

NORTH COUNTRY COMMUNITY MENTAL HEALTH

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
 - 05 Foster family (Children's Foster Care)
 - 06 Specialized residential Adult Foster Care home
 - 08 General residential Adult Foster Care home
 - 10 Prison/jail/juvenile detention
 - 12 Nursing care facility
 - 13 Institutional setting
 - 16 Supported Independent Living Program
- If dependent, what was last independent address?**

FAMILY AND SOCIAL LIFE

2 Marital Status

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

3 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

4 List Household Members

Name	Relationship	Age
	SELF	

Next Of Kin:
Address:
Phone:

5 EMPLOYMENT-Check one

- 0 I work full-time over 30 hours
- 02 I work part-time under 30 hours
- 03 I am unemployed, looking for work
- 04 I am unemployed, not looking for work
- 06 Retired
- 07 Sheltered Workshop
- 08 Not applicable (Child under 18)
- Unreported

6 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?

7 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 Ed
- 07 Attended or is attending undergraduate college
- 08 College graduate
- Unreported

8 LEGAL

Corrections Related Status

- 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
- Jail Diversion

Consumer Name	DOB	ID #	Date
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**NORTH COUNTRY COMMUNITY MENTAL HEALTH
CHILD/ADOLESCENT 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 child/adolescent last see their physician? For what reason?			
PREGNANCY AND DELIVERY			
Pregnancy: <input type="checkbox"/> Planned <input type="checkbox"/> Unplanned <input type="checkbox"/> Normal <input type="checkbox"/> Complications <input type="checkbox"/> Premature			
Explain:			
<input type="checkbox"/> Complication/Stressors during pregnancy			
<input type="checkbox"/> Exposure to toxins during pregnancy: <input type="checkbox"/> Drugs <input type="checkbox"/> Alcohol <input type="checkbox"/> Disease			
Explain:			
Insults: <input type="checkbox"/> Prenatal <input type="checkbox"/> Perinatal <input type="checkbox"/> Post-natal			
Explain:			
Delivery: <input type="checkbox"/> Natural <input type="checkbox"/> Prepared <input type="checkbox"/> Unprepared <input type="checkbox"/> Difficult <input type="checkbox"/> Uneventful <input type="checkbox"/> Induced			
Delivery at	weeks	Labor was	hours long
Birth weight:		Apgar Score:	
Problems at birth (birth defects, complications):			
<input type="checkbox"/> Exposure to toxins post-pregnancy: <input type="checkbox"/> Disease <input type="checkbox"/> Physical trauma			
Explain:			
If this child/adolescent is adopted, do you have information about the birth parents?			
DEVELOPMENTAL MILESTONES (Address only those that are applicable)			
Milestones (detail any delays or developmental issues - note age when milestone occurred)			
First crawled:		Walked independently:	
Toilet trained (daytime and nighttime):		Spoke understandable words:	
Toileting habits (i.e. hygiene, bedwetting):			
Spoke in sentences:			
How did child comfort him/herself?			
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			
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● INTAKE/ ● ANNUAL ASSESSMENT Section 2b
Child/Adolescent Health Screening (4-17 yrs.)

NORTH COUNTRY COMMUNITY MENTAL HEALTH

<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 female, is this child/adolescent pregnant?

If the child/adolescent has 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							

Has the child/adolescent been treated for any of the above conditions? Yes No

Which conditions?	Who treated you?	When?

Does the child/adolescent have any disability restrictions because of these conditions? Yes No

Condition:	Restrictions:

Weight: **Recent change:** Yes No **Height:**

Has there been a change in this child/s eating habits/appetite? Yes No

Nutritional Status/Food Preferences/Concerns:

What is the child's sleep patterns (total sleep time, problems initiating or maintaining, nightmares, sleep disturbances):

Is this child currently taking any prescribed medication? Yes No **If yes, please list below:**

Name of Medication	Dose	When Taken	For What condition?	Prescribed by

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Does this child/adolescent currently have or has she/he ever had medication allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list:						
Do they currently	Yes	No	Type used	How	How	Frequency Used
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>				
Non-prescription	<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?

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**

Reviewer **Date** **Other** **Date**

Comments:

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**NORTH COUNTRY COMMUNITY MENTAL HEALTH
CHILD/ADOLESCENT ASSESSMENT**

1 Worker:	Location of Interview:			
Who is present at the interview?				
2 Identifying Data				
Age: Sex: Current living arrangements:				
Primary Caregivers (names, relationship, military history, education, occupation, interaction w/ child):				
Current parent figures in home (relationships and interactions with each other):				
Surrogate caregivers/natural supports (daycare/how many hrs./days per week, extended family, etc.):				
Custody status:				
Legal issues/court involvement/truancy:				
Involvement of other agencies:				
Out of home placements (foster care, respite history):				
If family member/primary caregiver is not present, explain absence:				
3 Presenting Concerns (consumer and/or significant other's statement of presenting problem, precipitating factors, current symptoms, duration); If referral, state reason:				
Family presenting concerns, current symptoms and duration:				
Family stressors:				
Family role in treatment: *family member's perspective:				
Family dynamics affecting treatment:				
History of fire setting: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Cruelty to animals: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Fights: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Bullying: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Victim of bullying: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Runaway behavior: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Self-injurious behaviors: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Substance Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No				
4 Psychiatric History (previous treatment and medications, hospitalization/s, family psychiatric history, including suicide):				
5 Current Medications (prescribed and over-the-counter)				
Name of Medication	Dose	When Taken	For What Condition?	Prescribed By
6 Psychosocial History/Communication/ Family and Social Life/Education/Leisure-Recreation (behaviors, roles, patterns of interaction, strengths, values and beliefs; school/s attended, current grade).				
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School:	School/s attended:		
Current grade:	Type of educational program (Special Ed, Montessori):		
Recent changes in grade placement:			
History of academic achievement (grade history, problems identified):			
Behavior problems in school (detail type and response of school and parents):			
Favorite class/subject:		Least favorite class/subject:	
Child's favorite teacher:			
Child's friends:			
Play patterns (leisure activities, age appropriateness):			
How does child solve problems at school and at home:			
Leisure activities for parents and family:			
How do the parents/caregivers solve problems:			
Sleep patterns (total time, problems initiating or maintaining, nightmares, sleep disturbances):			
Eating patterns of family and child (do they eat meals together/where?):			
Discipline used in home:		Response:	
Attention (ability to pay attention, stay on task):			
Psychomotor agitation (able to sit still):			
Values and beliefs of family:			
7 Supports and Concerns: Basic Needs/Spiritual/Cultural/Financial/Gambling:			
8 Safety/Abuse-Neglect/Adaptive Equipment/Environmental Modifications/Mobility-Ambulation/Other Risk Factors (safety at home, community, work; abilities, needs, readiness; personal, mobility-ambulation):			
9 CAFAS included: <input type="checkbox"/>Yes <input type="checkbox"/>No, Explain:			

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● INTAKE/ ● ANNUAL ASSESSMENT Section 3b
Child/Adolescent Assessment

**NORTH COUNTRY COMMUNITY MENTAL HEALTH
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			
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				
<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				

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<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:				

Remarkable Mental Status Summary of Impressions & Observations:

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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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● INTAKE/ ● ANNUAL ASSESSMENT Section 4
Mental Status Summary

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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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**NORTH COUNTRY COMMUNITY MENTAL HEALTH
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 – Secondary			
Axis II – Primary	<input type="checkbox"/>		
Axis II – Secondary			
Axis III – Primary	<input type="checkbox"/>		
Axis III - Secondary			

Axis IV

Problems with primary support group
 Problems related to the social environment
 Educational problems
 Occupational problems

Housing problems
 Economic problems
 Problems with access to health care services
 Problems related to interaction with the legal system/crime
 Other psychosocial and environmental problems

Axis V

Current GAF Score (Document specific GAF score, not range) **OR**
 Current GAS Score (Document specific GAS score)

4 Integrated Summary of Assessed Clinical Needs:

5 Treatment Recommendation:

6 Additional Follow-Up Needed:

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

Yes No 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.

Yes No Unknown

Indicate if the person is receiving services that are primarily designed for **MENTAL ILLNESS** regardless of this person's diagnosis or disability

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	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
Other	Date	Other	Date

Start Time	Stop Time	Duration	Location	Activity Code	Cost Center

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