type="checkbox"/> Slight Awareness of Being Ill	<input type="checkbox"/> Blames Others	<input type="checkbox"/> Complete Denial of Illness
Observations:				
<u>Social Judgment</u>				
<input type="checkbox"/> Adequate	<input type="checkbox"/> Mildly Impaired	<input type="checkbox"/> Severely Impaired		
Observations:				

SUICIDAL/HOMICIDAL ASSESSMENT

<u>Suicidal</u>				
<input type="checkbox"/> No Suicidal Ideation	<input type="checkbox"/> Suicidal Plan	<input type="checkbox"/> Actively Suicidal	<input type="checkbox"/> Past Attempt	<input type="checkbox"/> Family History
<input type="checkbox"/> Suicidal Ideation	<input type="checkbox"/> Access to Method			
<u>Homicidal</u>				
<input type="checkbox"/> No Homicidal Ideation	<input type="checkbox"/> Threatening Behavior	<input type="checkbox"/> Homicidal Threat	<input type="checkbox"/> Actively Homicidal	<input type="checkbox"/> Past Attempt/s
<input type="checkbox"/> Homicidal Ideation				
<u>Potential for Violence</u>				
<input type="checkbox"/> No Reported History of Violence	<input type="checkbox"/> Current Violent Thought	<input type="checkbox"/> Self Mutilation/Abuse	<input type="checkbox"/> Property Damage	<input type="checkbox"/> Arson
<input type="checkbox"/> History of Violence	<input type="checkbox"/> Injury to Others			
Duty to Warn <input type="checkbox"/> Yes <input type="checkbox"/> No, Please explain any action taken in the Comments Section				
Comments/Observations:				

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Remarkable Mental Status Summary of Impressions & Observations:

SUBSTANCE ABUSE

Substance Abuse (Nicotine, Caffeine, Alcohol, Illicit Substance, Prescription Drugs)

- Reported usage of nicotine, caffeine, alcohol, illicit substance, prescription drugs, etc. suggest no need for further assessment
 - Substance Abuse Indicated and further assessment needed (Complete Chemical Use History Form)
- Indicate Usage:

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1 CONSUMER DATA QUESTIONNAIRE/CHEMICAL USE HISTORY

DRUG CATEGORY P=Primary S=Secondary T=Tertiary	FREQUENCY OF USE	CURRENT USE/ABUSE	METHOD OF USE	PREVIOUS OVERDOSE, WITHDRAWAL OR ADVERSE REACTION
Alcohol <input type="checkbox"/> P <input type="checkbox"/> S <input type="checkbox"/> T Year/Age of first use:	<input type="checkbox"/> Daily <input type="checkbox"/> Several times/wk. <input type="checkbox"/> Once/week <input type="checkbox"/> Less than once/wk. <input type="checkbox"/> None in past month	<input type="checkbox"/> Used in past 48 hrs. Types Abused:	<input type="checkbox"/> Oral <input type="checkbox"/> Injects <input type="checkbox"/> Smokes <input type="checkbox"/> Inhales <input type="checkbox"/> IV	<input type="checkbox"/> Yes <input type="checkbox"/> No Describe:
Prescription Drugs <input type="checkbox"/> P <input type="checkbox"/> S <input type="checkbox"/> T Year/Age of first use:	<input type="checkbox"/> Daily <input type="checkbox"/> Several times/wk. <input type="checkbox"/> Once/week <input type="checkbox"/> Less than once/wk. <input type="checkbox"/> None in past month	<input type="checkbox"/> Used in past 48 hrs.	<input type="checkbox"/> Oral <input type="checkbox"/> Injects <input type="checkbox"/> Smokes <input type="checkbox"/> Inhales <input type="checkbox"/> IV	<input type="checkbox"/> Yes <input type="checkbox"/> No Describe:
Cannabis <input type="checkbox"/> P <input type="checkbox"/> S <input type="checkbox"/> T Year/Age of first use:	<input type="checkbox"/> Daily <input type="checkbox"/> Several times/wk. <input type="checkbox"/> Once/week <input type="checkbox"/> Less than once/wk. <input type="checkbox"/> None in past month	<input type="checkbox"/> Used in past 48 hrs.	<input type="checkbox"/> Oral <input type="checkbox"/> Injects <input type="checkbox"/> Smokes <input type="checkbox"/> Inhales <input type="checkbox"/> IV	<input type="checkbox"/> Yes <input type="checkbox"/> No Describe:
Amphetamines <input type="checkbox"/> P <input type="checkbox"/> S <input type="checkbox"/> T Year/Age of first use:	<input type="checkbox"/> Daily <input type="checkbox"/> Several times/wk. <input type="checkbox"/> Once/week <input type="checkbox"/> Less than once/wk. <input type="checkbox"/> None in past month	<input type="checkbox"/> Used in past 48 hrs. Types Used:	<input type="checkbox"/> Oral <input type="checkbox"/> Injects <input type="checkbox"/> Smokes <input type="checkbox"/> Inhales <input type="checkbox"/> IV	<input type="checkbox"/> Yes <input type="checkbox"/> No Describe:
Sedatives <input type="checkbox"/> P <input type="checkbox"/> S <input type="checkbox"/> T Year/Age of first use:	<input type="checkbox"/> Daily <input type="checkbox"/> Several times/wk. <input type="checkbox"/> Once/week <input type="checkbox"/> Less than once/wk. <input type="checkbox"/> None in past month	<input type="checkbox"/> Used in past 48 hrs. Types Used:	<input type="checkbox"/> Oral <input type="checkbox"/> Injects <input type="checkbox"/> Smokes <input type="checkbox"/> Inhales <input type="checkbox"/> IV	<input type="checkbox"/> Yes <input type="checkbox"/> No Describe:
Cocaine <input type="checkbox"/> P <input type="checkbox"/> S <input type="checkbox"/> T Year/Age of first use:	<input type="checkbox"/> Daily <input type="checkbox"/> Several times/wk. <input type="checkbox"/> Once/week <input type="checkbox"/> Less than once/wk. <input type="checkbox"/> None in past month	<input type="checkbox"/> Used in past 48 hrs.	<input type="checkbox"/> Oral <input type="checkbox"/> Injects <input type="checkbox"/> Smokes <input type="checkbox"/> Inhales <input type="checkbox"/> IV	<input type="checkbox"/> Yes <input type="checkbox"/> No Describe:
Hallucinogens <input type="checkbox"/> P <input type="checkbox"/> S <input type="checkbox"/> T Year/Age of first use:	<input type="checkbox"/> Daily <input type="checkbox"/> Several times/wk. <input type="checkbox"/> Once/week <input type="checkbox"/> Less than once/wk. <input type="checkbox"/> None in past month	<input type="checkbox"/> Used in past 48 hrs.	<input type="checkbox"/> Oral <input type="checkbox"/> Injects <input type="checkbox"/> Smokes <input type="checkbox"/> Inhales <input type="checkbox"/> IV	<input type="checkbox"/> Yes <input type="checkbox"/> No Describe:
Inhalants <input type="checkbox"/> P <input type="checkbox"/> S <input type="checkbox"/> T Year/Age of first use:	<input type="checkbox"/> Daily <input type="checkbox"/> Several times/wk. <input type="checkbox"/> Once/week <input type="checkbox"/> Less than once/wk. <input type="checkbox"/> None in past month	<input type="checkbox"/> Used in past 48 hrs. Types Used:	<input type="checkbox"/> Oral <input type="checkbox"/> Injects <input type="checkbox"/> Smokes <input type="checkbox"/> Inhales <input type="checkbox"/> IV	<input type="checkbox"/> Yes <input type="checkbox"/> No Describe:
Heroin <input type="checkbox"/> P <input type="checkbox"/> S <input type="checkbox"/> T Year/Age of first use:	<input type="checkbox"/> Daily <input type="checkbox"/> Several times/wk. <input type="checkbox"/> Once/week <input type="checkbox"/> Less than once/wk. <input type="checkbox"/> None in past month	<input type="checkbox"/> Used in past 48 hrs.	<input type="checkbox"/> Oral <input type="checkbox"/> Injects <input type="checkbox"/> Smokes <input type="checkbox"/> Inhales <input type="checkbox"/> IV	<input type="checkbox"/> Yes <input type="checkbox"/> No Describe:

Are you bothered by others' concern about your drug use? Yes No

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SYMPTOMS (Check all that apply)

- Use in larger amounts or longer time period than intended
- Blackouts
- Increased time spent in substance-related activities
- Persistent desire and/or failed attempts to cut down/control
- Withdrawal
- Tolerance
- Continued use despite medical or psychological problems
- Continued use despite persistent social or interpersonal problems
- Recurrent use in hazardous situations
- Recurrent substance-related legal problems
- Current legal involvement
- Other compulsive behaviors evident?
 - Gambling
 - Eating disorder
 - Other
- History of alcoholism in family

2 IMPACT (family, work, school, etc.)

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3 PREVIOUS TREATMENT

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4 ASAM PLACEMENT DIMENSIONS (complete this section for consumers who are receiving Substance Abuse Services) Comment on severity for each dimension

	Level	As Evidenced By
<input type="checkbox"/> Acute intoxication and/or withdrawal potential		
<input type="checkbox"/> Biomedical conditions and complications		
<input type="checkbox"/> Emotional/behavioral or cognitive conditions and complications		
<input type="checkbox"/> Readiness to change		
<input type="checkbox"/> Relapse/continued use or continued problem potential		
<input type="checkbox"/> Recovery environment		

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DIAGNOSIS, DISABILITY AND SERVICE DESIGNATION

1 Assessment Tools:

- Basis-32
- CAFAS
- NC SNAP
- DCH DD Proxy Measures
- Folstein Mini-Mental Status
- Other:
- Not Appropriate

Comments :

2 Summary and Justification of Diagnosis:

3 Diagnostic Formulation			
	Principal	Code	Diagnosis
Axis I – Primary	<input type="checkbox"/>		
Axis I – ICD-9-CM if different from DSM-IV	<input type="checkbox"/>		
Axis I – Secondary			
Axis II – Primary	<input type="checkbox"/>		
Axis II – Secondary			
Axis III – Primary	<input type="checkbox"/>		
Axis III - Secondary			
Axis IV		<input type="checkbox"/> Housing problems <input type="checkbox"/> Economic problems <input type="checkbox"/> Problems with access to health care services <input type="checkbox"/> Problems related to interaction with the legal system/crime <input type="checkbox"/> Other psychosocial and environmental problems	
<input type="checkbox"/> Problems with primary support group <input type="checkbox"/> Problems related to the social environment <input type="checkbox"/> Educational problems <input type="checkbox"/> Occupational problems			
Axis V			
<input type="checkbox"/> Current GAF Score (Document specific GAF score, not range) OR <input type="checkbox"/> Current GAS Score (Document specific GAS score)			

4 Integrated Summary of Assessed Clinical Needs:

5 Treatment Recommendation:

6 Additional Follow-Up Needed:

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7 DISABILITY DESIGNATION:

<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Evaluated	DEVELOPMENTAL DISABILITY: Meets the 1996 Mental Health Code Definition of Developmental Disabilities regardless of whether they received services from the DD or MI service arrays.
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Evaluated	MENTAL ILLNESS: Has DSM-IV diagnosis, exclusive of mental retardation, developmental disability or substance abuse.
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Evaluated	SUBSTANCE ABUSE DISORDER: As defined in Section 61-7 of the public health code.

SERVICE DESIGNATION

<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate if the person is receiving services that are primarily designed for people with DEVELOPMENTAL DISABILITIES , regardless of this person's diagnosis or disability designation.
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate if the person is receiving services that are primarily designed for MENTAL ILLNESS regardless of this person's diagnosis or disability designation.
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate if the person is receiving services that are primarily designed for people with SUBSTANCE ABUSE DISORDERS , regardless of this person's diagnosis or disability designation.

8. Included in this assessment are :

- Section 1 – Demographics - **mandatory**
One from 2a, 2b or 2c
- Section 2a – Adult Health Screening
- Section 2b – Child/Adolescent Health Screening
- Section 2c – Infant's Birth Health Screening
- One from 3a or 3b**
- Section 3a – Adult Assessment
- Section 3b – Child and Adolescent Assessment
- Section 4 – Mental Status Summary
- Section 5 – Consumer Chemical Use History
- Section 6 – Diagnosis, Disability and Service Designation - **mandatory**

Signatures:

CMH Representative	Date	CMH Supervisor	Date
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Other	Date	Other	Date
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Start Time	Stop Time	Duration	Location	Activity Code	Cost Center
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