Mental Health Assessment

First Name		Last Name	
Date of Assessment		DOB		Age	
Street Address	
City, State, Zip	

Legal Guardian/Parent			
Relationship to Consumer			
Address		Primary Phone	
City, State, Zip		Alternate Phone	( )

LIST ALL OTHERS IN THE HOME:			
First Name	Last Name	Age	Relationship to consumer

Diagnosis:	
Behavioral	
Medical Conditions Physical Health Status	
Factors Influencing Health Status	

Clinical Concerns:	

Previous and Current Mental Health Treatment	Dates	Facility/Provider
❑ Outpatient		
❑ Partial		
❑ BHRSCA (wraparound)		
❑ Family-Based		
❑ Psychiatric hospitalization		
❑ Residential Treatment Facility		
Other(please specify)		

MH/MR Case Mgt.?	Yes ☐ No ☐	**Type**	ISC ☐	ICM ☐	RC ☐	ACM ☐	TCM ☐	BCM ☐
Case Manager's Name				**Phone**	( )			

School		**School District**	
School Placement Classification	No IEP ☐ 504 Plan: Y/N	Has IEP ☐ Provisions:	APS ☐ TYPE: Emotional Support ___ School PHP ___ Outpatient ___

MISA Screening	Date of Screening? Does person use drugs or alcohol?_ Last use________ Is there a substance abuse diagnosis? What is the plan for treatment_________________
Demonstration of Resiliency and Recovery	

Medication Name	Dosage	Frequency	Prescribing MD

Is child at risk for out of home placement?		☐ Yes ☐ No
System Involvement	**OCYF Involvement** Contact: Phone: ( )	☐ Yes ☐ No
	OCYF Adjudicated Dependent Contact: Phone: ( )	☐ Yes ☐ No
	JPO Involvement Contact: Phone: ( )	☐ Yes ☐ No
	JPO Adjudicated Delinquent Contact: Phone: ( )	☐ Yes ☐ No

Symptom Checklist:		
☐ Sexually acting out	☐ Theft	☐ Truancy/School Refusal
☐ Anxiety	☐ Criminal Mischief	☐ Property Destruction
☐ Depression	☐ Arson	☐ Use of alcohol
☐ Hyperactivity/Impulsivity	☐ Criminal Conspiracy	☐ Use of Drugs
☐ SI	☐ Vandalism	☐ Runaway
☐ HI	☐ Simple Assault	☐ Curfew Violations
☐ SIB	☐ Aggravated Assault	☐ Verbal Aggression
☐ Delinquent peer group	☐ Probation Violations	☐ Physical Aggression
☐ Cognitive/Developmental	☐ Trauma	☐ Family Relational Issues

OTHER PERTINENT INFORMATION:

Cigarette Smoking: screen was completed on
Does person smoke cigarettes? Has cessation been discussed?_____ If female, is she pregnant?______

Domestic Violence: screen was completed on
Is the person a witness to domestic violence in the home currently by history
Is the person a victim of domestic violence in the home currently by history
Was a referral made for treatment?______ To whom:_____________________________________

Members Height: Members Weight Members BMI:_________________

Physical Health issues that impact Behavioral Health functioning:
None____

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Members PCP:

Physical Within Past 12 Months?:

Therapist &Credentials		Phone	( )
Assessment Measure Utilized by Therapist			
Recommendation			
Therapist Signature:		Date	
Provider	Every Child, Inc.		

Final Recommendations and Prescription for Services to be Completed by Prescriber

X In Full Agreement with the recommendation of FFSS made by the Interagency Service Planning Team.

❑ Revised after consideration of the information presented by the interagency team. The final prescription for services is as follows:

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Psychologist/Psychiatrist _______________ License # _______________ Date _______________

Master's Level Clinician _______________ License # _______________ Date _______________