Date of Service: _____ Cost Center/Program: _____ Direct: Documentation: Travel: Total: Code:

Clinician's Name & License: _____ Client Identifier: _____

Consumer's Legal Name: _____ Date of Birth: _____ Gender: _____

Guardian's Name: _____ Guardian's Phone: _____

Address: _____ City: _____ Zip: _____ Phone Number: _____

Ethnicity: _____ Preferred Language: _____ Provider speaks preferred language: ☐ Yes No ☐

Is interpreter needed? ☐ Yes No ☐ Consumer accepts offer of interpretive services ☐ Yes No ☐

Conservatorship/Legal Issues *(If Applicable)*: _____

Education(Highest Grade Completed): _____ ☐ IEP ☐ Suspended ☐ Expelled Probation ☐ Yes No ☐

Current School: _____ Employment Status: _____ ☐ Veteran

Choice of Provider Offered (gender, location, culture, etc): _____ ☐ CalWorks

CASE CONCEPTUALIZATION: Consumer/Family progress toward happy life goal (in his/her own words), **Skills learned that will help the consumer/family get closer to their happy life goal** (in his/her own words).

WHAT DID CONSUMER WANT HELP WITH AS IDENTIFIED ON THE PREVIOUS ASSESSMENT:

Issues/Goals	Previous Stage of Change	Current Stage of Change
1.	<select one from below>	<select one from below>
2.	<select one from below>	<select one from below>
3.	<select one from below>	<select one from below>

WHAT DOES THE CONSUMER WANT HELP WITH NOW (in his/her own words):

Issues/Goals	Stage of Change
1.	<select one from below>
2.	<select one from below>
3.	<select one from below>

Are there co-occurring issues? ☐Yes No ☐

CHANGES SINCE LAST ASSESSMENT

Family Relationships: None

Substance Use: None

Medications: None

Physical Health Disorders: None

Allergies: ☐Yes No☐ List: Name/Phone Number of Primary Care Physician:

Clinician's Signature / License

Date

Clinician's Name & License Printed

Consumer's Name: _____

Client Identifier: _____

Please use the following scale to rate the individual's current problem severity for each domain & record duration (optional), in months or years. Check all adjectives that apply.
For ages 0-36 months replace with IFMH ADDENDUM. Use substance use/abuse addendums as needed.

0	1	2	3	4	5	6	7	8
No Problem	Less than Slight	Slight Problem	Slight to Moderate	Moderate Problem	Moderate to Severe	Severe Problem	Severe to Extreme	Extreme Problem

AFFECT DURATION

- ☐ Appropriate ☐ Labile ☐ Expansive
- ☐ Normal Range ☐ Constricted ☐ Blunted
- ☐ Other

ANXIETY DURATION

- ☐ Anti-anxiety meds. ☐ Obsessions ☐ Compulsions
- ☐ Calm ☐ Anxious/Tense ☐ Guilt
- ☐ Phobic ☐ Worried/Fearful ☐ Panic
- ☐ Other:

DEPRESSION DURATION

- ☐ Anti-Depressants ☐ Hopeless ☐ Sleep Problems
- ☐ Sad/Depressed ☐ Withdrawn ☐ Lacks Energy/Interest
- ☐ Irritable ☐ Grief ☐ Appetite Disturbance
- ☐ Angry ☐ Guilt ☐ WNL
- ☐ Other:

THOUGHT PROCESS DURATION

- ☐ Anti-psychotic Rx ☐ Oriented ☐ Circumstantial
- ☐ Intact ☐ Delusional ☐ Paranoid
- ☐ Illogical ☐ Ruminative ☐ Disoriented
- ☐ Loose Associations ☐ Tangential ☐ Hallucinations
- ☐ Dissociative State ☐ Disorganized
- ☐ Other:

HYPERACTIVITY DURATION

- ☐ ADHD Meds ☐ Inattentive ☐ Agitated
- ☐ Bipolar Meds ☐ Manic ☐ Mood Swings
- ☐ Relaxed ☐ Overactive/Hyperactive ☐ Impulsivity
- ☐ Sleep Deficit ☐ Pressured Speech
- ☐ Other:

COGNITIVE PROCESS DURATION

- ☐ Poor ☐ Insightful ☐ Impaired Judgment
- ☐ Developmental Disability ☐ Irrational ☐ Concrete Thinking
- ☐ Slow Processing ☐ Poor Memory:
- ☐ Other:

TRAUMATIC STRESS DURATION

- ☐ Acute ☐ Hyper vigilance ☐ History of Abuse
- ☐ Chronic ☐ Dreams/Nightmares ☐ Emotional
- ☐ Detached ☐ Repression/Amnesia ☐ Sexual
- ☐ Avoidance ☐ Emotional Numbness ☐ Physical
- ☐ Witnessing/ being victim of crime, severe accident, or natural disaster
- ☐ Other:

MEDICAL/PHYSICAL DURATION

- ☐ Good Health ☐ Acute Illness ☐ Chronic Illness
- ☐ Stress-Related Illness ☐ Pregnant ☐ Hypochondria
- ☐ Somatization ☐ Eating Disorder ☐ Poor Nutrition
- ☐ Rx Non-Compliance ☐ Seizures ☐ CNS Disorder
- ☐ Medical Tx Non-Compliance ☐ Medical Condition:
- ☐ Other:

RELATIONSHIPS DURATION

- ☐ Adequate Social Skills ☐ Poor Social Skills ☐ Egocentricity
- ☐ Supportive Relationships ☐ Problems w/Friends ☐ Overly Shy
- ☐ Marital Problems ☐ Relationship problems at work
- ☐ Negative Peer Influence ☐ Difficulty Establish/Maintain Relationships

Relatedness toward Examiner:

- ☐ Other:

BEHAVIOR AT HOME DURATION

- ☐ Within cultural norms ☐ Calm ☐ Intrusive
- ☐ Uncommunicative ☐ Uncooperative ☐ Disregards Rules
- ☐ Dominating ☐ Belligerent ☐ Threatening
- ☐ Tantrums ☐ Runs Away ☐ Inappropriate
- ☐ Sexualized ☐ Oppositional
- ☐ Other:

WORK SCHOOL DURATION

- ☐ Regular Attendance ☐ Tardiness ☐ Suspended
- ☐ Absenteeism ☐ Disruptive ☐ Defies Authority
- ☐ Poor Performance ☐ Dropped Out ☐ Learning Disabilities
- ☐ Expelled/Terminated ☐ Illiterate ☐ Employed Part-time
- ☐ Employed ☐ Not Employed ☐ Seeking Employment
- ☐ Permanent Disability:
- ☐ Other:

SOCIO-LEGAL DURATION

- ☐ Disregards Rules ☐ Lying ☐ Stealing
- ☐ Fire setting ☐ Initiates Fights ☐ Pending Charges
- ☐ Offense/Property ☐ Offense/Person ☐ Probation/Parole
- ☐ Street Gang Member ☐ CPS Involvement ☐ Restraining Order
- ☐ Detention/Incarceration Hx:
- ☐ Last Incarceration Date:
- ☐ Other:

DANGER TO SELF DURATION

- ☐ Doesn't Appear Dangerous to Self ☐ Denies
- ☐ Suicidal Ideation ☐ Past Attempt ☐ Serious Self-Neglect
- ☐ Past Ideation ☐ Recent Attempt ☐ Self-Mutilation
- ☐ Current Plan ☐ Self-Injury ☐ Inability to Care for Self

Last Hospitalization Date: Last attempt date:

- ☐ Other:

DANGER TO OTHERS DURATION

- ☐ Doesn't Appear Dangerous to Others ☐ Denies
- ☐ Threatens Others ☐ Cruelty to Animals ☐ Domestically Violent
- ☐ Violent Temper ☐ Assaultive ☐ Use of Weapons
- ☐ Homicidal Ideation ☐ Homicidal Threats ☐ Homicidal Attempt
- ☐ Accused of Child Abuse ☐ Accused of Sexual Assault
- ☐ Other:

Clinician's Signature / License

Date

Clinician's Name & License Printed

Consumer's Name:

Client Identifier:

CLINICAL SUMMARY/ PRESENTING MENTAL HEALTH PROBLEM:

MEDICAL NECESSITY -- Check all that demonstrate medical necessity for mental health services. ☐ No Medical Necessity NOA-A issued

☐ Significant Impairment ☐ Probability of significant deterioration ☐ Probable developmental arrest

CONSUMER IS IMPAIRED IN THE FOLLOWING AREAS:

☐ Living Arrangement ☐ Employment ☐ Daily Activities ☐ Social Relationships ☐ Health

Describe clinical impairment in above areas :

Is mental health treatment needed? ☐ Yes ☐ No	Prognosis: ☐ Good ☐ Fair ☐ Poor
General Medical Condition Concerns: ☐ Yes ☐ No Identify:	Allergies: ☐No ☐Yes Identify:
Primary Care Physician:	Phone:

ICD-10 DIAGNOSIS (Must complete using most current version of DSM codes.)

_____ (Primary)

_____

_____

_____

_____

_____

Clinician's Signature / License

Date

Clinician's Name & License Printed

Consumer's Name: _____

Client Identifier: _____