Referral, Coordination and Integration of Care

POLICY

It is the policy of the Detroit Wayne Mental Health Authority (DWMHA) to promote service coordination and integration at the individual and family level. This policy is achieved through integration and/or coordination of health care services, between physical care providers, behavioral health providers, SUD providers, health plans, Managers of Comprehensive Provider Networks (MCPN), and other service providers on an individual’s care team utilizing the person-centered planning process. The DWMHA has been dedicated to developing a service delivery system that coordinates and integrates care that is welcoming, recovery-focused, trauma-informed, and co-occurring disorders capable to meet the individuals’/families’ needs and inspire the hope of recovery.

PURPOSE

To provide direction to the MCPNs, behavioral health providers subcontracted with the MCPNs, as well as direct contracted providers to develop mechanisms to promote partnerships between behavioral health, SUD, physical health facilities, medical benefit plans and other community-based programs addressing issues including housing, legal, parenting, employment, etc.

APPLICATION

This policy applies to the DWMHA, MCPNs including their behavioral health subcontractors and direct contracted providers, as well as other appropriate providers delivering services to individuals through the DWMHA. The policy encompasses services for adults and children/youth with behavioral health, SUD, I/DD, and/or SED concerns. Individuals are typically served under Medicaid, MI Health Link, Block Grant, MI Child, PA 2 Funds, General Funds, and Autism, etc.

KEY WORDS

1. Access Center
2. Co-Occurring Disorders (also known as Co-occurring Issues or Conditions)
3. Coordination of Care
4. Cultural Competence
5. Federally Qualified Health Center (FQHC)
STANDARDS

1. As the gatekeeper of behavioral health services, the Access Center will:
   a. Respond to telephone calls for behavioral health services from persons seeking service, acute care settings, MHPs, and/or the community with the intent of linking individuals to appropriate services - behavioral health intellectual/developmental disabilities, and/or substance use disorder services.
   b. The Access Center staff will complete a screening tool to determine the appropriate level of care and service needs.
   c. Access Center staff will then refer to a calendar of intake appointments made available by the various service providers contracted/subcontracted with MCPN as well as direct contractors. The Access Center also refers to services outside the PIHP/CMHSP system as appropriate for persons not meeting criteria.
   d. Consumers have choice in the selection of providers first, or are referred to services within geographic proximity when there is no preference. Based on an individual’s address, he/she will be linked to the appropriate services with a service provider nearest to his/her home.

2. MCPNs, behavioral health providers subcontracted with the MCPN as well as direct contractors will meet or exceed the standards listed below. They will:
   a. Ensure the availability and access to a broad, flexible array of effective, community-based services and supports for adults, children and their families that address emotional, social, educational/vocational, and physical/behavioral health/SUD needs, utilizing traditional and non-traditional services/resources – engaging natural and informal support systems.
   b. Ensure services are delivered in an integrated and coordinated manner with effective linkages between agencies and programs.
   c. Ensure the use of DWMHA’s integrated screening and assessment that is comprehensive in addressing the physical/behavioral health, SUD, and IDD concerns of the individual while still being recovery-focused.
   d. Ensure that the biopsychosocial assessment identifies the individual’s needs in an integrated, holistic manner. These needs, with the individual’s consent, become part of the person-centered plan and identify any physical and behavioral health, substance use disorder, and/or IDD concerns.
   e. The State defines the Individual Plan of Service (IPOS), developed using a person-centered process, as the document that directs the supports and services. The IPOS enables individuals to achieve
their personally defined outcomes, and supports individual choice and control. Ensure the person-centered planning process clearly defines the respective responsibilities of the individual’s care team members – health care providers, behavioral health/SUD providers, natural supports, individual, etc.

f. Ensure that processes and technology are developed and implemented to facilitate the sharing of assessments, treatment plans and other pertinent information related to any changes in an individual’s care needs between internal and external members of the individual’s care team.

g. Ensure that policies and procedures are in place to allow for individuals and/or families to receive information related to their rights and the health information protections already in place.

h. Ensure that individuals sign all appropriate consent forms for exchange of protected health information – utilizing the State of Michigan’s Consent to Share Information (DCH-3927-12/14) that includes SUD information that is protected under 42CFR, Part 2.

i. Provide information to individuals receiving services or their guardians about the availability of family planning and health information. This information shall include a statement that receiving mental health services does not in any way depend upon requesting family planning services or health information services.

j. Ensure procedures are developed and implemented for notifying MHP, consulting MHP practitioners and other PCPs regarding the continuation and/or prescribing of new medication, particularly if there are significant co-occurring physical and behavioral health issues that are being addressed, maintaining ongoing communication and sharing completed and updated information.

k. Ensure full access to complaint, grievance, and appeals processes that enforce each individual’s IPOS/PCP Master Treatment Plan rights.

l. Ensure the development and implementation of policy and procedures related to competency with regard to cultural diversity – including ethnic, cultural, gender, and/or community values, etc.

m. Identify the development, implementation and monitoring of procedures to coordinate care with SUD treatment facilities and all coordinating contractors – i.e., individual practitioners, public agencies and/or their designees – for individuals and families receiving ongoing services and supports.

n. Provide care management at the practice level to ensure and monitor that multiple services are delivered in a coordinated and therapeutic manner; that allows the individual and families to move through the system in accordance with changing needs and without obstacles/barriers.

o. Refer the individual and/or family to community-based resources should the services requested not be available on-site or within network; coordination of care with the referral source would be provided.

p. Promote the rights of individuals and their families and provide effective and ongoing advocacy.

3. MHPs, ICOs and their contracted PCPs are expected to coordinate care by:

a. Referring adults or children/adolescents with definite or probable serious mental illness, SUD and/or intellectual/developmental disabilities to the centralized access center for screening and eligibility determination for specialized behavioral services. Exhausting the plan benefit is not necessary prior to referral.

b. Ensuring processes of screening and assessment are comprehensive in addressing the physical/behavioral health, SUD, and IDD concerns of the individual.

c. Communicating significant diagnoses, treatments, laboratory and other examination results to behavioral health and/or SUD service providers.
d. Obtaining any necessary signed releases of information from the individual served and/or the guardian to ensure treatment is shared without impediment between the individuals/entities noted on the consent.

QUALITY ASSURANCE/IMPROVEMENT

1. The DWMHA will review and monitor contractor adherence to this policy as one element in its network management program, and as one element of the QAPIP Goals and Objectives.

2. The contractor’s quality improvement program will include measures for monitoring and for the continuous improvement in the quality of the program, service, and/or process described in this policy.

3. Quality improvement indicators in the contractor's provider network should be connected to broader quality improvement activities related to systems transformation and the development of services that are welcoming, recovery-focused, and co-occurring disorder capable.

4. Each contractor should consider mechanisms to encourage partnership between mental health and SUD providers, medical treatment facilities, medical benefit coordinators and programs addressing other issues (housing, legal, employment, etc) who are serving common individuals, common geographic areas or common populations.

COMPLIANCE WITH ALL APPLICABLE LAWS

The DWMHA staff, MCPNs, contractors and subcontractors are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended.

LEGAL AUTHORITY


2. Detroit Wayne Mental Health Authority Coordinating Agreements FY2011 – FY2016

3. Detroit Wayne County Community Mental Health Coordination and Integration of Care Policy. (2013)


5. Substance Abuse and Mental Health Services Administration, Strategies for Developing Treatment Programs for People with Co-Occurring Substance Abuse and Mental Disorders, SAMHSA Publication No 3782, Rockville MD: SAMHSA 2003.

RELATED POLICIES

1. Detroit Wayne County Community Mental Health Coordination and Integration of Care Policy. (2013)

RELATED DEPARTMENTS

1. Claims Management

2. Clinical Practice Improvement

3. Compliance
4. Customer Service  
5. Information Technology  
6. Integrated Health Care  
7. Legal  
8. Managed Care Operations  
9. Quality Improvement  
10. Utilization Management  
11. Recipient Rights  
12. Substance Use Disorders

**CLINICAL POLICY**

**INTERNAL/EXTERNAL POLICY**

**EXTERNAL**

**EXHIBIT(S)**

1. Revised Consent to Share Information Form DCH-3927(12/14)  
2. All-inclusive biopsychosocial assessment  
3. What Integrated Care Looks Like – Process Flow

**Attachments:**

Integrated BioPsychosocial - Adult.pdf  
Integrated BioPsychosocial - Child (Age 0-3).pdf  
Integrated BioPsychosocial - Child (Age 11-17).pdf  
Integrated BioPsychosocial - Child (Age 4-6).pdf  
Integrated BioPsychosocial - Child (Age 7-10).pdf  
Integrated Care Process Flow  
Updated Blank Consent Form 01232017 (3).docx

**Approval Signatures**

<table>
<thead>
<tr>
<th>Approver</th>
<th>Date</th>
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<tbody>
<tr>
<td>Ronald Hocking: Chief Operating Officer</td>
<td>04/2017</td>
</tr>
<tr>
<td>Dana Lasenby: Deputy Chief Operating Officer</td>
<td>03/2017</td>
</tr>
<tr>
<td>Allison Smith: Project Manager, PMP</td>
<td>03/2017</td>
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<tr>
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<tr>
<td>Darlene Owens: Director, Substance Use Disorders, Initiatives</td>
<td>03/2017</td>
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<tr>
<td>Tracey Lee: Director Claims Management</td>
<td>03/2017</td>
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<tr>
<td>Kip Kliber: Director, Recipient Rights</td>
<td>03/2017</td>
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<tr>
<td>Muddasar Tawakkul: Director of Compliance/Purchasing [AS]</td>
<td>03/2017</td>
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<tr>
<td>Maha Sulaiman</td>
<td>03/2017</td>
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<tr>
<td>Mary Allix</td>
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<tr>
<td>Lorraine Taylor-Muhammad: Director, Managed Care Operations</td>
<td>03/2017</td>
</tr>
<tr>
<td>Crystal Palmer: Director, Children's Initiatives</td>
<td>03/2017</td>
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<tr>
<td>Rolf Lowe: Assistant General Counsel/HIPAA Privacy Officer</td>
<td>03/2017</td>
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<tr>
<td>Stacie Durant: CFO Management &amp; Budget</td>
<td>03/2017</td>
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<tr>
<td>Corine Mann: Chief Strategic Officer/Quality Improvement</td>
<td>03/2017</td>
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<tr>
<td>Jody Connally: Director, Human Resources</td>
<td>03/2017</td>
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<tr>
<td>Bessie Tetteh: CIO</td>
<td>03/2017</td>
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<tr>
<td>Michele Vasconcellos: Director, Customer Service</td>
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<tr>
<td>Sarah Sharp: Consultant</td>
<td>03/2017</td>
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<tr>
<td>Diana Hallifield: Consultant</td>
<td>02/2017</td>
</tr>
<tr>
<td>Julia Kyle: Director of Integrated Care</td>
<td>02/2017</td>
</tr>
<tr>
<td>Harriett Siddiqui</td>
<td>02/2017</td>
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Major Steps in the Care Delivery Process

**ORIENTATION**
- Advance Directives
- Ability To Pay
- After Hours Access
- Consents
- Customer Service Packets
- Grievances
- Guardianship Papers (if applicable)
- Receipt of all that was given
- Referrals for Eligibility
- Release of Information
- Rights
- Self Report/Packet of Information (i.e. health info, simple screening tool)
- Tour of the building

**BIO-PsyCHOSOCIAL INTAKE ASSESSMENT**
- Bio-Psychosocial Assessment
- Case Management Assessment
- Other Assessments as Indicated
  - DLA 20
  - ASAM
  - AUDIT
  - PHQ9
  - DAST 10
  - GAD
  - MIDAS
  - CAFAS
  - Mood Disorder Questionnaire
  - LOCUS (Coming in Dual Eligible’s)
  - SIS (Coming for all I/DD)

**REQUESTED FEEDBACK FROM EACH PROVIDER ORGANIZATION:**
1. Flow Chart the specifics of your organization’s process. You can use the boxes provided or create your own flow chart.
2. Identify the average length of time to complete each major step in the care delivery process.
3. Identify the type of staff who completes the components of each major step.
4. Identify the level of education and/or training for the type of staff who are completing the components of each major step.
5. Feel free to provide any explanation around your organization’s rationale for the flow, staff type or level of education/training.

**PRE-PPLANNING/PRELIMINARY PLAN**
- Who the consumer wants to be at the Treatment Planning Meeting
- Where the consumer wants the Treatment Planning Meeting
- When the consumer wants the Treatment Planning Meeting
- How the consumer wants the Treatment Planning Meeting
- Develop Crisis Support Plan
- Vitals are Teak
- Nursing Evaluation is scheduled (as indicated)
- Psychiatry Evaluation is scheduled (as indicated)
# Detroit Wayne Mental Health Authority
## Integrated BioPsychosocial Assessment

### IDENTIFYING INFORMATION

<table>
<thead>
<tr>
<th>NAME</th>
<th>DOB</th>
<th>MEMBER ID</th>
<th>GENDER</th>
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<th>CASE STATUS</th>
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<tr>
<td>[ ] New</td>
<td>[ ] Face to Face</td>
<td>[ ] Initial</td>
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<tr>
<td>[ ] Readmission</td>
<td>[ ] Phone</td>
<td>[ ] Quarterly</td>
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<td>[ ] Annual</td>
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<td>[ ] Other</td>
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<tr>
<th>IDENTIFYING INFORMATION</th>
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<tbody>
<tr>
<td>[ ] SBIRT (screening, brief intervention &amp; treatment) consumer</td>
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<tr>
<th>MEMBER ID</th>
<th>DATE OF BIRTH</th>
<th>DATE OF DEATH</th>
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<th>MIDDLE NAME</th>
<th>LAST NAME</th>
<th>SSN</th>
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<td>MI CHILD ID #</td>
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<td>COUNTY OF RESIDENCE</td>
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<th>PRIMARY SPOKEN LANGUAGE</th>
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<td>COMMUNICATION PREFERENCE</td>
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| REFERRAL SOURCE |
|----------------|---|
| RELIGION |

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<tr>
<th>RACE / ETHNIC ORIGIN 1</th>
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<tr>
<th>ETHNICITY</th>
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<tr>
<td>HISPANIC OR LATINO / LATINA</td>
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<td>[ ] Yes</td>
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<th>MARITAL STATUS</th>
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<th>PARENTAL STATUS</th>
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<tr>
<th>VETERAN STATUS</th>
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<table>
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<tr>
<th>CHILDREN &amp; FAMILIES</th>
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<tbody>
<tr>
<td>[ ] Yes</td>
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<table>
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<th>DEPARTMENT OF HUMAN SERVICES</th>
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<td>[ ] Yes</td>
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06/11/2015
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<thead>
<tr>
<th>Is Consumer a Child served by another DHS program</th>
<th>□ Yes □ No</th>
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**ADOPTION SUBSIDY**

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<tr>
<th>□ Yes □ No</th>
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**GUARDIAN OR LEGAL REPRESENTATION**

Who is responsible for making decisions regarding care for the individual?

- □ Individual
- □ Parent
- □ Guardian or Legal Representative
- □ Power of Attorney

**PRIMARY GUARDIAN INFORMATION**

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>TYPE OF GUARDIANSHIP</th>
<th>RELATIONSHIP TO CONSUMER</th>
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<tbody>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td>□ Father</td>
</tr>
<tr>
<td>Child</td>
<td></td>
<td></td>
<td>□ Unrelated</td>
</tr>
<tr>
<td>Spouse</td>
<td></td>
<td></td>
<td>□ Other</td>
</tr>
<tr>
<td>Sibling</td>
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- □ CHECK IF ADDRESS IS SAME AS CONSUMER

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<tr>
<th>PHONE NUMBER</th>
<th>ALTERNATIVE PHONE</th>
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**ADDITIONAL GUARDIAN NOTES**

**DOES THE INDIVIDUAL HAVE AN ADVANCE DIRECTIVE?**

- □ Yes
- □ No
- □ N/A

**PRESENTING NEEDS**

Briefly describe the presenting needs of the individual (e.g., what brought the person in for services today? How does the person view the referral? What led to the referral?)

**WHAT SUPPORTS/SERVICES ARE BEING REQUESTED TO HELP WITH THE PRESENTING NEEDS?**
SOCIAL/NATURAL SUPPORTS

Please indicate the supports in the person's daily life (family, friends, parent, others, etc.):

<table>
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<tr>
<th>Name of Support</th>
<th>Relationship</th>
<th>State how this person helps the individual achieve their goals</th>
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☐ No Natural Supports

IS THE INDIVIDUAL SATISFIED WITH THEIR SUPPORTS?
☐ Yes ☐ No

IS THERE A NEED TO CHANGE OR INCREASE SUPPORTS?
☐ Yes ☐ No

HAS THE INDIVIDUAL LOST ANY CLOSE RELATIVES/FAMILY MEMBERS/FRIENDS?
☐ Yes ☐ No

HAS THE INDIVIDUAL LOST ANY PETS/ANIMALS?
☐ Yes ☐ No

WHAT WERE THE INDIVIDUALS LIVING ARRANGEMENTS AS A CHILD?

PARENTING SUPPORT

WHO IS PRESENT WITH THE CHILD TODAY?
☐ Parent ☐ Legal Guardian ☐ N/A

PARENTS' TOTAL NUMBER OF DEPENDENTS (INCLUDING THIS CHILD):

CHILD SERVED BY DEPARTMENT OF HUMAN SERVICES?
☐ Yes ☐ No

PARENTS' VIEW OF PARENTING NEEDS?

ASSESSMENT OF PARENTING SKILLS/KNOWLEDGE?

RESOURCES OF PARENTING SUPPORT?

STATUS OF MENTAL HEALTH AFFECTING PARENT?

CONCERNS/ISSUES RELATED TO PARENT-CHILD RELATIONSHIP?

DOES THE PARENT / GUARDIAN HAVE ANY OF THE FOLLOWING CONCERNS? (CHECK ALL THAT APPLY)

TIME SPENT ON COMPUTER
☐ Yes ☐ No

TIME SPENT WATCHING TV
☐ Yes ☐ No

TIME SPENT WITH FRIENDS
☐ Yes ☐ No

INTERACTION DIFFICULTIES
☐ Child ☐ Parent ☐ N/A

COGNITIVE
☐ Child ☐ Parent ☐ N/A

SUBSTANCE USE
☐ Child ☐ Parent ☐ N/A

LEARNING/LITERACY PROBLEMS
☐ Child ☐ Parent ☐ N/A

06/11/2015
### ANXIETY
- Child: [ ]
- Parent: [ ]
- N/A: [ ]

### DEPRESSION
- Child: [ ]
- Parent: [ ]
- N/A: [ ]

### ISOLATION/WITHDRAWN
- Child: [ ]
- Parent: [ ]
- N/A: [ ]

### LOSS OF FAMILY MEMBER/FRIEND
- Child: [ ]
- Parent: [ ]
- N/A: [ ]

### LOSS OF PETS/ANIMALS
- Child: [ ]
- Parent: [ ]
- N/A: [ ]

### HISTORY OF POSTPARTUM DEPRESSION
- Parent: [ ]
- N/A: [ ]

### LOSS OF CHILD OR PREGNANCY
- Parent: [ ]
- N/A: [ ]

### PARENTS DIVORCED AS A CHILD?
- Yes: [ ]
- No: [ ]

### IF YES, AGE OF CHILD AT TIME OF PARENTS’ DIVORCE:

### THE PARENTS/GUARDIAN HAS BEEN ASSESSED AS WILLING AND ABLE TO BE PARTICIPANTS IN THE CHILD’S TREATMENT?
- Yes: [ ]
- No: [ ]

### WHAT ACTIVITIES/HOBBIES (SUCH AS COMPUTERS) DOES THE CHILD ENJOY?

### WOULD THE PARENT OR CHILD LIKE TO INCREASE COMMUNITY INVOLVEMENTS OR DAILY ACTIVITIES?
- Yes: [ ]
- No: [ ]

### MENTAL HEALTH SYMPTOMS

#### DURING THE PAST MONTH, HAVE YOU FELT DOWN, DEPRESSED, IRRITABLE, OR HOPELESS MOST DAYS?
- Yes: [ ]
- No: [ ]

#### HAVE YOU LOST INTEREST IN OR GOT LESS PLEASURE FROM THE THINGS YOU USED TO ENJOY?
- Yes: [ ]
- No: [ ]

#### HAVE YOU HAD THOUGHTS OR PLANS TO HURT YOURSELF OR OTHERS DURING THE PAST TWO WEEKS?
- Yes: [ ]
- No: [ ]

#### DO YOU FEEL YOU ARE IN CRISIS AND MAY NEED TO BE IN THE HOSPITAL?
- Yes: [ ]
- No: [ ]

#### DOES THE CHILD FEEL/ACT HYPER OR HIGH (LIKE ON DRUGS) EVEN THOUGH SHE/HE HASN’T TAKEN ANY?
- Yes: [ ]
- No: [ ]

#### DOES THE CHILD HAVE TIMES WHEN HIS/SER THOUGHTS RACE OR DOES SHE/HE NEED LESS SLEEP, LASTING MORE THAN A WEEK?
- Yes: [ ]
- No: [ ]

#### HAS THE CHILD EVER BELIEVED THAT PEOPLE WERE SPYING ON HIM/HER, OR THAT SOMEONE WAS PLOTTING AGAINST HIM/HER, OR TRYING TO HURT HIM/HER?
- Yes: [ ]
- No: [ ]

#### HAS THE CHILD EVER FELT LIKE OTHERS COULD READ HIS/HER MIND OR CONTROL HIS/HER THOUGHTS?
- Yes: [ ]
- No: [ ]

#### CAN THE CHILD BE DESCRIBED AS NERVOUS OR OVERLY FEARFUL?
- Yes: [ ]
- No: [ ]
**Does the child frequently argue with parents or people in authority?**
- [ ] Yes
- [ ] No

**Does the child openly disregard rules or limits to get their way?**
- [ ] Yes
- [ ] No

**Does the child have problems getting along with others?**
- [ ] Yes
- [ ] No

**Does the child do less well in school than you know he/she can?**
- [ ] Yes
- [ ] No

**Does the child have more trouble handling change/stress than other children his/her age?**
- [ ] Yes
- [ ] No

**Substance Use History**
- Section Not Applicable

**Risk and Safety Assessment**

**Any at-risk behaviors?**
- [ ] Yes
- [ ] No

**Any physical or verbal aggression?**
- [ ] Yes
- [ ] No

**Any self-injurious behaviors?**
- [ ] Yes
- [ ] No

**Any risk or safety issues with school (for children)?**
- [ ] Yes
- [ ] No

**Any risk or safety issues with community?**
- [ ] Yes
- [ ] No

**Any risk or safety issues with home environment?**
- [ ] Yes
- [ ] No

**Any risk or safety issues with work environment?**
- [ ] Yes
- [ ] No

**Any physical activities that put the individual at risk?**
- [ ] Yes
- [ ] No
EXPLAIN

ARE THERE ANY WEAPONS IN THE HOME?
☐ Accessible  ☐ Locked  ☐ No

EXPLAIN

DOES THE INDIVIDUAL HAVE ACCESS TO ANY OTHER WEAPONS?
☐ Yes  ☐ No

EXPLAIN

IS THERE A HISTORY OF SUICIDAL IDEATION?
☐ Yes  ☐ No

EXPLAIN

IS A CRISIS SCREENING NEEDED IMMEDIATELY?
☐ Yes  ☐ No

EXPLAIN

IS IMMEDIATE INTERVENTION FOR RISK/SAFETY NEEDED? IF YES, PLAN?
☐ Yes  ☐ No

EXPLAIN

IS THERE A CRISIS PLAN?
☐ Yes  ☐ No

EXPLAIN

IS THERE A HISTORY OF HOMICIDAL IDEATION?
☐ Yes  ☐ No

EXPLAIN

INTELLECTUAL/DEVELOPMENTAL HISTORY
☐ No reported history of intellectual/developmental disability

BRIEFLY DESCRIBE THE PRESENTING SYMPTOM(S) OF THE INTELLECTUAL/DEVELOPMENTAL DISABILITY:
WHAT YEAR AND AT WHAT AGE WAS THE INDIVIDUAL INITIALLY DETERMINED TO HAVE AN INTELLECTUAL/DEVELOPMENTAL DISABILITY?

WHERE DID THE EVALUATION DETERMINATION OCCUR AND WHY?

WHAT WAS THE ORIGINAL DIAGNOSIS?

<table>
<thead>
<tr>
<th>CHILD / ADOLESCENT DEVELOPMENTAL HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>DURING PREGNANCY, DID THE MOTHER EXPERIENCE ANY DEPRESSION, INCLUDING POST-PARTUM DEPRESSION?</td>
</tr>
<tr>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>DURING PREGNANCY, DID THE MOTHER EXPERIENCE ANY INFECTIONS?</td>
</tr>
<tr>
<td>□ Yes □ No □ Unknown</td>
</tr>
</tbody>
</table>

EXPLAIN
DURING PREGNANCY, DID THE MOTHER HAVE ANY COMPLICATIONS?
- Yes
- No
- Unknown
EXPLAIN

DURING PREGNANCY, DID THE MOTHER USE TOBACCO, ALCOHOL, OR DRUGS?
- Yes
- No
- Unknown
EXPLAIN

DURING PREGNANCY, DID THE MOTHER INHALE OR EAT TOXIC AGENTS?
- Yes
- No
- Unknown
EXPLAIN

WERE THERE ANY COMPLICATIONS DURING DELIVERY?
- Yes
- No
- Unknown
EXPLAIN

DID THE MOTHER REPORT THE CHILD AS HAVING PHYSICAL MALFORMATIONS AT BIRTH?
- Yes
- No
- Unknown
EXPLAIN

DID THE MOTHER HAVE A FULL TERM PREGNANCY?
- Yes
- No
- Unknown
EXPLAIN

DID THE INFANT EXHIBIT ANY EATING PROBLEMS?
- Yes
- No
- Unknown
EXPLAIN

DID THE INFANT EXHIBIT ANY SLEEPING PROBLEMS?
- Yes
- No
- Unknown
EXPLAIN

WHAT WAS THE CHILD'S BIRTH WEIGHT?

WHAT WAS THE AGE OF THE MOTHER AT THE CHILD'S BIRTH?

AT WHAT AGE DID THE CHILD DO THE FOLLOWING ... (IF NEVER OCCURRED, INDICATE UNABLE)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Age (in months)</th>
<th>Unable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roll Over</td>
<td>AGE</td>
<td></td>
</tr>
<tr>
<td>Crawl</td>
<td>AGE</td>
<td></td>
</tr>
<tr>
<td>Sit Up On Own</td>
<td>AGE</td>
<td></td>
</tr>
<tr>
<td>Walk</td>
<td>AGE</td>
<td></td>
</tr>
</tbody>
</table>
FETAL ALCOHOL SYNDROME (FAS) PRE-SCREEN

FAS is a birth defect caused by alcohol use during pregnancy. FAS is a medical diagnosis. This pre-screen is not intended to take the place of a diagnostic evaluation. It is intended to make the proper referral for diagnosis and treatment.

1. HEIGHT AND WEIGHT SEEM SMALL FOR AGE?
   □ Yes □ No

2. SIZE OF HEAD SEEMS SMALL FOR AGE?
   □ Yes □ No

3. BEHAVIORAL CONCERNS (CHECK ALL THAT APPLY - ANY OF THESE QUALIFIES AS AN IDENTIFIER)
   □ Sleeping/eating problems
   □ I/DD or IQ below familial expectations
   □ Attention problem/impulsive/restless
   □ Learning disability
   □ Problem with reasoning and judgement
   □ Speech and/or language delays
   □ Acts younger than children same age

4. FACIAL ABNORMALITIES?
   □ Yes □ No

5. MATERNAL ALCOHOL USE DURING PREGNANCY?
   □ Yes □ No

If YES to 2 or more above, the individual should be referred for a full FAS diagnostic evaluation.

Contact the nearest center to schedule a complete FAS diagnostic evaluation: Detroit 313-993-3891 Ann Arbor 734-936-9777

BEHAVIOR TREATMENT PLAN

DOES THE INDIVIDUAL REQUIRE A REFERRAL FOR A BEHAVIORAL ASSESSMENT?
   □ Yes □ No

IF YES, EXPLAIN AND PROVIDER REFERRAL INFORMATION:

HAS THE INDIVIDUAL EVER HAD A BEHAVIOR TREATMENT PLAN?
   □ Yes □ No □ N/A

BRIEFLY DESCRIBE HISTORY IF APPLICABLE:
### Trauma History

**Have you ever been involved in a traumatic event that caused you to fear for your life? (e.g., sexual assault, physical attack, military combat, robbery, severe car accident, or sexual assault as a child)**

- [ ] Yes
- [ ] No

**Child**

**Adult**

**Ongoing**

**Explain if needed**

**History of emotional abuse? (e.g., someone repeatedly made you feel bad through harsh words)**

- [ ] Yes
- [ ] No

**Child**

**Adult**

**Ongoing**

**Explain if needed**

**History of physical abuse? (e.g., someone repeatedly caused you physical harm)**

- [ ] Yes
- [ ] No

**Child**

**Adult**

**Ongoing**

**Explain if needed**

**History of sexual abuse? (e.g., someone forced sexual advances or acts)**

- [ ] Yes
- [ ] No

**Child**

**Adult**

**Ongoing**

**Explain if needed**

**History of neglect? (e.g., a caretaker denied basic needs, such as adequate food, clothes, and supervision)**

- [ ] Yes
- [ ] No

**Child**

**Adult**

**Ongoing**

**Explain if needed**

**History of violence? (e.g., the use of physical force against oneself, another person, or a community, which has a high likelihood of resulting in injury, death, or psychological harm)**

- [ ] Yes
- [ ] No

**Child**

**Adult**

**Ongoing**

**Explain if needed**

**History of domestic violence? (e.g., a pattern of abusive behavior in an intimate relationship, which is used by one partner to gain or maintain power and control over another partner)**

- [ ] Yes
- [ ] No

**Child**

**Adult**

**Ongoing**

**Explain if needed**
HISTORY OF BULLYING? (E.G., UNWANTED AND REPEATED AGGRESSIVE BEHAVIOR AMONG SCHOOL AGED CHILDREN THAT INVOLVES A REAL OR PERCEIVED POWER IMBALANCE. INCLUDES VERBAL AND/OR PHYSICAL ABUSE)

☐ Yes  ☐ No

☐ Child  ☐ Adult  ☐ Ongoing

EXPLAIN IF NEEDED

Trauma/Abuse/Stress Screening for Children
1. ARE YOU AWARE OF OR DO YOU SUSPECT THE CHILD HAS EXPERIENCED ANY OF THE FOLLOWING:

☐ Physical abuse
☐ Suspected neglectful home environment
☐ Emotional abuse
☐ Exposure to domestic violence
☐ Known or suspected exposure to drug activity aside from parental/caregiver use
☐ Known or suspected exposure to any other violence not already identified
☐ Parental/caregiver drug use/substance abuse
☐ Multiple separations from parent or caregiver
☐ Frequent and multiple moves or homelessness
☐ Sexual abuse or exposure
☐ Other

If you are not aware of a trauma history, but multiple concerns are present in the questions 2-5, then there may be a trauma history that has not come to your attention.

Note: Concerns in the following areas do not necessarily indicate trauma; however, there is a strong relationship.

2. DOES THE CHILD SHOW ANY OF THESE BEHAVIORS?

☐ Excessive aggression or violence towards self
☐ Excessive aggression or violence towards others
☐ Explosive behavior (going 0-100 instantly)
☐ Hyperactivity, distractibility, inattention
☐ Very withdrawn or excessively shy
☐ Oppositional and/or defiant behavior
☐ Sexual behaviors not typical for a child's age
☐ Peculiar patterns of forgetfulness
☐ Inconsistency in skills
☐ Other

3. DOES THE CHILD EXHIBIT ANY OF THE FOLLOWING EMOTIONS OR MOODS?

☐ Excessive mood swings
☐ Chronic sadness, doesn't seem to enjoy any activities
☐ Very flat affect or withdrawn behavior
☐ Quick, explosive anger
☐ Other

4. IS THE CHILD HAVING PROBLEMS AT SCHOOL?

☐ Low or failing grades
☐ Inadequate performance
☐ Difficulty with authority
☐ Attention or memory problems
☐ Other

5. WILL TRAUMA HISTORY BE A GOAL OF PCP?

☐ Yes  ☐ No

HISTORY OF PRIOR TREATMENT SERVICES
List of hospitals, CMH providers, DHS involvement
<table>
<thead>
<tr>
<th>Treatment Provider</th>
<th>Location</th>
<th>Reason</th>
<th>Date/LOS</th>
<th>Did the individual find the treatment helpful?</th>
</tr>
</thead>
</table>

### PHYSICAL HEALTH HISTORY

**INDIVIDUAL’S REPORTED CURRENT HEALTH STATUS:**

- [ ] Excellent
- [ ] Good
- [ ] Fair
- [ ] Poor

**DOES THE INDIVIDUAL HAVE ANY DIAGNOSED PHYSICAL ILLNESS OR CONDITION(S)? CHECK ALL THAT APPLY.**

- [ ] Allergies
- [ ] Chronic fatigue
- [ ] Endometriosis
- [ ] Heart disease
- [ ] Multiple sclerosis
- [ ] Ulcers
- [ ] Anemia
- [ ] Chronic pain
- [ ] Fibromyalgia
- [ ] Hepatitis
- [ ] Renal failure
- [ ] Other
- [ ] Arrhythmias
- [ ] COPD
- [ ] Gastritis
- [ ] Hernia
- [ ] Sleep apnea
- [ ] Stroke
- [ ] Arthritis
- [ ] Crohns disease
- [ ] Gout
- [ ] HIV/AIDS
- [ ] Stroke
- [ ] Cancer
- [ ] Eating Disorder
- [ ] Headache/migraines
- [ ] Menopause
- [ ] Tuberculosis

**HAVE ANY OF THE INDIVIDUAL’S IMMEDIATE FAMILY MEMBERS OR DECEASED RELATIVES (PARENTS, SIBLINGS) HAD ANY OF THE FOLLOWING CONDITIONS? CHECK ALL THAT APPLY.**

- [ ] Asthma
- [ ] Allergies
- [ ] Cancer
- [ ] COPD
- [ ] Diabetes
- [ ] Heart Disease
- [ ] Hypertension
- [ ] Stroke
- [ ] Suicide
- [ ] Mental health
- [ ] Substance use
- [ ] Developmental disability

### ADVERSE REACTIONS

<table>
<thead>
<tr>
<th>DRUG / ALLERGEN</th>
<th>REPORTED BY</th>
<th>REACTIONS</th>
<th>SEVERITY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>[ ] Not Assessed</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>[ ] Mild</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>[ ] Severe</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>[ ] Life-Threatening</td>
</tr>
</tbody>
</table>

**NOTES**

**START**

<table>
<thead>
<tr>
<th>DRUG / ALLERGEN</th>
<th>REPORTED BY</th>
<th>REACTIONS</th>
<th>SEVERITY</th>
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<tr>
<td></td>
<td></td>
<td></td>
<td>[ ] Life-Threatening</td>
</tr>
</tbody>
</table>

**NOTES**

**START**

### HEALTH INDICATORS AND OTHER CONDITIONS FOR ALL POPULATIONS

**DATE REVIEWED**

#### HEARING

- **ABILITY TO HEAR (WITH HEARING APPLIANCE NORMALLY USED)**
  - [ ] Adequate
    - No difficulty in normal conversation, social interaction, listening to TV
  - [ ] Minimal difficulty
    - Difficulty in some environments (e.g., when person speaks softly or is more than 6 feet away)
  - [ ] Moderate difficulty
    - Problem hearing normal conversation, requires quiet setting to hear well
  - [ ] Severe difficulty
    - Difficulty in all situations (e.g., speaker has to talk loudly or speak very slowly; or person reports that all speech is mumbled)
  - [ ] No hearing

- **HEARING AID USED**
  - [ ] Yes
  - [ ] No

#### VISION

- **ABILITY TO SEE IN ADEQUATE LIGHT (WITH GLASSES OR WITH OTHER VISUAL APPLIANCE NORMALLY USED)**
  - [ ] Adequate
Sees fine detail, including regular print in newspapers/books or small items in pictures
- **Minimal difficulty**
  - Sees large print, but not regular print in newspapers/books or cannot identify large objects in pictures
- **Moderate difficulty**
  - Limited vision; not able to see newspaper headlines or small items in pictures, but can identify objects in his/her environment
- **Severe difficulty**
  - Object identification in question, but the person's eyes appear to follow objects, or the person sees only light, colors, shapes
  - **No vision**
    - Eyes do not appear to follow objects; absence of sight

### Visual Appliance
- **Yes**
- **No**

## Health Conditions

Indicate whether or not the individual had the presence of each of the following health conditions, as reported by the individual, a health care professional or family member, in the past 12 months.

### Pneumonia (2 or More Times) - Including Aspiration Pneumonia
- **Never present**
- **History of condition, but not treated for the condition within the past 12 months**
- **Treated for the condition within the past 12 months**
- **Information unavailable**

### Asthma
- **Never present**
- **History of condition, but not treated for the condition within the past 12 months**
- **Treated for the condition within the past 12 months**
- **Information unavailable**

### Upper Respiratory Infections (3 or More Times Within Past 12 Months)
- **Never present**
- **History of condition, but not treated for the condition within the past 12 months**
- **Treated for the condition within the past 12 months**
- **Information unavailable**

### Gastroesophageal Reflux, or GERD
- **Never present**
- **History of condition, but not treated for the condition within the past 12 months**
- **Treated for the condition within the past 12 months**
- **Information unavailable**

### Chronic Bowel Impactions
- **Never present**
- **History of condition, but not treated for the condition within the past 12 months**
- **Treated for the condition within the past 12 months**
- **Information unavailable**

### Seizure Disorder or Epilepsy
- **Never present**
- **History of condition, but not treated for the condition within the past 12 months**
- **Treated for the condition within the past 12 months and seizure free**
- **Treated for the condition within the past 12 months, but still experience occasional seizures (less than one per month)**
- **Treated for the condition within the past 12 months, but still experience frequent seizures**
- **Information unavailable**

### Progressive Neurological Disease, Include, Alzheimer's and Parkinson's Disease
- **Not present**
- **Treated for the condition within the past 12 months**
- **Information unavailable**

### Diabetes
- **Never present**
- **History of condition, but not treated for the condition within the past 12 months**
- **Treated for the condition within the past 12 months**
- **Information unavailable**

### Hypertension
- **Never present**
- **History of condition, but not treated for the condition within the past 12 months**
- **Treated for condition within the past 12 months and blood pressure is stable**
- **Treated for condition within the past 12 months, but blood pressure remains high or unstable**
- **Information is unavailable**

### Obesity
- **Not present**
- **Medical diagnosis of obesity present or Body Mass Index (BMI) > 30**

---

**Do you have a Primary Care Doctor/Family Physician/Pediatrician that you are seeing?**
- **Yes**
- **No**

---

06/11/2015
### PRIMARY CARE PHYSICIAN

**WHEN WAS THE LAST TIME THE INDIVIDUAL SAW A PRIMARY CARE DOCTOR/FAMILY PHYSICIAN/PEDIATRICIAN?**

- [ ] Yes
- [ ] No

**IS A REFERRAL NEEDED TO GET THE INDIVIDUAL SET UP WITH A PHYSICAL HEALTH DOCTOR?**

- [ ] Yes
- [ ] No

**WHEN WAS THE LAST TIME THE INDIVIDUAL SAW A DENTIST?**

**WHEN WAS THE LAST TIME THE INDIVIDUAL HAD AN EYE EXAM?**

**IS THE INDIVIDUAL CURRENT ON ALL VACCINES/IMMUNIZATIONS?**

- [ ] Yes
- [ ] No
- [ ] Referral Needed

### HISTORY OF CHRONIC PAIN

**HAVE YOU HAD CHRONIC PAIN (I.E., PAIN FOR MORE THAN 6 MONTHS)?**

- [ ] Yes
- [ ] No
- [ ] Current
- [ ] Past

**WHERE IS THE PAIN LOCATED?**

**HOW LONG HAVE YOU HAD THIS PAIN? WHEN DID THE PAIN FIRST START?**

**HOW OFTEN DO YOU EXPERIENCE THE PAIN? (I.E., WEEKLY, DAILY, 2-3 TIMES PER DAY, ETC.?)**

**HOW LONG, DURING A TYPICAL DAY WHEN YOU EXPERIENCE PAIN, DOES THE PAIN LAST FOR?**

**HOW SEVERE IS THE PAIN (ON A SCALE FROM 0 TO 10, WITH 10 BEING THE WORSE)?**

**HOW DO YOU MANAGE THIS PAIN? PLEASE LIST ALL SOURCES (E.G., MEDICATION, EXERCISE, RELAXATION, ACUPUNCTURE, ETC.)**

### DIET AND EXERCISE

**DO YOU THINK YOU EAT A HEALTHY DIET (REGULAR MEALS, FRUITS, VEGETABLES, MINIMUM TAKEOUT/RESTAURANTS)?**

- [ ] Yes
- [ ] No

**DO YOU THINK YOU TAKE PART IN ANY PHYSICAL ACTIVITY OR EXERCISE (INCLUDING WALKING, CYCLING, GARDENING)?**

- [ ] Yes
- [ ] No

**HOW OFTEN DO YOU EXERCISE OR ENGAGE IN PHYSICAL ACTIVITY DURING A TYPICAL WEEK (INDICATE HOW MANY TIMES PER WEEK, AND MINUTES/HOURS PER WEEK)?**

### SMOKING HABITS

**DO YOU SMOKE CIGARETTES OR TOBACCO?**

- [ ] Yes
- [ ] No

**IF YES, HOW MUCH DO YOU SMOKE PER DAY? (AMOUNT)**

**AND HOW LONG HAVE YOU SMOKED FOR? (MONTHS/YEARS)**

**IF NO, HAVE YOU EVER SMOKED IN THE PAST?**

- [ ] Yes
- [ ] No

**IF YES, FOR HOW LONG? (MONTHS/YEARS)**

**HAVE YOU TRIED TO STOP SMOKING IN THE PAST?**

- [ ] Yes
- [ ] No

**DO YOU WANT TO STOP SMOKING NOW?**

- [ ] Yes
- [ ] No

### SEXUAL ACTIVITIES

- [ ] Section N/A

**ARE YOU SEXUALLY ACTIVE?**

- [ ] Yes
- [ ] No
- [ ] Prefer Not To Answer

**ARE YOU USING A METHOD OF PROTECTION DURING SEXUAL ACTIVITIES TO REDUCE YOUR RISK OF SEXUALLY TRANSMITTED INFECTIONS AND/OR PREGNANCY (E.G., CONDOMS, DENTAL DAMS, CONTRACEPTIVES, ETC.)?**

- [ ] Yes
- [ ] No
- [ ] Prefer Not To Answer

**ARE YOU AWARE OF THE RISKS OF SEXUALLY TRANSMITTED INFECTIONS SUCH AS HEPATITIS, HIV/AIDS, SYPHILIS, ETC.?**

- [ ] Yes
- [ ] No
- [ ] Prefer Not To Answer

**HAVE YOU EVER HAD UNPROTECTED SEX OR ENGAGED IN SEXUAL BEHAVIORS (ORAL, ANAL, GENITAL) WITH A PERSON WHOSE HIV, HEPATITIS, OR STI STATUS WAS UNKNOWN TO YOU (SUCH AS SEX WHEN DRUNK OR HIGH WITH SOMEONE YOU DID NOT KNOW VERY WELL)?**

- [ ] Yes
- [ ] No
- [ ] Unsure

**HAVE YOU EVER ENGAGED IN SEXUAL BEHAVIORS WITH ANYONE WHO HAS:**
INJECTED DRUGS?
- [ ] Yes
- [ ] No
- [ ] Unsure

TRADED SEX FOR DRUGS?
- [ ] Yes
- [ ] No
- [ ] Unsure

MANY SEXUAL PARTNERS?
- [ ] Yes
- [ ] No
- [ ] Unsure

HIV/AIDS?
- [ ] Yes
- [ ] No
- [ ] Unsure

HEPATITIS?
- [ ] Yes
- [ ] No
- [ ] Unsure

STI'S?
- [ ] Yes
- [ ] No
- [ ] Unsure

HAVE YOU EVER EXPERIENCED OTHER FORMS OF BLOOD-TO-BLOOD OR BODILY FLUID CONTACT (FOR EXAMPLE, BLOOD TRANSFUSIONS, HEMOPHILIA TREATMENTS, EMPLOYMENT IN MEDICAL FIELD, ETC.) AND HAVE CONCERNS ABOUT YOUR RISK FOR HIV, HEPATITIS, OR STI'S?
- [ ] Yes
- [ ] No
- [ ] Unsure

WOULD THE INDIVIDUAL LIKE FURTHER INFORMATION ON ANY SEXUAL HEALTH ISSUES?
- [ ] Yes
- [ ] No

SEXUAL ORIENTATION:

VITALS
COLLECTION INFORMATION

COLLECTION DATE

COLLECTION TIME

GENERAL INFORMATION

HEIGHT:
- [ ] Declined
- [ ] No Information Collected

WEIGHT:
- [ ] Declined
- [ ] No Information Collected

WAIST CIRCUMFERENCE:
- [ ] Declined
- [ ] No Information Collected

BMI:

COMMENTS

REPRODUCTIVE HEALTH

PREGNANT:
- [ ] Yes
- [ ] No
- [ ] N/A

LAST MONTHLY PERIOD DATE

BIRTH CONTROL METHOD

IF OTHER, EXPLAIN:

TOBACCO USE

SMOKING STATUS:
- [ ] Declined
- [ ] No Information Collected

OTHER TOBACCO USE:

PROVIDED CONSUMER WITH ADVICE TO QUIT SMOKING OR TOBACCO USE, OR RECOMMENDED OR DISCUSSED SMOKING OR TOBACCO USE CESSION, MEDICATIONS, METHODS, OR STRATEGIES
- [ ] Yes
- [ ] No

TEMPERATURE
- [ ] Declined
<table>
<thead>
<tr>
<th><strong>VALUE:</strong></th>
<th>□ No Information Collected</th>
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</thead>
<tbody>
<tr>
<td><strong>SITE:</strong></td>
<td>□ Axillary  □ Rectal  □ Non-invasive thermometer  □ Oral  □ Temporal  □ Tympanic</td>
</tr>
<tr>
<td><strong>COMMENTS</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PULSE</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>VALUE:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>RHYTHM:</strong></td>
<td>□ Irregular  □ Regular</td>
</tr>
<tr>
<td><strong>FORCE:</strong></td>
<td>□ Bounding  □ Normal  □ Thready  □ Weak</td>
</tr>
<tr>
<td><strong>METHOD USED:</strong></td>
<td>□ Machine  □ Manual</td>
</tr>
<tr>
<td><strong>SITE:</strong></td>
<td>□ Apical (over heart)  □ Brachial (upper arm)  □ Cartoid (neck)  □ Femoral (inner thigh)  □ Popliteal (behind knee)  □ Radial (wrist)</td>
</tr>
<tr>
<td><strong>COMMENTS</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>RESPIRATION</strong></th>
<th>□ Declined  □ No Information Collected</th>
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</thead>
<tbody>
<tr>
<td><strong>VALUE:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>LUNG SOUNDS:</strong></td>
<td>□ Declined  □ No Information Collected</td>
</tr>
<tr>
<td>□ Clear  □ Rales  □ Rhonchi  □ Wheeze  □ Other</td>
<td></td>
</tr>
<tr>
<td><strong>COMMENTS</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>BLOOD PRESSURE</strong></th>
<th>□ Declined  □ No Information Collected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sitting</strong></td>
<td></td>
</tr>
<tr>
<td>SYSTOLIC  mmHg / DIASTOLIC mmHg</td>
<td></td>
</tr>
<tr>
<td><strong>Standing</strong></td>
<td></td>
</tr>
<tr>
<td>SYSTOLIC  mmHg / DIASTOLIC mmHg</td>
<td></td>
</tr>
<tr>
<td><strong>METHOD USED:</strong></td>
<td>□ Machine  □ Manual</td>
</tr>
<tr>
<td><strong>COMMENTS</strong></td>
<td></td>
</tr>
</tbody>
</table>
### RESULTS OF BREATHALYZER & URINE DRUG SCREEN (UDS)

<table>
<thead>
<tr>
<th>BAC (BLOOD ALCOHOL CONTENT):</th>
</tr>
</thead>
<tbody>
<tr>
<td>URINE DRUG SCREEN RESULTS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BLOOD GLUCOSE RESULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Declined</td>
</tr>
<tr>
<td>□ No Information Collected</td>
</tr>
</tbody>
</table>

**COMMENTS**

- **REACTION:**
  - □ Cooperative
  - □ Declined
  - □ Resisted (Uncooperative)

**COMMENTS**

### PRESCRIBED MEDICATIONS

**OTHER MEDICATIONS**

- **DO YOU HAVE ANY PROBLEMS WITH ANY OF THESE MEDICATIONS (SIDE EFFECTS)?**
  - □ Yes
  - □ No

  **IF YES, PLEASE EXPLAIN:**

### LEGAL ISSUES

**CORRECTIONS RELATED STATUS**

- **Most Recent Offense**
- **Date**

**JUDGE NAME:**

06/11/2015
<table>
<thead>
<tr>
<th><strong>EDUCATION</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CHILD’S EDUCATION</strong></td>
<td></td>
</tr>
<tr>
<td>☐ Not Applicable</td>
<td></td>
</tr>
<tr>
<td><strong>EDUCATION HISTORY</strong></td>
<td></td>
</tr>
<tr>
<td>☐ Unreported</td>
<td></td>
</tr>
<tr>
<td>☐ Completed less than high school</td>
<td></td>
</tr>
<tr>
<td>☐ Completed special education, high school, or GED</td>
<td></td>
</tr>
<tr>
<td>☐ In school - Kindergarten through 12th grade</td>
<td></td>
</tr>
<tr>
<td>☐ In training program</td>
<td></td>
</tr>
<tr>
<td>☐ In Special Education</td>
<td></td>
</tr>
<tr>
<td>☐ Attended or is attending undergraduate college</td>
<td></td>
</tr>
<tr>
<td>☐ College graduate</td>
<td></td>
</tr>
<tr>
<td><strong>HIGHEST GRADE</strong></td>
<td></td>
</tr>
<tr>
<td>☐ Preschool</td>
<td>☐ Day Care Center</td>
</tr>
<tr>
<td><strong>CURRENT SCHOOL/SCHOOL DISTRICT:</strong></td>
<td></td>
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<tr>
<td><strong>IN SPECIAL EDUCATION?</strong></td>
<td></td>
</tr>
<tr>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td><strong>DATE OF FSP</strong></td>
<td></td>
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<tr>
<td><strong>DATE OF LAST IEPC</strong></td>
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<td><strong>AT AGE-APPROPRIATE GRADE LEVEL?</strong></td>
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<td>☐ Yes</td>
<td>☐ No</td>
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<tr>
<td><strong>Expelled</strong></td>
<td>☐ Excessive Absenteeism</td>
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<tr>
<td><strong>LIMITED ENGLISH PROFICIENCY?</strong></td>
<td></td>
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<tr>
<td>☐ Yes</td>
<td>☐ No</td>
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<tr>
<td><strong>MOTHER’S EDUCATION</strong></td>
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<tr>
<td>☐ Not Applicable</td>
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<tr>
<td><strong>EDUCATION</strong></td>
<td>☐ Literacy Issues</td>
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<tr>
<td><strong>FATHER’S EDUCATION</strong></td>
<td></td>
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<tr>
<td>☐ Not Applicable</td>
<td></td>
</tr>
<tr>
<td><strong>EDUCATION</strong></td>
<td>☐ Literacy Issues</td>
</tr>
</tbody>
</table>

**DOES THE CHILD/INDIVIDUAL NEED ASSISTANCE TO ACHIEVE EDUCATION/WORK GOALS?**

☐ Yes ☐ No

IF YES, EXPLAIN:
DOES THE FAMILY NEED ASSISTANCE TO HELP WITH INDIVIDUAL ACHIEVING EDUCATION AND/OR WORK GOALS?

☐ Yes  ☐ No

IF YES, EXPLAIN:

EMPLOYMENT

EMPLOYMENT STATUS

☐ Employed full time (30 hours or more per week) competitively or self-employed.

☐ Employed part time (less than 30 hours per week) in competitively or self-employed.

☐ Unemployed - looking for work, and/or on layoff from job

☐ Sheltered workshop or work services participant in non-integrated setting

☐ In unpaid work (e.g. volunteering, internship, community service)

☐ Self-employed (e.g. micro-enterprise).

☐ In enclaves/mobile crews, agency-owned transitional employment.

☐ Participates in facility-based activity program where an array of specialty supports and services are provided to assist an individual in achieving his/her non-work related goals

☐ Not in the competitive labor force-includes homemaker, child, student age 18 and over, retired from work, resident of an institution (including nursing home), or incarcerated.

EARNED WAGE IS MINIMUM WAGE OR GREATER

☐ Yes  ☐ No  ☐ N/A - Person is not working

CULTURE/SPRITUALITY/RELIGION

DOES THE INDIVIDUAL IDENTIFY CULTURAL, SPIRITUAL, OR RELIGIOUS VALUES THAT PLAY A ROLE IN THEIR LIFE WHERE THEY WOULD PREFER SERVICES SPECIFIC TO THEIR CULTURE VALUES?

☐ Yes  ☐ No

IF YES, PLEASE EXPLAIN:
**CURRENT LIVING ARRANGEMENTS**

**RESIDENTIAL LIVING ARRANGEMENT**

<table>
<thead>
<tr>
<th>FOSTER CARE FACILITY / LICENSE #</th>
</tr>
</thead>
</table>

Describe any concerns/issues with current living situation (indicate appropriateness, mobility, restrictiveness, accessibility, caregiver concerns)

---

**TRANSPORTATION**

Are there any concerns or problems related to transportation?

- [ ] Yes
- [x] No

Assessment of transportation needs:

Explain if necessary

---

**MENTAL STATUS**

Is individual oriented to: (check all that apply):

<table>
<thead>
<tr>
<th>INDIVIDUAL</th>
<th>PLACE</th>
<th>TIME</th>
<th>SITUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Yes</td>
<td>[ ] No</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>[ ] Yes</td>
<td>[ ] No</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
</tbody>
</table>

Explain if necessary
GROOMING
☐ Excellent  ☐ Good  ☐ Marginal  ☐ Poor

HYGIENE
☐ Excellent  ☐ Good  ☐ Marginal  ☐ Poor

DRESS
☐ Inappropriate to Weather  ☐ Unkempt  ☐ Unusual  ☐ Unremarkable

MEMORY
☐ Impaired Immediate  ☐ Impaired Recent  ☐ Impaired Remote  ☐ Not Determined

AWARENESS
☐ Alert  ☐ Dull  ☐ Stupor

EXPLAIN IF NECESSARY

CONCENTRATION
☐ Normal  ☐ Able to Focus  ☐ Distractible

EXPLAIN IF NECESSARY

JUDGMENT
☐ Good  ☐ Fair  ☐ Poor

EXPLAIN IF NECESSARY

INSIGHT
☐ None  ☐ Limited  ☐ Insightful

EXPLAIN IF NECESSARY

HALLUCINATIONS: (CHECK ALL THAT APPLY)
☐ N/A  ☐ Auditory  ☐ Visual  ☐ Other

EXPLAIN IF NECESSARY

THOUGHT PROCESS: (CHECK ALL THAT APPLY)
☐ Unremarkable  ☐ Obsessions  ☐ Compulsions  ☐ Paranoid  ☐ Irrational
☐ Peculiar  ☐ Loosely Organized  ☐ Illogical  ☐ Other (explain)

EXPLAIN IF NECESSARY

STREAM OF MENTAL ACTIVITY:
☐ Normal  ☐ Delayed Reponse  ☐ Perseverating  ☐ Circumstantial  ☐ Tangential
☐ Flight of Ideas  ☐ Slowed  ☐ Racing  ☐ Blocked  ☐ Other (explain)

EXPLAIN IF NECESSARY

CHARACTERISTICS OF SPEECH:
☐ Unremarkable  ☐ Soft  ☐ Loud  ☐ Pressured  ☐ Nonverbal
☐ Stuttering  ☐ Incoherent  ☐ Other (explain)

EXPLAIN IF NECESSARY

PRESENTATION DURING THE INTERVIEW:
☐ Unremarkable  ☐ Embarrassed  ☐ Seductive  ☐ Impulsive  ☐ Dramatic
☐ Needy  ☐ Guarded  ☐ Other (explain)

EXPLAIN IF NECESSARY

EMOTIONAL STATE / AFFECT / REACTION:
☐ Appropriate  ☐ Inappropriate  ☐ Irritable  ☐ Angry  ☐ Calm
☐ Sad  ☐ Depressed  ☐ Anxious  ☐ Absence of Emotions  ☐ Unstable Emotions
☐ Emotions are Incongruent with Thought Content  ☐ Other (explain)

EXPLAIN IF NECESSARY

MOOD AS STATED BY THE INDIVIDUAL:

CLINICAL IMPRESSIONS

CLINICAL SUMMARY

RECOMMENDATIONS

06/11/2015
## DIAGNOSTIC SUMMARY

### DICTIONARY

**ALPHABETICAL INDEX**

1. **A** - 
2. **B** - 
3. **C** - 
4. **D** - 
5. **E** - 
6. **F** - 
7. **G** - 
8. **H** - 
9. **I** - 
10. **J** - 
11. **K** - 
12. **L** - 
13. **M** - 
14. **N** - 
15. **O** - 
16. **P** - 
17. **Q** - 
18. **R** - 
19. **S** - 
20. **T** - 
21. **U** - 
22. **V** - 
23. **W** - 
24. **X** - 
25. **Y** - 
26. **Z** -

### DIAGNOSIS

<table>
<thead>
<tr>
<th>Axis</th>
<th>ICD-9</th>
<th>ICD-10</th>
<th>Description</th>
<th>Status Date</th>
<th>Status</th>
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<tr>
<td>Axis II</td>
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<tr>
<td>Axis III</td>
<td></td>
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</tbody>
</table>

### AXIS IV

- Economic problems
- Problem accessing healthcare
- Educational problems
- Occupational problems
- Housing problems
- Problem related to social environment
- Problem related to interaction with legal system
- Other psychosocial and environmental problems
- Behavioral / Personality issues

### AXIS V

- CURRENT GAF
- GAF DATE

### Diagnostic Summary

### Additional Information

- CO-OCCURRING CONSUMER QUADRANT
- Mild Psychopathology with Substance Abuse (Psych. Low/Substance Low)
- Psychiatrically Complicated Substance Dependence (Psych. Low/Substance High)
- Serious & Persistent Mental Illness with Substance Abuse (Psych. High/Substance Low)
- Serious & Persistent Mental Illness with Substance Dependence (Psych. High/Substance High)

**DIAGNOSIS MADE BY (NAME/CREDENTIALS)**

**DIAGNOSIS EFFECTIVE DATE**
For purposes of these data elements, when the term 'support' is used, it means support from a paid or un-paid person or technological support needed to enable the individual to achieve his/her desired future. The kinds of support a person might need are:

- 'Limited' means the person can complete approximately 75% or more of the activity without support and the caregiver provides support for approximately 25% or less of the activity.
- 'Moderate' means the person can complete approximately 50% of the activity and the caregiver supports the other 50%.
- 'Extensive' means the person can complete approximately 25% of the activity and relies on the caregiver to support 75% of the activity.
- 'Total' means the person is unable to complete the activity and the caregiver is providing 100% of support.

**PREDOMINANT COMMUNICATION STYLE**

- English language spoken by the individual
- Assistive technology used
  - Includes computer, other electronic devices or symbols such as Bliss board, or other 'low tech' communication devices.
- Interpreter used
  - Includes a foreign language or American Sign Language (ASL) interpreter, or someone who knows the individual well enough to interpret speech or behavior.
- Alternative language used
  - Includes a foreign language or sign language without an interpreter.
- Non-language forms of communication used
  - Gestures, vocalizations or behavior.
- No ability to communicate
- Unknown (Missing Value)

**ABILITY TO MAKE SELF UNDERSTOOD**

- Always Understood
  - Expresses self without difficulty
- Usually Understood
  - Difficulty communicating BUT if given time and/or familiarity can be understood, little or no prompting required
- Often Understood
  - Difficulty communicating AND prompting usually required
- Sometimes Understood
  - Ability is limited to making concrete requests or understood only by a very limited number of people
- Rarely or Never Understood
  - Understanding is limited to interpretation of very person-specific sounds or body language
- Unknown (Missing Value)

**SUPPORT WITH MOBILITY**

- Independent
  - Able to walk (with or without an assistive device) or propel wheelchair and move about
- Guidance/Limited Support
  - Able to walk (with or without an assistive device) or propel wheelchair and move about with guidance, prompting, reminders, stand by support, or with limited physical support
- Moderate Support
  - May walk very short distances with support but uses wheelchair as primary method of mobility, needs moderate physical support to transfer, move the chair, and/or shift positions in chair or bed
- Extensive Support
  - Uses wheelchair exclusively, needs extensive support to transfer, move the wheelchair, and/or shift positions in chair or bed
- Total Support
  - Uses wheelchair with total support to transfer, move the wheelchair, and/or shift positions or may be unable to sit in a wheelchair; needs total support to shift positions throughout the day
- Unknown (Missing Value)

**MODE OF NUTRITIONAL INTAKE**

- Normal
  - Swallows all types of foods
Modified independent  
  e.g., liquid is sipped, takes limited solid food, need for modification may be unknown

Requires diet modification to swallow solid food  
  e.g., mechanical diet (e.g., puree, minced) or only able to ingest specific foods

Requires modification to swallow liquids  
  e.g., thickened liquids

Can swallow only pureed solids AND thickened liquids

Combined oral and parenteral or tube feeding  
  e.g., G-tube or PEG tube

Enteral feeding into jejunum  
  e.g., J-tube or PEG-J tube

Parenteral feeding only  
  Includes all types of parenteral feedings, such as total parenteral nutrition (TPN)

Unknown (Missing Value)

### SUPPORT WITH PERSONAL CARE

Ability to complete personal care, including bathing, toileting, hygiene, dressing and grooming tasks, including the amount of help required by another person to assist. This measure is an overall estimation of the person's ability in the category of personal care. If the person requires guidance only for all tasks but bathing, where he or she needs extensive support, score 'Guidance/Limited Support' to reflect the overall average ability. The person may or may not use assistive devices like shower or commode chairs, long-handled brushes, etc. Note: assistance with medication should NOT be included.

Independent  
  Able to complete all personal care tasks without physical support

Guidance/Limited Support  
  Able to perform personal care tasks with guidance, prompting, reminding or with limited physical support for less than 25% of the activity

Moderate Physical Support  
  Able to perform personal care tasks with moderate support of another person

Extensive Support  
  Able to perform personal care tasks with extensive support of another person

Total Support  
  Requires full support of another person to complete personal care tasks (unable to participate in tasks)

Unknown (Missing Value)

### RELATIONSHIPS

Indicate whether or not the individual has 'natural supports' defined as persons outside of the mental health system involved in his/her life who provide emotional support or companionship.

Extensive involvement, such as daily emotional support/companionship

Moderate involvement, such as several times a month up to several times a week

Limited involvement, such as intermittent or up to once a month

Involved in planning or decision-making, but does not provide emotional support/companionship

No involvement

Unknown (Missing Value)

### STATUS OF FAMILY/FRIEND SUPPORT SYSTEM

Indicate whether current (unpaid) family/friend caregiver status is at risk in the next 12 months; including instances of caregiver disability/illness, aging, and/or re-location. 'At risk' means caregiver will likely be unable to continue providing the current level of help, or will cease providing help altogether but no plan for replacing the caregiver's help is in place.

Caregiver status is not at risk

Caregiver is likely to reduce current level of help provided

Caregiver is likely to cease providing help altogether

Family/friends do not currently provide care

Information unavailable

Unknown (Missing Value)

### SUPPORT FOR ACCOMMODATING CHALLENGING BEHAVIORS

Indicate the level of support the individual needs, if any, to accommodate challenging behaviors. 'Challenging behaviors' include those that are self-injurious, or place others at risk of harm. (Support includes direct line of sight supervision)

No challenging behaviors, or no support needed

Limited Support, such as support up to once a month

Moderate Support, such as support once a week

Extensive Support, such as support several times a week

Total Support - Intermittent, such as support once or twice a day

Total Support - Continuous, such as full-time support

Unknown (Missing Value)

### PRESENCE OF A BEHAVIOR PLAN

Indicate the presence of a behavior plan during the past 12 months.

No Behavior Plan
Positive Behavior Support Plan or Behavior Treatment Plan without restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee

Behavior Treatment Plan with restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee

Unknown (Missing Value)

Use of Psychotropic Medications

- Positive Behavior Support Plan or Behavior Treatment Plan without restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee
- Behavior Treatment Plan with restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee
- Unknown (Missing Value)

Use of Psychotropic Medications

Fill in the number of anti-psychotic and other psychotropic medications the individual is prescribed. See the codebook for further definition of 'anti-psychotic' and 'other psychotropic' and a list of the most common medications.

<table>
<thead>
<tr>
<th>Number of Anti-Psychotic Medications</th>
<th>Number of Other Psychotropic Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric medications primarily used to manage psychosis.</td>
<td>Includes anti-convulsant, anti-anxiety, anti-depressant, ADHD, Bi-Polar, OCD and other psychiatric medications prescribed.</td>
</tr>
</tbody>
</table>

Major Mental Illness (MMI) Diagnosis

This measure identifies major mental illnesses characterized by psychotic symptoms or severe affective symptoms. Indicate whether or not the individual has one or more of the following major mental illness diagnoses: Schizophrenia, Schizophreniform Disorder, or Schizoaffective Disorder (ICD code 295.xx); Delusional Disorder (ICD code 297.1); Psychotic Disorder NOS (ICD code 298.9); Psychotic Disorder due to a general medical condition (ICD codes 293.81 or 293.82); Dementia with delusions (ICD code 294.42); Bipolar I Disorder (ICD codes 296.0x, 296.4x, 296.5x, 296.6x, or 296.7); or Major Depressive Disorder (ICD codes 296.2x and 296.3x). The ICD code must match the codes provided above. Note: Any digit or no digit at all, may be substituted for each 'x' in the codes.

- One or more MMI diagnosis present
- No MMI diagnosis present
- Unknown (Missing Value)

Level of Care/Care Recommendation

Indicate recommended level of care

Indicate estimated length of treatment

Signatures

Staff Signature / Credentials

Date

06/11/2015
<table>
<thead>
<tr>
<th>IDENTIFYING INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME</td>
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<tr>
<td>DOB</td>
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<tr>
<td>MEMBER ID</td>
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<td>GENDER</td>
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<th>ADDRESS</th>
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<table>
<thead>
<tr>
<th>ASSESSMENT DATE</th>
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<tbody>
<tr>
<td>START TIME</td>
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<tr>
<td>AGE</td>
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<tbody>
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<td>Face to Face</td>
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<td>Initial</td>
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<td>Quarterly</td>
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<td>Annual</td>
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<td>Other</td>
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<table>
<thead>
<tr>
<th>IDENTIFYING INFORMATION</th>
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<tbody>
<tr>
<td>☐ SBIRT (screening, brief intervention &amp; treatment) consumer</td>
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<table>
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<th>MEMBER ID</th>
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<tbody>
<tr>
<td>DATE OF BIRTH</td>
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<tr>
<td>DATE OF DEATH</td>
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<table>
<thead>
<tr>
<th>GENDER</th>
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</thead>
<tbody>
<tr>
<td>☐ Female</td>
</tr>
<tr>
<td>☐ Male</td>
</tr>
<tr>
<td>☐ Transgender/Transsexual</td>
</tr>
<tr>
<td>☐ Intersex</td>
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<tr>
<td>☐ Questioning</td>
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<th>FIRST NAME</th>
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<tbody>
<tr>
<td>MIDDLE NAME</td>
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<th>ALIASES AND OTHER IDENTIFYING INFORMATION</th>
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<tr>
<td>MI CHILD ID #</td>
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<table>
<thead>
<tr>
<th>HOME ADDRESS</th>
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<tbody>
<tr>
<td>HOME PHONE</td>
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<tr>
<td>ALTERNATE PHONE</td>
</tr>
<tr>
<td>COUNTY OF RESIDENCE</td>
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<table>
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<th>PRIMARY SPOKEN LANGUAGE</th>
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<td>COMMUNICATION PREFERENCE</td>
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<th>REFERRAL SOURCE</th>
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<tbody>
<tr>
<td>RELIGION</td>
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<table>
<thead>
<tr>
<th>RACE / ETHNIC ORIGIN 1</th>
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<table>
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<tr>
<th>RACE / ETHNIC ORIGIN 2</th>
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<table>
<thead>
<tr>
<th>RACE / ETHNIC ORIGIN 3</th>
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<table>
<thead>
<tr>
<th>ETHNICITY</th>
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<tbody>
<tr>
<td>☐ Yes</td>
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<td>☐ Unknown</td>
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<table>
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<table>
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<tbody>
<tr>
<td>☐ Divorced</td>
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<tr>
<td>☐ Separated</td>
</tr>
<tr>
<td>☐ Never Married</td>
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<tr>
<td>☐ Widowed</td>
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<table>
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<th>PARENTAL STATUS</th>
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<tbody>
<tr>
<td>Indicate if the Consumer (no matter what age) is the natural or adoptive parent of a minor child (under 18 years old)</td>
</tr>
<tr>
<td>☐ Yes</td>
</tr>
<tr>
<td>☐ No</td>
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<table>
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<tr>
<th>VETERAN STATUS</th>
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</thead>
<tbody>
<tr>
<td>☐ Yes</td>
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<td>☐ No</td>
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<tr>
<td>☐ Unknown</td>
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<table>
<thead>
<tr>
<th>CHILDREN &amp; FAMILIES</th>
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</thead>
<tbody>
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<td>☐ Yes</td>
</tr>
<tr>
<td>☐ No</td>
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<table>
<thead>
<tr>
<th>DEPARTMENT OF HUMAN SERVICES</th>
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<tbody>
<tr>
<td>☐ Yes</td>
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<tr>
<td>☐ No</td>
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<table>
<thead>
<tr>
<th>Is Consumer a Child enrolled in Early On Wraparound Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes</td>
</tr>
<tr>
<td>☐ No</td>
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<table>
<thead>
<tr>
<th>Is Consumer a Child served by DHS for abuse and neglect</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes</td>
</tr>
<tr>
<td>☐ No</td>
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</table>
Is Consumer a Child served by another DHS program  □ Yes  □ No

ADOPTION SUBSIDY
□ Yes  □ No

GUARDIAN OR LEGAL REPRESENTATION
WHO IS RESPONSIBLE FOR MAKING DECISIONS REGARDING CARE FOR THE INDIVIDUAL?
□ Individual  □ Parent  □ Guardian or Legal Representative  □ Power of Attorney

PRIMARY GUARDIAN INFORMATION

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>TYPE OF GUARDIANSHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

RELATIONSHIP TO CONSUMER
□ Mother  □ Father
□ Child   □ Unrelated
□ Spouse  □ Other
□ Sibling

□ CHECK IF ADDRESS IS SAME AS CONSUMER

PHONE NUMBER

ALTERNATIVE PHONE

ADDITIONAL GUARDIAN NOTES

DOES THE INDIVIDUAL HAVE AN ADVANCE DIRECTIVE?
□ Yes  □ No  □ N/A

PRESENTING NEEDS
BRIEFLY DESCRIBE THE PRESENTING NEEDS OF THE INDIVIDUAL (E.G., WHAT BROUGHT THE PERSON IN FOR SERVICES TODAY? HOW DOES THE PERSON VIEW THE REFERRAL? WHAT LED TO THE REFERRAL?)

WHAT SUPPORTS/SERVICES ARE BEING REQUESTED TO HELP WITH THE PRESENTING NEEDS?
SOCIAL/NATURAL SUPPORTS

Please indicate the supports in the person's daily life (family, friends, parent, others, etc.):

<table>
<thead>
<tr>
<th>Name of Support</th>
<th>Relationship</th>
<th>State how this person helps the individual achieve their goals</th>
</tr>
</thead>
</table>

☐ No Natural Supports

IS THE INDIVIDUAL SATISFIED WITH THEIR SUPPORTS?
☐ Yes ☐ No

IS THERE A NEED TO CHANGE OR INCREASE SUPPORTS?
☐ Yes ☐ No

HAS THE INDIVIDUAL LOST ANY CLOSE RELATIVES/FAMILY MEMBERS/FRIENDS?
☐ Yes ☐ No

HAS THE INDIVIDUAL LOST ANY PETS/ANIMALS?
☐ Yes ☐ No

WHAT WERE THE INDIVIDUALS LIVING ARRANGEMENTS AS A CHILD?

PARENTING SUPPORT

WHO IS PRESENT WITH THE CHILD TODAY?
☐ Parent ☐ Legal Guardian ☐ N/A

PARENTS' TOTAL NUMBER OF DEPENDENTS (INCLUDING THIS CHILD):

CHILD SERVED BY DEPARTMENT OF HUMAN SERVICES?
☐ Yes ☐ No

PARENTS' VIEW OF PARENTING NEEDS?

ASSESSMENT OF PARENTING SKILLS/KNOWLEDGE?

SOURCES OF PARENTING SUPPORT?

STATUS OF MENTAL HEALTH AFFECTING PARENT?

CONCERNS/ISSUES RELATED TO PARENT-CHILD RELATIONSHIP?

DOES THE PARENT / GUARDIAN HAVE ANY OF THE FOLLOWING CONCERNS? (CHECK ALL THAT APPLY)

TIME SPENT ON COMPUTER
☐ Yes ☐ No

TIME SPENT WATCHING TV
☐ Yes ☐ No

TIME SPENT WITH FRIENDS
☐ Yes ☐ No

INTERACTION DIFFICULTIES
☐ Child ☐ Parent ☐ N/A

COGNITIVE
☐ Child ☐ Parent ☐ N/A

SUBSTANCE USE
☐ Child ☐ Parent ☐ N/A

LEARNING/LITERACY PROBLEMS
☐ Child ☐ Parent ☐ N/A
<table>
<thead>
<tr>
<th>Mental Health Symptoms</th>
<th>Parenting/Family Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child</strong></td>
<td><strong>Parent</strong></td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
</tr>
<tr>
<td>Child</td>
<td>Parent</td>
</tr>
<tr>
<td>Depression</td>
<td>Parent</td>
</tr>
<tr>
<td>Child</td>
<td>Parent</td>
</tr>
<tr>
<td>Isolation/Withdrawn</td>
<td>Parent</td>
</tr>
<tr>
<td>Child</td>
<td>Parent</td>
</tr>
<tr>
<td>Loss of Family Member/Friend</td>
<td>Parent</td>
</tr>
<tr>
<td>Child</td>
<td>Parent</td>
</tr>
<tr>
<td>Loss of Pets/Animals</td>
<td>Parent</td>
</tr>
<tr>
<td>Child</td>
<td>Parent</td>
</tr>
<tr>
<td>History of Postpartum Depression</td>
<td>Parent</td>
</tr>
<tr>
<td>Child</td>
<td>Parent</td>
</tr>
<tr>
<td>Loss of Child or Pregnancy</td>
<td>Parent</td>
</tr>
<tr>
<td>Parents Divorced as a Child?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>EXPLAIN</td>
</tr>
<tr>
<td>Is There a Need for Child Care? Current Situation?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>EXPLAIN</td>
</tr>
<tr>
<td>Has There Been Domestic Violence in the Home?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>EXPLAIN</td>
</tr>
</tbody>
</table>
HAS THERE EVER BEEN A NEED TO ADVOCATE FOR THE CHILD?
☐ Yes  ☐ No
EXPLAIN

IS ONE OR BOTH PARENTS USING SUBSTANCES?
☐ Yes  ☐ No
EXPLAIN

IS THE PARENT EXPERIENCING MENTAL/EMOTIONAL PROBLEMS?
☐ Yes  ☐ No
EXPLAIN

ANY COGNITIVE CONCERNS OF THE CAREGIVERS?
☐ Yes  ☐ No
EXPLAIN

COMMUNITY INVOLVEMENT/INCLUSION

ARE EXTENDED FAMILY MEMBERS INVOLVED WITH THE CHILD?
☐ Yes  ☐ No
EXPLAIN

PLEASE DESCRIBE ANY FAMILY ACTIVITIES:

IS THE FAMILY INVOLVED WITH NEIGHBORS/FRIENDS?
☐ Yes  ☐ No
EXPLAIN

IS YOUR FAMILY INVOLVED WITH COMMUNITY SERVICES?
☐ Yes  ☐ No
EXPLAIN

LIVING SITUATION

ARE YOU SATISFIED WITH YOUR CURRENT HOUSING SITUATION?
☐ Yes  ☐ No
SATISFIED WITH HOUSING SITUATION EXPLAIN

06/11/2015
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Explain</th>
</tr>
</thead>
<tbody>
<tr>
<td>IS THE ACCESSIBILITY TO THE HOME ADEQUATE?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ANY ENVIRONMENTAL OR SAFETY CONCERNS AT THE HOME?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ARE THERE WORKING SMOKE ALARMS IN THE HOME?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ANY HOUSEHOLD HEALTH HAZARDS PRESENT (E.G. LEAD)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HAS THE HOME BEEN CHILDDPROOFED ADEQUATELY?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IS THERE CONSISTENT TRANSPORTATION AVAILABLE?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DO YOU HAVE THE APPROPRIATE CAR SEAT IN YOUR CAR?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUBSTANCE USE HISTORY</td>
<td></td>
<td></td>
<td>Section Not Applicable</td>
</tr>
<tr>
<td>ANY AT-RISK BEHAVIORS?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ANY PHYSICAL OR VERBAL AGGRESSION?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ANY SELF-INJURIOUS BEHAVIORS?
☐ Yes  ☐ No
EXPLAIN

ANY RISK OR SAFETY ISSUES WITH SCHOOL (FOR CHILDREN)?
☐ Yes  ☐ No
EXPLAIN

ANY RISK OR SAFETY ISSUES WITH COMMUNITY?
☐ Yes  ☐ No
EXPLAIN

ANY RISK OR SAFETY ISSUES WITH HOME ENVIRONMENT?
☐ Yes  ☐ No
EXPLAIN

ANY RISK OR SAFETY ISSUES WITH WORK ENVIRONMENT?
☐ Yes  ☐ No
EXPLAIN

ANY PHYSICAL ACTIVITIES THAT PUT THE INDIVIDUAL AT RISK?
☐ Yes  ☐ No
EXPLAIN

ARE THERE ANY WEAPONS IN THE HOME?
☐ Accessible  ☐ Locked  ☐ No
EXPLAIN

DOES THE INDIVIDUAL HAVE ACCESS TO ANY OTHER WEAPONS?
☐ Yes  ☐ No
EXPLAIN

IS THERE A HISTORY OF SUICIDAL IDEATION?
☐ Yes  ☐ No
EXPLAIN

IS A CRISIS SCREENING NEEDED IMMEDIATELY?
☐ Yes  ☐ No
EXPLAIN
IS IMMEDIATE INTERVENTION FOR RISK/SAFETY NEEDED? IF YES, PLAN?
☐ Yes  ☐ No
EXPLAIN

IS THERE A CRISIS PLAN?
☐ Yes  ☐ No
EXPLAIN

IS THERE A HISTORY OF HOMICIDAL IDEATION?
☐ Yes  ☐ No
EXPLAIN

INTELLECTUAL/DEVELOPMENTAL HISTORY
☐ No reported history of intellectual/developmental disability

BRIEFLY DESCRIBE THE PRESENTING SYMPTOM(S) OF THE INTELLECTUAL/DEVELOPMENTAL DISABILITY:

WHAT YEAR AND AT WHAT AGE WAS THE INDIVIDUAL INITIALLY DETERMINED TO HAVE AN INTELLECTUAL/DEVELOPMENTAL DISABILITY?

WHERE DID THE EVALUATION DETERMINATION OCCUR AND WHY?
## WHAT WAS THE ORIGINAL DIAGNOSIS?

<table>
<thead>
<tr>
<th>Child / Adolescent Developmental History</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>During Pregnancy, did the mother experience any depression, including post-partum depression?</strong></td>
</tr>
<tr>
<td>☐ Yes  ☐ No</td>
</tr>
<tr>
<td><strong>During Pregnancy, did the mother experience any infections?</strong></td>
</tr>
<tr>
<td>☐ Yes  ☐ No  ☐ Unknown</td>
</tr>
<tr>
<td><strong>Explain</strong></td>
</tr>
<tr>
<td><strong>During Pregnancy, did the mother have any complications?</strong></td>
</tr>
<tr>
<td>☐ Yes  ☐ No  ☐ Unknown</td>
</tr>
<tr>
<td><strong>Explain</strong></td>
</tr>
<tr>
<td><strong>During Pregnancy, did the mother use tobacco, alcohol, or drugs?</strong></td>
</tr>
<tr>
<td>☐ Yes  ☐ No  ☐ Unknown</td>
</tr>
<tr>
<td><strong>Explain</strong></td>
</tr>
<tr>
<td><strong>During Pregnancy, did the mother inhale or eat toxic agents?</strong></td>
</tr>
<tr>
<td>☐ Yes  ☐ No  ☐ Unknown</td>
</tr>
<tr>
<td><strong>Explain</strong></td>
</tr>
<tr>
<td><strong>Were there any complications during delivery?</strong></td>
</tr>
<tr>
<td>☐ Yes  ☐ No  ☐ Unknown</td>
</tr>
<tr>
<td><strong>Explain</strong></td>
</tr>
<tr>
<td><strong>Did the mother report the child as having physical malformations at birth?</strong></td>
</tr>
<tr>
<td>☐ Yes  ☐ No  ☐ Unknown</td>
</tr>
</tbody>
</table>
DID THE MOTHER HAVE A FULL TERM PREGNANCY?
☐ Yes  ☐ No  ☐ Unknown

DID THE INFANT EXHIBIT ANY EATING PROBLEMS?
☐ Yes  ☐ No  ☐ Unknown

DID THE INFANT EXHIBIT ANY SLEEPING PROBLEMS?
☐ Yes  ☐ No  ☐ Unknown

WHAT WAS THE CHILD'S BIRTH WEIGHT?

WHAT WAS THE AGE OF THE MOTHER AT THE CHILD'S BIRTH?

AT WHAT AGE DID THE CHILD DO THE FOLLOWING ... (IF NEVER OCCURRED, INDICATE UNABLE)

Roll Over  AGE (in months)  ☐ Unable
Crawl  AGE (in months)  ☐ Unable
Sit Up On Own  AGE (in months)  ☐ Unable
Walk  AGE (in months)  ☐ Unable
Speak Words  AGE (in months)  ☐ Unable
Speak Sentences  AGE (in months)  ☐ Unable
Become Toilet Trained  AGE (in months)  ☐ Unable

IF THE INFORMATION IS UNKNOWN, INDICATE WHY:

FETAL ALCOHOL SYNDROME (FAS) PRE-SCREEN

FAS is a birth defect caused by alcohol use during pregnancy. FAS is a medical diagnosis. This pre-screen is not intended to take the place of a diagnostic evaluation. It is intended to make the proper referral for diagnosis and treatment.

1. HEIGHT AND WEIGHT SEEM SMALL FOR AGE?
   ☐ Yes  ☐ No
2. SIZE OF HEAD SEEMS SMALL FOR AGE?
   ☐ Yes  ☐ No
3. BEHAVIORAL CONCERNS (CHECK ALL THAT APPLY - ANY OF THESE QUALIFIES AS AN IDENTIFIER)
   ☐ Sleeping/eating problems  ☐ I/DD or IQ below familial expectations
   ☐ Attention problem/impulsive/restless  ☐ Learning disability  ☐ Speech and/or language delays
   ☐ Problem with reasoning and judgement  ☐ Acts younger than children same age
4. FACIAL ABNORMALITIES?
   ☐ Yes  ☐ No
5. MATERNAL ALCOHOL USE DURING PREGNANCY?
   ☐ Yes  ☐ No

If YES to 2 or more above, the individual should be referred for a full FAS diagnostic evaluation.
Contact the nearest center to schedule a complete FAS diagnostic evaluation: Detroit 313-993-3891 Ann Arbor 734-936-9777

BEHAVIOR TREATMENT PLAN

DOES THE INDIVIDUAL REQUIRE A REFERRAL FOR A BEHAVIORAL ASSESSMENT?

☐ Yes  ☐ No

IF YES, EXPLAIN AND PROVIDER REFERRAL INFORMATION:

HAS THE INDIVIDUAL EVER HAD A BEHAVIOR TREATMENT PLAN?

☐ Yes  ☐ No  ☐ N/A

BRIEFLY DESCRIBE HISTORY IF APPLICABLE:

TRAUMA HISTORY

HAVE YOU EVER BEEN INVOLVED IN A TRAUMATIC EVENT THAT CAUSED YOU TO FEAR FOR YOUR LIFE? (E.G., SEXUAL ASSAULT, PHYSICAL ATTACK, MILITARY COMBAT, ROBBERY, SEVERE CAR ACCIDENT, OR SEXUAL ASSAULT AS A CHILD)

☐ Yes  ☐ No

☐ Child  ☐ Adult  ☐ Ongoing

EXPLAIN IF NEEDED

HISTORY OF EMOTIONAL ABUSE? (E.G., SOMEONE REPEATEDLY MADE YOU FEEL BAD THROUGH HARSH WORDS)

☐ Yes  ☐ No

☐ Child  ☐ Adult  ☐ Ongoing

EXPLAIN IF NEEDED

HISTORY OF PHYSICAL ABUSE? (E.G., SOMEONE REPEATEDLY CAUSED YOU PHYSICAL HARM)

☐ Yes  ☐ No

☐ Child  ☐ Adult  ☐ Ongoing

EXPLAIN IF NEEDED
HISTORY OF SEXUAL ABUSE? (E.G., SOMEONE FORCED SEXUAL ADVANCES OR ACTS)
☐ Yes ☐ No
☐ Child ☐ Adult ☐ Ongoing
EXPLAIN IF NEEDED

HISTORY OF NEGLECT? (E.G., A CARETAKER DENIED BASIC NEEDS, SUCH AS ADEQUATE FOOD, CLOTHES, AND SUPERVISION)
☐ Yes ☐ No
☐ Child ☐ Adult ☐ Ongoing
EXPLAIN IF NEEDED

HISTORY OF VIOLENCE? (E.G., THE USE OF PHYSICAL FORCE AGAINST ONESELF, ANOTHER PERSON, OR A COMMUNITY, WHICH HAS A HIGH LIKELIHOOD OF RESULTING INJURY, DEATH, OR PSYCHOLOGICAL HARM)
☐ Yes ☐ No
☐ Child ☐ Adult ☐ Ongoing
EXPLAIN IF NEEDED

HISTORY OF DOMESTIC VIOLENCE? (E.G., A PATTERN OF ABUSIVE BEHAVIOR IN AN INTIMATE RELATIONSHIP, WHICH IS USED BY ONE PARTNER TO GAIN OR MAINTAIN POWER AND CONTROL OVER ANOTHER PARTNER)
☐ Yes ☐ No
☐ Child ☐ Adult ☐ Ongoing
EXPLAIN IF NEEDED

HISTORY OF BULLYING? (E.G., UNWANTED AND REPEATED AGGRESSIVE BEHAVIOR AMONG SCHOOL AGED CHILDREN THAT INVOLVES A REAL OR PERCEIVED POWER IMBALANCE. INCLUDES VERBAL AND/OR PHYSICAL ABUSE)
☐ Yes ☐ No
☐ Child ☐ Adult ☐ Ongoing
EXPLAIN IF NEEDED

Trauma/Abuse/Stress Screening for Children
1. ARE YOU AWARE OF OR DO YOU SUSPECT THE CHILD HAS EXPERIENCED ANY OF THE FOLLOWING:
☐ Physical abuse
☐ Suspected neglectful home environment
☐ Emotional abuse
☐ Exposure to domestic violence
☐ Known or suspected exposure to drug activity aside from parental/caregiver use
☐ Known or suspected exposure to any other violence not already identified
☐ Parental/caregiver drug use/substance abuse
☐ Multiple separations from parent or caregiver
☐ Frequent and multiple moves or homelessness
☐ Sexual abuse or exposure
☐ Other

If you are not aware of a trauma history, but multiple concerns are present in the questions 2-5, then there may be a trauma history that has not come to your attention.

Note: Concerns in the following areas do not necessarily indicate trauma; however, there is a strong relationship.
2. DOES THE CHILD SHOW ANY OF THESE BEHAVIORS?

- Excessive aggression or violence towards self
- Excessive aggression or violence towards others
- Explosive behavior (going form 0-100 instantly)
- Hyperactivity, distractibility, inattention
- Very withdrawn or excessively shy
- Oppositional and/or defiant behavior
- Sexual behaviors not typical for a child's age
- Peculiar patterns of forgetfulness
- Inconsistency in skills
- Other

3. DOES THE CHILD EXHIBIT ANY OF THE FOLLOWING EMOTIONS OR MOODS?

- Excessive mood swings
- Chronic sadness, doesn't seem to enjoy any activities
- Very flat affect or withdrawn behavior
- Quick, explosive anger
- Other

4. IS THE CHILD HAVING PROBLEMS AT SCHOOL?

- Low or failing grades
- Inadequate performance
- Difficulty with authority
- Attention or memory problems
- Other

5. WILL TRAUMA HISTORY BE A GOAL OF PCP?

- Yes
- No

HISTORY OF PRIOR TREATMENT SERVICES
List of hospitals, CMH providers, DHS involvement

<table>
<thead>
<tr>
<th>Treatment Provider</th>
<th>Location</th>
<th>Reason</th>
<th>Date/LOS</th>
<th>Did the individual find the treatment helpful?</th>
</tr>
</thead>
</table>

PHYSICAL HEALTH HISTORY

INDIVIDUAL’S REPORTED CURRENT HEALTH STATUS:

- Excellent
- Good
- Fair
- Poor

DOES THE INDIVIDUAL HAVE ANY DIAGNOSED PHYSICAL ILLNESS OR CONDITION(S)? CHECK ALL THAT APPLY.

- Allergies
- Chronic fatigue
- Endometriosis
- Heart disease
- Multiple sclerosis
- Ulcers
- Anemia
- Chronic pain
- Fibromyalgia
- Hepatitis
- Renal failure
- Arterithms
- COPD
- Gastritis
- Hernia
- Sleep apnea
- Arthritis
- Crohn's disease
- Gout
- HIV/AIDS
- Stroke
- Cancer
- Eating Disorder
- Headache/migraines
- Menopause
- Tuberculosis

HAVE ANY OF THE INDIVIDUAL’S IMMEDIATE FAMILY MEMBERS OR DECEASED RELATIVES (PARENTS, SIBLINGS) HAD ANY OF THE FOLLOWING CONDITIONS? CHECK ALL THAT APPLY.

- Asthma
- Heart Disease
- Substance use
- Allergies
- Cancer
- COPD
- Diabetes
- Hypertension
- Stroke
- Suicide
- Mental health
- Developmental disability

ADVERSE REACTIONS

<table>
<thead>
<tr>
<th>DRUG / ALLERGEN</th>
<th>SEVERITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>REPORTED BY</td>
<td></td>
</tr>
</tbody>
</table>
|                 | □ Not Assessed
|                 | □ Mild
|                 | □ Severe
|                 | □ Life-Threatening
<p>|                 | □ This is an Allergy |</p>
<table>
<thead>
<tr>
<th>DRUG / ALLERGEN REPORTED BY</th>
<th>SEVERITY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Not Assessed</td>
</tr>
<tr>
<td></td>
<td>□ Mild</td>
</tr>
<tr>
<td></td>
<td>□ Severe</td>
</tr>
<tr>
<td></td>
<td>□ Life-Threatening</td>
</tr>
<tr>
<td></td>
<td>□ This is an Allergy</td>
</tr>
</tbody>
</table>

| NOTES | START |

**HEALTH INDICATORS AND OTHER CONDITIONS FOR ALL POPULATIONS**

**DATE REVIEWED**

**HEARING**

ABILITY TO HEAR (WITH HEARING APPLIANCE NORMALLY USED)

- □ Adequate
  No difficulty in normal conversation, social interaction, listening to TV
- □ Minimal difficulty
  Difficulty in some environments (e.g., when person speaks softly or is more than 6 feet away)
- □ Moderate difficulty
  Problem hearing normal conversation, requires quiet setting to hear well
- □ Severe difficulty
  Difficulty in all situations (e.g., speaker has to talk loudly or speak very slowly; or person reports that all speech is mumbled)
- □ No hearing

HEARING AID USED

- □ Yes
- □ No

**VISION**

ABILITY TO SEE IN ADEQUATE LIGHT (WITH GLASSES OR WITH OTHER VISUAL APPLIANCE NORMALLY USED)

- □ Adequate
  Sees fine detail, including regular print in newspapers/books or small items in pictures
- □ Minimal difficulty
  Sees large print, but not regular print in newspapers/books or cannot identify large objects in pictures
- □ Moderate difficulty
  Limited vision; not able to see newspaper headlines or small items in pictures, but can identify objects in his/her environment
- □ Severe difficulty
  Object identification in question, but the person’s eyes appear to follow objects, or the person sees only light, colors, shapes
- □ No vision
  Eyes do not appear to follow objects; absence of sight

VISUAL APPLIANCE

- □ Yes
- □ No

**HEALTH CONDITIONS**

*Indicate whether or not the individual had the presence of each of the following health conditions, as reported by the individual, a health care professional or family member, in the past 12 months.*

**PNEUMONIA (2 OR MORE TIMES) - INCLUDING ASPIRATION PNEUMONIA**

- □ Never present
- □ History of condition, but not treated for the condition within the past 12 months
- □ Treated for the condition within the past 12 months
- □ Information unavailable

**ASTHMA**

- □ Never present
- □ History of condition, but not treated for the condition within the past 12 months
- □ Treated for the condition within the past 12 months
- □ Information unavailable

**UPPER RESPIRATORY INFECTIONS (3 OR MORE TIMES WITHIN PAST 12 MONTHS)**

- □ Never present
- □ History of condition, but not treated for the condition within the past 12 months
- □ Treated for the condition within the past 12 months
- □ Information unavailable

**GASTROESOPHAGEAL REFLUX, OR GERD**

- □ Never present
<table>
<thead>
<tr>
<th>Condition</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Bowel Impactions</td>
<td>Never present, History of condition, but not treated within past 12 months, Treated for condition within past 12 months, Information unavailable</td>
</tr>
<tr>
<td>Seizure Disorder or Epilepsy</td>
<td>Never present, History of condition, but not treated within past 12 months, Treated for condition within past 12 months and seizure free, Treated for condition within past 12 months, but still experience occasional seizures (less than one per month), Treated for condition within past 12 months, but still experience frequent seizures, Information unavailable</td>
</tr>
<tr>
<td>Progressive Neurological Disease, Include, Alzheimer's and Parkinson's Disease</td>
<td>Not present, Treated for condition within past 12 months, Information unavailable</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Never present, History of condition, but not treated within past 12 months, Treated for condition within past 12 months, Information unavailable</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Never present, History of condition, but not treated within past 12 months, Treated for condition within past 12 months and blood pressure is stable, Treated for condition within past 12 months, but blood pressure remains high or unstable, Information is unavailable</td>
</tr>
<tr>
<td>Obesity</td>
<td>Not present, Medical diagnosis of obesity present or Body Mass Index (BMI) &gt; 30</td>
</tr>
</tbody>
</table>

**DO YOU HAVE A PRIMARY CARE DOCTOR/FAMILY PHYSICIAN/PEDIATRICIAN THAT YOU ARE SEEING?**
- Yes
- No

**PRIMARY CARE PHYSICIAN**

**WHEN WAS THE LAST TIME THE INDIVIDUAL SAW A PRIMARY CARE DOCTOR/FAMILY PHYSICIAN/PEDIATRICIAN?**

**IS A REFERRAL NEEDED TO GET THE INDIVIDUAL SET UP WITH A PHYSICAL HEALTH DOCTOR?**
- Yes
- No

**WHEN WAS THE LAST TIME THE INDIVIDUAL SAW A DENTIST?**

**WHEN WAS THE LAST TIME THE INDIVIDUAL HAD AN EYE EXAM?**

**IS THE INDIVIDUAL CURRENT ON ALL VACCINES/IMMUNIZATIONS?**
- Yes
- No
- Referral Needed

**HISTORY OF CHRONIC PAIN**

**HAVE YOU HAD CHRONIC PAIN (I.E., PAIN FOR MORE THAN 6 MONTHS)?**
- Yes
- No
- Current
- Past

**WHERE IS THE PAIN LOCATED?**

**HOW LONG HAVE YOU HAD THIS PAIN? WHEN DID THE PAIN FIRST START?**

**HOW OFTEN DO YOU EXPERIENCE THE PAIN? (I.E., WEEKLY, DAILY, 2-3 TIMES PER DAY, ETC.,)?**

**HOW LONG, DURING A TYPICAL DAY WHEN YOU EXPERIENCE PAIN, DOES THE PAIN LAST FOR?**

**HOW SEVERE IS THE PAIN (ON A SCALE FROM 0 TO 10, WITH 10 BEING THE WORSE)?**

**HOW DO YOU MANAGE THIS PAIN? PLEASE LIST ALL SOURCES (E.G., MEDICATION, EXERCISE, RELAXATION, ACUPUNCTURE, ETC.)**
DIET AND EXERCISE

DO YOU THINK YOU EAT A HEALTHY DIET (REGULAR MEALS, FRUITS, VEGETABLES, MINIMUM TAKEOUT/RESTAURANTS)?

☐ Yes  ☐ No

DO YOU THINK YOU TAKE PART IN ANY PHYSICAL ACTIVITY OR EXERCISE (INCLUDING WALKING, CYCLING, GARDENING)?

☐ Yes  ☐ No

HOW OFTEN DO YOU EXERCISE OR ENGAGE IN PHYSICAL ACTIVITY DURING A TYPICAL WEEK (INDICATE HOW MANY TIMES PER WEEK, AND MINUTES/HOURS PER WEEK)?

SMOKING HABITS

DO YOU SMOKE CIGARETTES OR TOBACCO?

☐ Yes  ☐ No

IF YES, HOW MUCH DO YOU SMOKE PER DAY? (AMOUNT)

AND HOW LONG HAVE YOU SMOKED FOR? (MONTHS/YEARS)

IF NO, HAVE YOU EVER SMOKED IN THE PAST?

☐ Yes  ☐ No

IF YES, FOR HOW LONG? (MONTHS/YEARS)

HAVE YOU TRIED TO STOP SMOKING IN THE PAST?

☐ Yes  ☐ No

DO YOU WANT TO STOP SMOKING NOW?

☐ Yes  ☐ No

SEXUAL ACTIVITIES

☐ Section N/A

ARE YOU SEXUALLY ACTIVE?

☐ Yes  ☐ No  ☐ Prefer Not To Answer

ARE YOU USING A METHOD OF PROTECTION DURING SEXUAL ACTIVITIES TO REDUCE YOUR RISK OF SEXUALLY TRANSMITTED INFECTIONS AND/OR PREGNANCY (E.G., CONDOMS, DENTAL DAMS, CONTRACEPTIVES, ETC.)?

☐ Yes  ☐ No  ☐ Prefer Not To Answer

ARE YOU AWARE OF THE RISKS OF SEXUALLY TRANSMITTED INFECTIONS SUCH AS HEPATITIS, HIV/AIDS, SYPHILIS, ETC.?

☐ Yes  ☐ No  ☐ Prefer Not To Answer

HAVE YOU EVER HAD UNPROTECTED SEX OR ENGAGED IN SEXUAL BEHAVIORS (ORAL, ANAL, GENITAL) WITH A PERSON WHOSE HIV, HEPATITIS, OR STI STATUS WAS UNKNOWN TO YOU (SUCH AS SEX WHEN DRUNK OR HIGH WITH SOMEONE YOU DID NOT KNOW VERY WELL)?

☐ Yes  ☐ No  ☐ Unsure

HAVE YOU EVER ENGAGED IN SEXUAL BEHAVIORS WITH ANYONE WHO HAS:

- INJECTED DRUGS?
  ☐ Yes  ☐ No  ☐ Unsure

- TRADED SEX FOR DRUGS?
  ☐ Yes  ☐ No  ☐ Unsure

- MANY SEXUAL PARTNERS?
  ☐ Yes  ☐ No  ☐ Unsure

- HIV/AIDS?
  ☐ Yes  ☐ No  ☐ Unsure

- HEPATITIS?
  ☐ Yes  ☐ No  ☐ Unsure

- STI'S?
  ☐ Yes  ☐ No  ☐ Unsure

HAVE YOU EVER EXPERIENCED OTHER FORMS OF BLOOD-TO-BLOOD OR BODILY FLUID CONTACT (FOR EXAMPLE, BLOOD TRANSFUSIONS, HEMOPHILIA TREATMENTS, EMPLOYMENT IN MEDICAL FIELD, ETC.) AND HAVE CONCERNS ABOUT YOUR RISK FOR HIV, HEPATITIS, OR STI'S?

☐ Yes  ☐ No  ☐ Unsure

WOULD THE INDIVIDUAL LIKE FURTHER INFORMATION ON ANY SEXUAL HEALTH ISSUES?

☐ Yes  ☐ No

SEXUAL ORIENTATION:

VITALS

COLLECTION INFORMATION

COLLECTION DATE  COLLECTED TIME

GENERAL INFORMATION

HEIGHT:  ft  in  ☐ Declined  ☐ No Information Collected
### Weight
- **lbs**
- **oz**
- Declined
- No Information Collected

### Waist Circumference
- **in**
- Declined
- No Information Collected

### BMI
- Comments

### Reproductive Health
- **Pregnant:**
  - Yes
  - No
  - N/A
- **Last Monthly Period Date**
- **Birth Control Method**
  - If Other, Explain:

### Tobacco Use
- **Smoking Status:**
- Effective:
- **Other Tobacco Use:**
  - Provided Consumer with Advice to Quit Smoking or Tobacco Use, or Recommended or Discussed Smoking or Tobacco Use Cessation, Medications, Methods, or Strategies:
  - Yes
  - No

### Temperature
- **Value:**
- **Site:**
  - Axillary
  - Rectal
  - Non-invasive thermometer
  - Oral
  - Temporal
  - Tympanic
  - Other
  - Non-invasive thermometer
- **Comments**

### Pulse
- **Value:**
- **Rhythm:**
  - Irregular
  - Regular
- **Force:**
  - Bounding
  - Normal
  - Thready
  - Weak
- **Method Used:**
  - Machine
  - Manual
- **Site:**
  - Apical (over heart)
  - Femoral (inner thigh)
  - Brachial (upper arm)
  - Popliteal (behind knee)
  - Cartoid (neck)
  - Radial (wrist)
- **Comments**

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06/11/2015
RESPIRATION

VALUE:

LUNG SOUNDS:

☐ Clear  ☐ Rales  ☐ Rhonchi  ☐ Wheeze  ☐ Other

COMMENTS

BLOOD PRESSURE

☐ Declined  ☐ No Information Collected

Sitting
SYSTOLIC
mmHg /
DIASTOLIC
mmHg

Standing
SYSTOLIC
mmHg /
DIASTOLIC
mmHg

METHOD USED:
☐ Machine  ☐ Manual

COMMENTS

RESULTS OF BREATHALYZER & URINE DRUG SCREEN (UDS)

BAC (BLOOD ALCOHOL CONTENT):

URINE DRUG SCREEN RESULTS

BLOOD GLUCOSE RESULTS

☐ Declined  ☐ No Information Collected

COMMENTS

REACTION:
☐ Cooperative  ☐ Declined  ☐ Resisted(Uncooperative)

COMMENTS
### PRESCRIBED MEDICATIONS

**OTHER MEDICATIONS**

DO YOU HAVE ANY PROBLEMS WITH ANY OF THESE MEDICATIONS (SIDE EFFECTS)?
- [ ] Yes
- [ ] No

IF YES, PLEASE EXPLAIN:

### LEGAL ISSUES

**CORRECTIONS RELATED STATUS**

<table>
<thead>
<tr>
<th>Most Recent Offense</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

JUDGE NAME:

COURT:

CMO AGENCY NAME:

PAROLE OFFICER NAME:  

PHONE #:

PROBATION OFFICER NAME:

PHONE #:

RETURNING CITIZEN (RELEASE FROM INCARCERATION - NO PROBATION/PAROLE)?
- [ ] Yes
- [ ] No

CMO CONTACT INFORMATION:

### EDUCATION

**CHILD’S EDUCATION**

- [ ] Not Applicable

**EDUCATION HISTORY**

- [ ] Unreported
- [ ] Completed less than high school
- [ ] Completed special education, high school, or GED
- [ ] In school - Kindergarten through 12th grade
- [ ] In training program
- [ ] In Special Education
- [ ] Attended or is attending undergraduate college
- [ ] College graduate

HIGHEST GRADE:

<table>
<thead>
<tr>
<th>Preschool</th>
<th>Day Care Center</th>
<th>Head Start</th>
<th>Early On</th>
<th>Home Day Center</th>
</tr>
</thead>
</table>
CURRENT SCHOOL/SCHOOL DISTRICT:
- **IN SPECIAL EDUCATION?**
  - Yes  No
  - **DATE OF FSP**
  - **IF YES, SERVICE TYPE PROVIDED:**
  - **DATE OF LAST IEP:**

AT AGED-APPROPRIATE GRADE LEVEL?
- Yes  No
- **If No, Explain:**
  - Expelled
  - Excessive Absenteeism

LIMITED ENGLISH PROFICIENCY?
- Yes  No
- **If Yes, Explain:**

MOTHER’S EDUCATION
- Not Applicable
  - Literacy Issues

FATHER’S EDUCATION
- Not Applicable
  - Literacy Issues

DOES THE CHILD/INDIVIDUAL NEED ASSISTANCE TO ACHIEVE EDUCATION/WORK GOALS?
- Yes  No
- **If Yes, Explain:**

DOES THE FAMILY NEED ASSISTANCE TO HELP WITH INDIVIDUAL ACHIEVING EDUCATION AND/OR WORK GOALS?
- Yes  No
- **If Yes, Explain:**

EMPLOYMENT

EMPLOYMENT STATUS
- Employed full time (30 hours or more per week) competitively or self-employed.
Employed part time (less than 30 hours per week) in competitively or self-employed.

☐ Unemployed - looking for work, and/or on layoff from job

☐ Sheltered workshop or work services participant in non-integrated setting

☐ In unpaid work (e.g. volunteering, internship, community service)

☐ Self-employed (e.g. micro-enterprise).

☐ In enclaves/mobile crews, agency-owned transitional employment.

☐ Participates in facility-based activity program where an array of specialty supports and services are provided to assist an individual in achieving his/her non-work related goals

☐ Not in the competitive labor force-includes homemaker, child, student age 18 and over, retired from work, resident of an institution (including nursing home), or incarcerated.

EARNED WAGE IS MINIMUM WAGE OR GREATER

☐ Yes ☐ No ☐ N/A - Person is not working

CULTURE/ SPIRITUALITY/ RELIGION

DOES THE INDIVIDUAL IDENTIFY CULTURAL, SPIRITUAL, OR RELIGIOUS VALUES THAT PLAY A ROLE IN THEIR LIFE WHERE THEY WOULD PREFER SERVICES SPECIFIC TO THEIR CULTURE VALUES?

☐ Yes ☐ No

IF YES, PLEASE EXPLAIN:

CURRENT LIVING ARRANGEMENTS

RESIDENTIAL LIVING ARRANGEMENT

FOSTER CARE FACILITY / LICENSE #

DESCRIBE ANY CONCERNS/ISSUES WITH CURRENT LIVING SITUATION (INDICATE APPROPRIATENESS, MOBILITY, RESTRICTIVENESS, ACCESSIBILITY, CAREGIVER CONCERNS)

DO YOU HAVE ANYONE LIVING IN YOUR HOME WHO IS DEPENDENT ON YOU?

☐ Yes ☐ No

IF YES, PLEASE LIST AGE, RELATION, AND NAME OF PERSON(S).
TRANSPORTATION

ARE THERE ANY CONCERNS OR PROBLEMS RELATED TO TRANSPORTATION?

☐ Yes  ☐ No

ASSESSMENT OF TRANSPORTATION NEEDS:

EXPLAIN IF NECESSARY

MENTAL STATUS

IS INDIVIDUAL ORIENTED TO: (CHECK ALL THAT APPLY):

INDIVIDUAL  PLACE  TIME  SITUATION

☐ Yes  ☐ No  ☐ Yes  ☐ No  ☐ Yes  ☐ No  ☐ Yes  ☐ No

EXPLAIN IF NECESSARY

GROOMING

☐ Excellent  ☐ Good  ☐ Marginal  ☐ Poor

HYGIENE

☐ Excellent  ☐ Good  ☐ Marginal  ☐ Poor

DRESS

☐ Inappropriate to Weather  ☐ Unkempt  ☐ Unusual  ☐ Unremarkable

MEMORY

☐ Impaired Immediate  ☐ Impaired Recent  ☐ Impaired Remote  ☐ Not Determined

EXPLAIN IF NECESSARY

AWARENESS

☐ Alert  ☐ Dull  ☐ Stupor

EXPLAIN IF NECESSARY

CONCENTRATION

☐ Normal  ☐ Able to Focus  ☐ Distractible

EXPLAIN IF NECESSARY

JUDGMENT

☐ Good  ☐ Fair  ☐ Poor

EXPLAIN IF NECESSARY
### INSIGHT
- None
- Limited
- Insightful

**EXPLAIN IF NECESSARY**

### HALLUCINATIONS: (CHECK ALL THAT APPLY)
- N/A
- Auditory
- Visual
- Other

**EXPLAIN IF NECESSARY**

### THOUGHT PROCESS: (CHECK ALL THAT APPLY)
- Unremarkable
- Obsessions
- Compulsions
- Paranoid
- Irrational
- Peculiar
- Loosely Organized
- Illogical
- Other (explain)

**EXPLAIN IF NECESSARY**

### STREAM OF MENTAL ACTIVITY:
- Normal
- Delayed Response
- Perseverating
- Circumstantial
- Tangential
- Flight of Ideas
- Slowed
- Racing
- Blocked
- Other (explain)

**EXPLAIN IF NECESSARY**

### CHARACTERISTICS OF SPEECH:
- Unremarkable
- Soft
- Loud
- Pressured
- Nonverbal
- Stuttering
- Incoherent
- Other (explain)

**EXPLAIN IF NECESSARY**

### PRESENTATION DURING THE INTERVIEW:
- Unremarkable
- Embarrassed
- Seductive
- Impulsive
- Dramatic
- Needy
- Guarded
- Other (explain)

**EXPLAIN IF NECESSARY**

### EMOTIONAL STATE / AFFECT / REACTION:
- Appropriate
- Inappropriate
- Irritable
- Angry
- Calm
- Sad
- Depressed
- Anxious
- Absence of Emotions
- Unstable Emotions
- Emotions are Incongruent with Thought Content
- Other (explain)

**EXPLAIN IF NECESSARY**

### MOOD AS STATED BY THE INDIVIDUAL:
<table>
<thead>
<tr>
<th>CLINICAL IMPRESSIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLINICAL SUMMARY</td>
</tr>
</tbody>
</table>

**RECOMMENDATIONS**

### DIAGNOSTIC SUMMARY

#### DIAGNOSIS

<table>
<thead>
<tr>
<th>AXIS I</th>
<th>ICD-9</th>
<th>ICD-10</th>
<th>Description</th>
<th>Status Date</th>
<th>Status</th>
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<table>
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<tr>
<th>AXIS III</th>
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<th>ICD-10</th>
<th>Description</th>
<th>Status Date</th>
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</tbody>
</table>
### AXIS IV
- Economic problems
- Problem accessing healthcare
- Educational problems
- Occupational problems
- Housing problems
- Problem with primary support group
- Problem related to social environment
- Problem related to interaction with legal system
- Other psychosocial and environmental problems
- Behavioral / Personality issues

### AXIS V
<table>
<thead>
<tr>
<th>CURRENT GAF</th>
<th>GAF DATE</th>
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</thead>
</table>

### Diagnostic Summary

**CO-OCCURRING CONSUMER QUADRANT**
- Mild Psychopathology with Substance Abuse (Psych. Low/Substance Low)
- Psychiatrically Complicated Substance Dependence (Psych. Low/Substance High)
- Serious & Persistent Mental Illness with Substance Abuse (Psych. High/Substance Low)
- Serious & Persistent Mental Illness with Substance Dependence (Psych. High/Substance High)

**DIAGNOSIS MADE BY (NAME/CREDSNTIALS)**

**DIAGNOSIS EFFECTIVE DATE**

---

**DD PROXY**

For purposes of these data elements, when the term 'support' is used, it means support from a paid or un-paid person or technological support needed to enable the individual to achieve his/her desired future. The kinds of support a person might need are:

- **Limited** means the person can complete approximately 75% or more of the activity without support and the caregiver provides support for approximately 25% or less of the activity.
- **Moderate** means the person can complete approximately 50% of the activity and the caregiver supports the other 50%.
- **Extensive** means the person can complete approximately 25% of the activity and relies on the caregiver to support 75% of the activity.
- **Total** means the person is unable to complete the activity and the caregiver is providing 100% of support.

### PREDOMINANT COMMUNICATION STYLE

- English language spoken by the individual
- Assistive technology used
- Interpreter used
- Alternative language used
- Non-language forms of communication used
- No ability to communicate
- Unknown (Missing Value)
### ABILITY TO MAKE SELF UNDERSTOOD

Ability to communicate needs, both verbal and non-verbal, to family, friends, or staff.

- **Always Understood**
  - Expresses self without difficulty
- **Usually Understood**
  - Difficulty communicating BUT if given time and/or familiarity can be understood, little or no prompting required
- **Often Understood**
  - Ability is limited to making concrete requests or understood only by a very limited number of people
- **Sometimes Understood**
  - Difficulty communicating AND prompting usually required
- **Rarely or Never Understood**
  - Understanding is limited to interpretation of very person-specific sounds or body language
- **Unknown (Missing Value)**

### SUPPORT WITH MOBILITY

- **Independent**
  - Able to walk (with or without an assistive device) or propel wheelchair and move about
- **Guidance/Limited Support**
  - Able to walk (with or without an assistive device) or propel wheelchair and move about with guidance, prompting, reminders, stand by support, or with limited physical support
- **Moderate Support**
  - May walk very short distances with support but uses wheelchair as primary method of mobility, needs moderate physical support to transfer, move the chair, and/or shift positions in chair or bed
- **Extensive Support**
  - Uses wheelchair exclusively, needs extensive support to transfer, move the wheelchair, and/or shift positions in chair or bed
- **Total Support**
  - Uses wheelchair with total support to transfer, move the wheelchair, and/or shift positions throughout the day
- **Unknown (Missing Value)**

### MODE OF NUTRITIONAL INTAKE

- **Normal**
  - Swallows all types of foods
- **Modified independent**
  - e.g., liquid is sipped, takes limited solid food, need for modification may be unknown
- **Requires diet modification to swallow solid food**
  - e.g., mechanical diet (e.g., puree, minced) or only able to ingest specific foods
- **Requires modification to swallow liquids**
  - e.g., thickened liquids
- **Can swallow only pureed solids AND thickened liquids**
- **Combined oral and parenteral or tube feeding**
- **Enteral feeding into stomach**
  - e.g., G-tube or PEG tube
- **Enteral feeding into jejunum**
  - e.g., J-tube or PEG-J tube
- **Parenteral feeding only**
  - Includes all types of parenteral feedings, such as total parenteral nutrition (TPN)
- **Unknown (Missing Value)**

### SUPPORT WITH PERSONAL CARE

Ability to complete personal care, including bathing, toileting, hygiene, dressing and grooming tasks, including the amount of help required by another person to assist. This measure is an overall estimation of the person's ability in the category of personal care. If the person requires guidance only for all tasks but bathing, where he or she needs extensive support, score 'Guidance/Limited Support' to reflect the overall average ability. The person may or may not use assistive devices like shower or commode chairs, long-handled brushes, etc. Note: assistance with medication should NOT be included.

- **Independent**
  - Able to complete all personal care tasks without physical support
- **Guidance/Limited Support**
  - Able to perform personal care tasks with guidance, prompting, reminding or with limited physical support for less than 25% of the activity
- **Moderate Physical Support**
  - Able to perform personal care tasks with moderate support of another person
- **Extensive Support**
  - Able to perform personal care tasks with extensive support of another person
- **Total Support**
  - Requires full support of another person to complete personal care tasks (unable to participate in tasks)
- **Unknown (Missing Value)**
## RELATIONSHIPS

Indicate whether or not the individual has 'natural supports' defined as persons outside of the mental health system involved in his/her life who provide emotional support or companionship.

- Extensive involvement, such as daily emotional support/companionship
- Moderate involvement, such as several times a month up to several times a week
- Limited involvement, such as intermittent or up to once a month
- Involved in planning or decision-making, but does not provide emotional support/companionship
- No involvement
- Unknown (Missing Value)

## STATUS OF FAMILY/FRIEND SUPPORT SYSTEM

Indicate whether current (unpaid) family/friend caregiver status is at risk in the next 12 months; including instances of caregiver disability/illness, aging, and/or re-location. 'At risk' means caregiver will likely be unable to continue providing the current level of help, or will cease providing help altogether but no plan for replacing the caregiver's help is in place.

- Caregiver status is not at risk
- Caregiver is likely to reduce current level of help provided
- Caregiver is likely to cease providing help altogether
- Family/friends do not currently provide care
- Information unavailable
- Unknown (Missing Value)

## SUPPORT FOR ACCOMMODATING CHALLENGING BEHAVIORS

Indicate the level of support the individual needs, if any, to accommodate challenging behaviors. 'Challenging behaviors' include those that are self-injurious, or place others at risk of harm. (Support includes direct line of sight supervision)

- No challenging behaviors, or no support needed
- Limited Support, such as support up to once a month
- Moderate Support, such as support once a week
- Extensive Support, such as support several times a week
- Total Support - Intermittent, such as support once or twice a day
- Total Support - Continuous, such as full-time support
- Unknown (Missing Value)

## PRESENCE OF A BEHAVIOR PLAN

Indicate the presence of a behavior plan during the past 12 months.

- No Behavior Plan
- Positive Behavior Support Plan or Behavior Treatment Plan without restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee
- Behavior Treatment Plan with restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee
- Unknown (Missing Value)

## USE OF PSYCHOTROPIC MEDICATIONS

Fill in the number of anti-psychotic and other psychotropic medications the individual is prescribed. See the codebook for further definition of 'anti-psychotic' and 'other psychotropic' and a list of the most common medications.

<table>
<thead>
<tr>
<th>NUMBER OF ANTIPSYCHOTIC MEDICATIONS</th>
<th>NUMBER OF OTHER PSYCHOTROPIC MEDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric medications primarily used to manage psychosis.</td>
<td>Includes anti-convulsant, anti-anxiety, anti-depressant, ADHD, Bi-Polar, OCD and other psychiatric medications prescribed.</td>
</tr>
</tbody>
</table>

## MAJOR MENTAL ILLNESS (MMI) DIAGNOSIS

This measure identifies major mental illnesses characterized by psychotic symptoms or severe affective symptoms. Indicate whether or not the individual has one or more of the following major mental illness diagnoses: Schizophrenia, Schizoaffective Disorder, or Bipolar Disorder (ICD code 295.xx); Delusional Disorder (ICD code 297.1); Psychotic Disorder NOS (ICD code 298.9); Psychotic Disorder due to a general medical condition (ICD codes 293.81 or 293.82); Dementia with delusions (ICD code 294.42); Bipolar I Disorder (ICD codes 296.0x, 296.4x, 296.5x, 296.6x, or 296.7); or Major Depressive Disorder (ICD codes 296.2x and 296.3x). The ICD code must match the codes provided above. Note: Any digit or no digit at all, may be substituted for each ‘x’ in the codes.

- One or more MMI diagnosis present
- No MMI diagnosis present
- Unknown (Missing Value)

## LEVEL OF CARE/CARE RECOMMENDATION

Indicate recommended level of care.
INDICATE ESTIMATED LENGTH OF TREATMENT

SIGNATURES

STAFF SIGNATURE / CREDENTIALS

DATE

06/11/2015
<table>
<thead>
<tr>
<th><strong>Is Consumer a Child served by another DHS program</strong></th>
<th>☐ Yes ☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ADOPTION SUBSIDY</strong></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td><strong>GUARDIAN OR LEGAL REPRESENTATION</strong></td>
<td></td>
</tr>
<tr>
<td>WHO IS RESPONSIBLE FOR MAKING DECISIONS REGARDING CARE FOR THE INDIVIDUAL?</td>
<td>☐ Individual ☐ Parent ☐ Guardian or Legal Representative ☐ Power of Attorney</td>
</tr>
<tr>
<td><strong>PRIMARY GUARDIAN INFORMATION</strong></td>
<td></td>
</tr>
<tr>
<td>LAST NAME</td>
<td>FIRST NAME</td>
</tr>
<tr>
<td>☐ Mother</td>
<td>☐ Father</td>
</tr>
<tr>
<td>☐ Child</td>
<td>☐ Unrelated</td>
</tr>
<tr>
<td>☐ Spouse</td>
<td>☐ Other</td>
</tr>
<tr>
<td>☐ Sibling</td>
<td></td>
</tr>
<tr>
<td>☐ CHECK IF ADDRESS IS SAME AS CONSUMER</td>
<td>PHONE NUMBER</td>
</tr>
<tr>
<td><strong>ADDITIONAL GUARDIAN NOTES</strong></td>
<td></td>
</tr>
<tr>
<td><strong>DOES THE INDIVIDUAL HAVE AN ADVANCE DIRECTIVE?</strong></td>
<td>☐ Yes ☐ No ☐ N/A</td>
</tr>
<tr>
<td><strong>PRESENTING NEEDS</strong></td>
<td></td>
</tr>
<tr>
<td>BRIEFLY DESCRIBE THE PRESENTING NEEDS OF THE INDIVIDUAL (E.G., WHAT BROUGHT THE PERSON IN FOR SERVICES TODAY? HOW DOES THE PERSON VIEW THE REFERRAL? WHAT LED TO THE REFERRAL?)</td>
<td></td>
</tr>
<tr>
<td><strong>WHAT SUPPORTS/SERVICES ARE BEING REQUESTED TO HELP WITH THE PRESENTING NEEDS?</strong></td>
<td></td>
</tr>
</tbody>
</table>
SOCIAL/NATURAL SUPPORTS

Please indicate the supports in the person's daily life (family, friends, parent, others, etc.):

<table>
<thead>
<tr>
<th>Name of Support</th>
<th>Relationship</th>
<th>State how this person helps the individual achieve their goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ No Natural Supports</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

IS THE INDIVIDUAL SATISFIED WITH THEIR SUPPORTS?
☐ Yes  ☐ No

IS THERE A NEED TO CHANGE OR INCREASE SUPPORTS?
☐ Yes  ☐ No

HAS THE INDIVIDUAL LOST ANY CLOSE RELATIVES/FAMILY MEMBERS/FRIENDS?
☐ Yes  ☐ No

HAS THE INDIVIDUAL LOST ANY PETS/ANIMALS?
☐ Yes  ☐ No

WHAT WERE THE INDIVIDUALS LIVING ARRANGEMENTS AS A CHILD?

PARENTING SUPPORT

WHO IS PRESENT WITH THE CHILD TODAY?
☐ Parent  ☐ Legal Guardian  ☐ N/A

PARENTS' TOTAL NUMBER OF DEPENDENTS (INCLUDING THIS CHILD):

CHILD SERVED BY DEPARTMENT OF HUMAN SERVICES?
☐ Yes  ☐ No

PARENTS' VIEW OF PARENTING NEEDS?

ASSESSMENT OF PARENTING SKILLS/KNOWLEDGE?

SOURCES OF PARENTING SUPPORT?

STATUS OF MENTAL HEALTH AFFECTING PARENT?

CONCERNS/ISSUES RELATED TO PARENT-CHILD RELATIONSHIP?

DOES THE PARENT / GUARDIAN HAVE ANY OF THE FOLLOWING CONCERNS? (CHECK ALL THAT APPLY)

TIME SPENT ON COMPUTER
☐ Yes  ☐ No

TIME SPENT WATCHING TV
☐ Yes  ☐ No

TIME SPENT WITH FRIENDS
☐ Yes  ☐ No

INTERACTION DIFFICULTIES
☐ Child  ☐ Parent  ☐ N/A

COGNITIVE
☐ Child  ☐ Parent  ☐ N/A

SUBSTANCE USE
☐ Child  ☐ Parent  ☐ N/A

LEARNING/LITERACY PROBLEMS
☐ Child  ☐ Parent  ☐ N/A
Child □ Parent □ N/A

ANXIETY
Child □ Parent □ N/A

DEPRESSION
Child □ Parent □ N/A

ISOLATION/WITHDRAWN
Child □ Parent □ N/A

LOSS OF FAMILY MEMBER/FRIEND
Child □ Parent □ N/A

LOSS OF PETS/ANIMALS
Child □ Parent □ N/A

HISTORY OF POSTPARTUM DEPRESSION
Parent □ N/A

LOSS OF CHILD OR PREGNANCY
Parent □ N/A

PARENTS DIVORCED AS A CHILD?
Yes □ No

IF YES, AGE OF CHILD AT TIME OF PARENTS' DIVORCE:

THE PARENTS/GUARDIAN HAS BEEN ASSESSED AS WILLING AND ABLE TO BE PARTICIPANTS IN THE CHILD'S TREATMENT?
Yes □ No

WHAT ACTIVITIES/HOBBIES (SUCH AS COMPUTERS) DOES THE CHILD ENJOY?

WOULD THE PARENT OR CHILD LIKE TO INCREASE COMMUNITY INVOLVEMENTS OR DAILY ACTIVITIES?
Yes □ No

MENTAL HEALTH SYMPTOMS

DURING THE PAST MONTH, HAVE YOU FELT DOWN, DEPRESSED, IRRITABLE, OR HOPELESS MOST DAYS?
Yes □ No

HAVE YOU LOST INTEREST IN OR GOT LESS PLEASURE FROM THE THINGS YOU USED TO ENJOY?
Yes □ No

HAVE YOU HAD THOUGHTS OR PLANS TO HURT YOURSELF OR OTHERS DURING THE PAST TWO WEEKS?
Yes □ No

DO YOU FEEL YOU ARE IN CRISIS AND MAY NEED TO BE IN THE HOSPITAL?
Yes □ No

HAS THE CHILD BEEN FIDGETY, UNABLE TO SIT STILL, IRRITABLE, OR ANGRY MOST DAYS?
Yes □ No

DOES THE CHILD HAVE TIMES WHEN HIS/HER THOUGHTS RACE OR DOES SHE/HE NEED LESS SLEEP, LASTING MORE THAN A WEEK?
Yes □ No

CAN THE CHILD BE DESCRIBED AS NERVOUS OR OVERLY FEARFUL?
Yes □ No

DOES THE CHILD FREQUENTLY ARGUE WITH PARENTS OR PEOPLE IN AUTHORITY?
Yes □ No

DOES THE CHILD OPENLY DISREGARD RULES OR LIMITS TO GET THEIR WAY?
Yes □ No

DOES THE CHILD HAVE PROBLEMS GETTING ALONG WITH OTHERS?
Yes □ No
DOES THE CHILD HAVE MORE TROUBLE HANDLING CHANGE/STRESS THAN OTHER CHILDREN HIS/HER AGE?
☐ Yes  ☐ No

SUBSTANCE USE HISTORY
Section Not Applicable

RISK AND SAFETY ASSESSMENT

ANY AT-RISK BEHAVIORS?
☐ Yes  ☐ No
EXPLAIN

ANY PHYSICAL OR VERBAL AGGRESSION?
☐ Yes  ☐ No
EXPLAIN

ANY SELF-INJURIOUS BEHAVIORS?
☐ Yes  ☐ No
EXPLAIN

ANY RISK OR SAFETY ISSUES WITH SCHOOL (FOR CHILDREN)?
☐ Yes  ☐ No
EXPLAIN

ANY RISK OR SAFETY ISSUES WITH COMMUNITY?
☐ Yes  ☐ No
EXPLAIN

ANY RISK OR SAFETY ISSUES WITH HOME ENVIRONMENT?
☐ Yes  ☐ No
EXPLAIN

ANY RISK OR SAFETY ISSUES WITH WORK ENVIRONMENT?
☐ Yes  ☐ No
EXPLAIN

ANY PHYSICAL ACTIVITIES THAT PUT THE INDIVIDUAL AT RISK?
☐ Yes  ☐ No
EXPLAIN

ARE THERE ANY WEAPONS IN THE HOME?
☐ Accessible  ☐ Locked  ☐ No
EXPLAIN
DOES THE INDIVIDUAL HAVE ACCESS TO ANY OTHER WEAPONS?
☐ Yes  ☐ No
EXPLAIN

IS THERE A HISTORY OF SUICIDAL IDEATION?
☐ Yes  ☐ No
EXPLAIN

IS A CRISIS SCREENING NEEDED IMMEDIATELY?
☐ Yes  ☐ No
EXPLAIN

IS IMMEDIATE INTERVENTION FOR RISK/SAFETY NEEDED? IF YES, PLAN?
☐ Yes  ☐ No
EXPLAIN

IS THERE A CRISIS PLAN?
☐ Yes  ☐ No
EXPLAIN

IS THERE A HISTORY OF HOMICIDAL IDEATION?
☐ Yes  ☐ No
EXPLAIN

INTELLECTUAL/DEVELOPMENTAL HISTORY
☐ No reported history of intellectual/developmental disability

BRIEFLY DESCRIBE THE PRESENTING SYMPTOM(S) OF THE INTELLECTUAL/DEVELOPMENTAL DISABILITY:

WHAT YEAR AND AT WHAT AGE WAS THE INDIVIDUAL INITIALLY DETERMINED TO HAVE AN INTELLECTUAL/DEVELOPMENTAL DISABILITY?
WHERE DID THE EVALUATION DETERMINATION OCCUR AND WHY?

WHAT WAS THE ORIGINAL DIAGNOSIS?

<table>
<thead>
<tr>
<th>CHILD / ADOLESCENT DEVELOPMENTAL HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>DURING PREGNANCY, DID THE MOTHER EXPERIENCE ANY DEPRESSION, INCLUDING POST-PARTUM DEPRESSION?</td>
</tr>
<tr>
<td>☐ Yes  ☐ No</td>
</tr>
<tr>
<td>DURING PREGNANCY, DID THE MOTHER EXPERIENCE ANY INFECTIONS?</td>
</tr>
<tr>
<td>☐ Yes  ☐ No  ☐ Unknown</td>
</tr>
<tr>
<td>EXPLAIN</td>
</tr>
</tbody>
</table>

DURING PREGNANCY, DID THE MOTHER HAVE ANY COMPLICATIONS? |
| ☐ Yes  ☐ No  ☐ Unknown |
| EXPLAIN |

DURING PREGNANCY, DID THE MOTHER USE TOBACCO, ALCOHOL, OR DRUGS? |
| ☐ Yes  ☐ No  ☐ Unknown |
DURING PREGNANCY, DID THE MOTHER INHALE OR EAT TOXIC AGENTS?
☐ Yes  ☐ No  ☐ Unknown

WERE THERE ANY COMPLICATIONS DURING DELIVERY?
☐ Yes  ☐ No  ☐ Unknown

DID THE MOTHER REPORT THE CHILD AS HAVING PHYSICAL MALFORMATIONS AT BIRTH?
☐ Yes  ☐ No  ☐ Unknown

DID THE MOTHER HAVE A FULL TERM PREGNANCY?
☐ Yes  ☐ No  ☐ Unknown

DID THE INFANT EXHIBIT ANY EATING PROBLEMS?
☐ Yes  ☐ No  ☐ Unknown

DID THE INFANT EXHIBIT ANY SLEEPING PROBLEMS?
☐ Yes  ☐ No  ☐ Unknown

WHAT WAS THE CHILD'S BIRTH WEIGHT?

WHAT WAS THE AGE OF THE MOTHER AT THE CHILD'S BIRTH?

AT WHAT AGE DID THE CHILD DO THE FOLLOWING ... (IF NEVER OCCURRED, INDICATE UNABLE)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Age (in months)</th>
<th>Unable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roll Over</td>
<td>AGE (in months)</td>
<td>☐</td>
</tr>
<tr>
<td>Crawl</td>
<td>AGE (in months)</td>
<td>☐</td>
</tr>
<tr>
<td>Sit Up On Own</td>
<td>AGE (in months)</td>
<td>☐</td>
</tr>
<tr>
<td>Walk</td>
<td>AGE (in months)</td>
<td>☐</td>
</tr>
<tr>
<td>Speak Words</td>
<td>AGE (in months)</td>
<td>☐</td>
</tr>
<tr>
<td>Speak Sentences</td>
<td>AGE (in months)</td>
<td>☐</td>
</tr>
<tr>
<td>Become Toilet Trained</td>
<td>AGE (in months)</td>
<td>☐</td>
</tr>
</tbody>
</table>

IF THE INFORMATION IS UNKNOWN, INDICATE WHY:
FETAL ALCOHOL SYNDROME (FAS) PRE-SCREEN

FAS is a birth defect caused by alcohol use during pregnancy. FAS is a medical diagnosis. This pre-screen is not intended to take the place of a diagnostic evaluation. It is intended to make the proper referral for diagnosis and treatment.

1. HEIGHT AND WEIGHT SEEM SMALL FOR AGE?
   - Yes
   - No

2. SIZE OF HEAD SEEMS SMALL FOR AGE?
   - Yes
   - No

3. BEHAVIORAL CONCERNS (CHECK ALL THAT APPLY - ANY OF THESE QUALIFIES AS AN IDENTIFIER)
   - Sleeping/eating problems
   - I/DD or IQ below familial expectations
   - Attention problem/impulsive/restless
   - Learning disability
   - Speech and/or language delays
   - Problem with reasoning and judgement
   - Acts younger than children same age

4. FACIAL ABNORMALITIES?
   - Yes
   - No

5. MATERNAL ALCOHOL USE DURING PREGNANCY?
   - Yes
   - No

If YES to 2 or more above, the individual should be referred for a full FAS diagnostic evaluation.

Contact the nearest center to schedule a complete FAS diagnostic evaluation: Detroit 313-993-3891 Ann Arbor 734-936-9777

BEHAVIOR TREATMENT PLAN

DOES THE INDIVIDUAL REQUIRE A REFERRAL FOR A BEHAVIORAL ASSESSMENT?
   - Yes
   - No

IF YES, EXPLAIN AND PROVIDER REFERRAL INFORMATION:

HAS THE INDIVIDUAL EVER HAD A BEHAVIOR TREATMENT PLAN?
   - Yes
   - No
   - N/A

BRIEFLY DESCRIBE HISTORY IF APPLICABLE:
### Trauma History

**Have you ever been involved in a traumatic event that caused you to fear for your life? (E.g., sexual assault, physical attack, military combat, robbery, severe car accident, or sexual assault as a child)**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Ongoing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult</td>
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<tr>
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</tbody>
</table>

**Explain if needed**

---

**History of Emotional Abuse? (E.g., someone repeatedly made you feel bad through harsh words)**

<table>
<thead>
<tr>
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</table>

**Explain if needed**

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**History of Physical Abuse? (E.g., someone repeatedly caused you physical harm)**

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</tbody>
</table>

**Explain if needed**

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**History of Sexual Abuse? (E.g., someone forced sexual advances or acts)**

<table>
<thead>
<tr>
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<td>Ongoing</td>
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</tbody>
</table>

**Explain if needed**

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**History of Neglect? (E.g., a caretaker denied basic needs, such as adequate food, clothes, and supervision)**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
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<td>Ongoing</td>
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</tbody>
</table>

**Explain if needed**

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**History of Violence? (E.g., the use of physical force against oneself, another person, or a community, which has a high likelihood of resulting in injury, death, or psychological harm)**

<table>
<thead>
<tr>
<th></th>
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<td>Ongoing</td>
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</tbody>
</table>

**Explain if needed**

---

**History of Domestic Violence? (E.g., a pattern of abusive behavior in an intimate relationship, which is used by one partner to gain or maintain power and control over another partner)**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Ongoing</th>
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</thead>
<tbody>
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<td></td>
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<tr>
<td>Ongoing</td>
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</tr>
</tbody>
</table>

**Explain if needed**

---

**History of Bullying? (E.g., unwanted and repeated aggressive behavior among school aged children that involves a real or perceived power imbalance. Includes verbal and/or physical abuse)**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Ongoing</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

**Explain if needed**
Trauma/Abuse/Stress Screening for Children

1. ARE YOU AWARE OF OR DO YOU SUSPECT THE CHILD HAS EXPERIENCED ANY OF THE FOLLOWING:
   - Physical abuse
   - Suspected neglectful home environment
   - Emotional abuse
   - Exposure to domestic violence
   - Known or suspected exposure to drug activity aside from parental/caregiver use
   - Known or suspected exposure to any other violence not already identified
   - Parental/caregiver drug use/substance abuse
   - Multiple separations from parent or caregiver
   - Frequent and multiple moves or homelessness
   - Sexual abuse or exposure
   - Other

If you are not aware of a trauma history, but multiple concerns are present in the questions 2-5, then there may be a trauma history that has not come to your attention.

Note: Concerns in the following areas do not necessarily indicate trauma; however, there is a strong relationship.

2. DOES THE CHILD SHOW ANY OF THESE BEHAVIORS?
   - Excessive aggression or violence towards self
   - Excessive aggression or violence towards others
   - Explosive behavior (going from 0-100 instantly)
   - Hyperactivity, distractibility, inattention
   - Very withdrawn or excessively shy
   - Oppositional and/or defiant behavior
   - Sexual behaviors not typical for a child's age
   - Peculiar patterns of forgetfulness
   - Inconsistency in skills
   - Other

3. DOES THE CHILD EXHIBIT ANY OF THE FOLLOWING EMOTIONS OR MOODS?
   - Excessive mood swings
   - Chronic sadness, doesn't seem to enjoy any activities
   - Very flat affect or withdrawn behavior
   - Quick, explosive anger
   - Other

4. IS THE CHILD HAVING PROBLEMS AT SCHOOL?
   - Low or failing grades
   - Inadequate performance
   - Difficulty with authority
   - Attention or memory problems
   - Other

5. WILL TRAUMA HISTORY BE A GOAL OF PCP?
   - Yes
   - No

HISTORY OF PRIOR TREATMENT SERVICES

List of hospitals, CMH providers, DHS involvement

<table>
<thead>
<tr>
<th>Treatment Provider</th>
<th>Location</th>
<th>Reason</th>
<th>Date/LOS</th>
<th>Did the individual find the treatment helpful?</th>
</tr>
</thead>
</table>

PHYSICAL HEALTH HISTORY

INDIVIDUAL'S REPORTED CURRENT HEALTH STATUS:
- Excellent
- Good
- Fair
- Poor

DOES THE INDIVIDUAL HAVE ANY DIAGNOSED PHYSICAL ILLNESS OR CONDITION(S)? CHECK ALL THAT APPLY.
HAVE ANY OF THE INDIVIDUAL’S IMMEDIATE FAMILY MEMBERS OR DECEASED RELATIVES (PARENTS, SIBLINGS) HAD ANY OF THE FOLLOWING CONDITIONS? CHECK ALL THAT APPLY.

- Asthma
- Allergies
- Cancer
- COPD
- Diabetes
- Heart Disease
- Hypertension
- Stroke
- Suicide
- Mental health
- SubSTANCE USE
- DEVELOPMENTAL DISABILITY

---

**HEALTH INDICATORS AND OTHER CONDITIONS FOR ALL POPULATIONS**

**DATE REVIEWED**

**HEARING**

**ABILITY TO HEAR (WITH HEARING APPLIANCE NORMALLY USED)**

- **Adequate**
  - No difficulty in normal conversation, social interaction, listening to TV

- **Minimal difficulty**
  - Difficulty in some environments (e.g., when person speaks softly or is more than 6 feet away)

- **Moderate difficulty**
  - Problem hearing normal conversation, requires quiet setting to hear well

- **Severe difficulty**
  - Difficulty in all situations (e.g., speaker has to talk loudly or speak very slowly; or person reports that all speech is mumbled)

- **No hearing**

**HEARING AID USED**

- **Yes**
- **No**

**VISION**

**ABILITY TO SEE IN ADEQUATE LIGHT (WITH GLASSES OR WITH OTHER VISUAL APPLIANCE NORMALLY USED)**

- **Adequate**
  - Sees fine detail, including regular print in newspapers/books or small items in pictures

- **Minimal difficulty**
  - Sees large print, but not regular print in newspapers/books or cannot identify large objects in pictures

- **Moderate difficulty**
  - Limited vision; not able to see newspaper headlines or small items in pictures, but can identify objects in his/her environment

- **Severe difficulty**
  - Object identification in question, but the person’s eyes appear to follow objects, or the person sees only light, colors, shapes

- **No vision**
### HEALTH CONDITIONS

Indicate whether or not the individual had the presence of each of the following health conditions, as reported by the individual, a health care professional or family member, in the past 12 months.

#### PNEUMONIA (2 OR MORE TIMES) - INCLUDING ASPIRATION PNEUMONIA
- □ Never present
- □ History of condition, but not treated for the condition within the past 12 months
- □ Treated for the condition within the past 12 months
- □ Information unavailable

#### ASTHMA
- □ Never present
- □ History of condition, but not treated for the condition within the past 12 months
- □ Treated for the condition within the past 12 months
- □ Information unavailable

#### UPPER RESPIRATORY INFECTIONS (3 OR MORE TIMES WITHIN PAST 12 MONTHS)
- □ Never present
- □ History of condition, but not treated for the condition within the past 12 months
- □ Treated for the condition within the past 12 months
- □ Information unavailable

#### GASTROESOPHAGEAL REFLUX, OR GERD
- □ Never present
- □ History of condition, but not treated for the condition within the past 12 months
- □ Treated for the condition within the past 12 months
- □ Information unavailable

#### CHRONIC BOWEL IMPACTIONS
- □ Never present
- □ History of condition, but not treated for the condition within the past 12 months
- □ Treated for the condition within the past 12 months
- □ Information unavailable

#### SEIZURE DISORDER OR EPILEPSY
- □ Never present
- □ History of condition, but not treated for the condition within the past 12 months
- □ Treated for the condition within the past 12 months and seizure free
- □ Treated for the condition within the past 12 months, but still experience occasional seizures (less than one per month)
- □ Treated for the condition within the past 12 months, but still experience frequent seizures
- □ Information unavailable

#### PROGRESSIVE NEUROLOGICAL DISEASE, INCLUDE, ALZHEIMER'S AND PARKINSON'S DISEASE
- □ Not present
- □ Treated for the condition within the past 12 months
- □ Information unavailable

#### DIABETES
- □ Never present
- □ History of condition, but not treated for the condition within the past 12 months
- □ Treated for the condition within the past 12 months
- □ Information unavailable

#### HYPERTENSION
- □ Never present
- □ History of condition, but not treated for the condition within the past 12 months
- □ Treated for condition within the past 12 months and blood pressure is stable
- □ Treated for condition within the past 12 months, but blood pressure remains high or unstable
- □ Information is unavailable

#### OBESITY
- □ Not present
- □ Medical diagnosis of obesity present or Body Mass Index (BMI) > 30

---

**DO YOU HAVE A PRIMARY CARE DOCTOR/FAMILY PHYSICIAN/PEDIATRICIAN THAT YOU ARE SEEING?**
- □ Yes  □ No

**PRIMARY CARE PHYSICIAN**

WHEN WAS THE LAST TIME THE INDIVIDUAL SAW A PRIMARY CARE DOCTOR/FAMILY PHYSICIAN/PEDIATRICIAN?

IS A REFERRAL NEEDED TO GET THE INDIVIDUAL SET UP WITH A PHYSICAL HEALTH DOCTOR?
- □ Yes  □ No
WHEN WAS THE LAST TIME THE INDIVIDUAL SAW A DENTIST?

WHEN WAS THE LAST TIME THE INDIVIDUAL HAD AN EYE EXAM?

IS THE INDIVIDUAL CURRENT ON ALL VACCINES/IMMUNIZATIONS?
☐ Yes  ☐ No  ☐ Referral Needed

HISTORY OF CHRONIC PAIN

HAVE YOU HAD CHRONIC PAIN (I.E., PAIN FOR MORE THAN 6 MONTHS)?
☐ Yes  ☐ No  ☐ Current  ☐ Past

WHERE IS THE PAIN LOCATED?

HOW LONG HAVE YOU HAD THIS PAIN? WHEN DID THE PAIN FIRST START?

HOW OFTEN DO YOU EXPERIENCE THE PAIN? (I.E., WEEKLY, DAILY, 2-3 TIMES PER DAY, ETC.)?

HOW LONG, DURING A TYPICAL DAY WHEN YOU EXPERIENCE PAIN, DOES THE PAIN LAST FOR?

HOW SEVERE IS THE PAIN (ON A SCALE FROM 0 TO 10, WITH 10 BEING THE WORSE)?

HOW DO YOU MANAGE THIS PAIN? PLEASE LIST ALL SOURCES (E.G., MEDICATION, EXERCISE, RELAXATION, ACUPUNCTURE, ETC.)

DIET AND EXERCISE

DO YOU THINK YOU EAT A HEALTHY DIET (REGULAR MEALS, FRUITS, VEGETABLES, MINIMUM TAKEOUT/RESTAURANTS)?
☐ Yes  ☐ No

DO YOU THINK YOU TAKE PART IN ANY PHYSICAL ACTIVITY OR EXERCISE (INCLUDING WALKING, CYCLING, GARDENING)?
☐ Yes  ☐ No

HOW OFTEN DO YOU EXERCISE OR ENGAGE IN PHYSICAL ACTIVITY DURING A TYPICAL WEEK (INDICATE HOW MANY TIMES PER WEEK, AND MINUTES/HOURS PER WEEK)?

SMOKING HABITS

DO YOU SMOKE CIGARETTES OR TOBACCO?
☐ Yes  ☐ No

IF YES, HOW MUCH DO YOU SMOKE PER DAY? (AMOUNT)

AND HOW LONG HAVE YOU SMOKED FOR? (MONTHS/YEARS)

IF NO, HAVE YOU EVER SMOKED IN THE PAST?
☐ Yes  ☐ No

IF YES, FOR HOW LONG? (MONTHS/YEARS)

HAVE YOU TRIED TO STOP SMOKING IN THE PAST?
☐ Yes  ☐ No

DO YOU WANT TO STOP SMOKING NOW?
☐ Yes  ☐ No

SEXUAL ACTIVITIES

☐ Section N/A

ARE YOU SEXUALLY ACTIVE?
☐ Yes  ☐ No  ☐ Prefer Not To Answer

ARE YOU USING A METHOD OF PROTECTION DURING SEXUAL ACTIVITIES TO REDUCE YOUR RISK OF SEXUALLY TRANSMITTED INFECTIONS AND/OR PREGNANCY (E.G., CONDOMS, DENTAL DAMS, CONTRACEPTIVES, ETC.)?
☐ Yes  ☐ No  ☐ Prefer Not To Answer

ARE YOU AWARE OF THE RISKS OF SEXUALLY TRANSMITTED INFECTIONS SUCH AS HEPATITIS, HIV/AIDS, SYPHILIS, ETC.?
☐ Yes  ☐ No  ☐ Prefer Not To Answer

HAVE YOU EVER HAD UNPROTECTED SEX OR ENGAGED IN SEXUAL BEHAVIORS (ORAL, ANAL, GENITAL) WITH A PERSON WHOSE HIV, HEPATITIS, OR STI STATUS WAS UNKNOWN TO YOU (SUCH AS SEX WHEN DRUNK OR HIGH WITH SOMEONE YOU DID NOT KNOW VERY WELL)?
☐ Yes  ☐ No  ☐ Unsure

HAVE YOU EVER ENGAGED IN SEXUAL BEHAVIORS WITH ANYONE WHO HAS:

INJECTED DRUGS?
☐ Yes  ☐ No  ☐ Unsure

TRADED SEX FOR DRUGS?
☐ Yes  ☐ No  ☐ Unsure

MANY SEXUAL PARTNERS?
☐ Yes  ☐ No  ☐ Unsure

HIV/AIDS?
☐ Yes  ☐ No  ☐ Unsure
HEPATITIS?
- Yes
- No
- Unsure

STI'S?
- Yes
- No
- Unsure

HAVE YOU EVER EXPERIENCED OTHER FORMS OF BLOOD-TO-BLOOD OR BODILY FLUID CONTACT (FOR EXAMPLE, BLOOD TRANSFUSIONS, HEMOPHILIA TREATMENTS, EMPLOYMENT IN MEDICAL FIELD, ETC.) AND HAVE CONCERNS ABOUT YOUR RISK FOR HIV, HEPATITIS, OR STI'S?
- Yes
- No
- Unsure

WOULD THE INDIVIDUAL LIKE FURTHER INFORMATION ON ANY SEXUAL HEALTH ISSUES?
- Yes
- No

SEXUAL ORIENTATION:

<table>
<thead>
<tr>
<th>VITALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>COLLECTION INFORMATION</td>
</tr>
<tr>
<td>COLLECTION DATE</td>
</tr>
<tr>
<td>GENERAL INFORMATION</td>
</tr>
<tr>
<td>HEIGHT: ft in</td>
</tr>
<tr>
<td>WEIGHT: lbs oz</td>
</tr>
<tr>
<td>WAIST CIRCUMFERENCE: in</td>
</tr>
<tr>
<td>BMI:</td>
</tr>
<tr>
<td>COMMENTS</td>
</tr>
</tbody>
</table>

| REPRODUCTIVE HEALTH |
| Declined No Information Collected |

PREGNANT:
- Yes
- No
- N/A

LAST MONTHLY PERIOD DATE

BIRTH CONTROL METHOD

IF OTHER, EXPLAIN:

| TOBACCO USE |
| Declined No Information Collected |

SMOKING STATUS: EFFECTIVE:

OTHER TOBACCO USE:

PROVIDED CONSUMER WITH ADVICE TO QUIT SMOKING OR TOBACCO USE, OR RECOMMENDED OR DISCUSSED SMOKING OR TOBACCO USE CESSATION, MEDICATIONS, METHODS, OR STRATEGIES
- Yes
- No

| TEMPERATURE |
| Declined No Information Collected |

VALUE:

SITE:
- Axillary
- Rectal
- Non-invasive thermometer
- Oral
- Temporal
- Tympanic

COMMENTS
### PULSE

- **VALUE:**  
  - □ Declined  
  - □ No Information Collected

- **RHYTHM:**  
  - □ Irregular  
  - □ Regular

- **FORCE:**  
  - □Bounding  
  - □ Normal  
  - □ Thready  
  - □ Weak

- **METHOD USED:**  
  - □ Machine  
  - □ Manual

- **SITE:**  
  - □ Apical (over heart)  
  - □ Femoral (inner thigh)  
  - □ Brachial (upper arm)  
  - □ Popliteal (behind knee)  
  - □ Cartoid (neck)  
  - □ Radial (wrist)

- **COMMENTS**

### RESPIRATION

- **VALUE:**  
  - □ Declined  
  - □ No Information Collected

- **LUNG SOUNDS:**  
  - □ Declined  
  - □ No Information Collected

  - □ Clear  
  - □ Rales  
  - □ Rhonchi  
  - □ Wheeze  
  - □ Other

- **COMMENTS**

### BLOOD PRESSURE

- **Sitting**  
  - SYSTOLIC: mmHg  
  - DIASTOLIC: mmHg

- **Standing**  
  - SYSTOLIC: mmHg  
  - DIASTOLIC: mmHg

- **METHOD USED:**  
  - □ Machine  
  - □ Manual

- **COMMENTS**

### RESULTS OF BREATHALYZER & URINE DRUG SCREEN (UDS)

- **BAC (BLOOD ALCOHOL CONTENT):**  
  - □ Declined

- **URINE DRUG SCREEN RESULTS**

### BLOOD GLUCOSE RESULTS

- □ Declined
COMMENTS

REACTION:
☐ Cooperative  ☐ Declined  ☐ Resisted (Uncooperative)

COMMENTS

PRESCRIBED MEDICATIONS

OTHER MEDICATIONS

DO YOU HAVE ANY PROBLEMS WITH ANY OF THESE MEDICATIONS (SIDE EFFECTS)?
☐ Yes  ☐ No

IF YES, PLEASE EXPLAIN:

LEGAL ISSUES

CORRECTIONS RELATED STATUS

<table>
<thead>
<tr>
<th>Most Recent Offense</th>
<th>Date</th>
</tr>
</thead>
</table>

JUDGE NAME:

COURT:

CMO AGENCY NAME:

PAROLE OFFICER NAME:  PHONE #:

PROBATION OFFICER NAME:  PHONE #:

RETURNING CITIZEN (RELEASE FROM INCARCERATION - NO PROBATION/PAROLE)?
☐ Yes  ☐ No
### EDUCATION

<table>
<thead>
<tr>
<th>CHILD'S EDUCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Not Applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EDUCATION HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Unreported</td>
</tr>
<tr>
<td>□ Completed less than high school</td>
</tr>
<tr>
<td>□ Completed special education, high school, or GED</td>
</tr>
<tr>
<td>□ In school - Kindergarten through 12th grade</td>
</tr>
<tr>
<td>□ In training program</td>
</tr>
<tr>
<td>□ In Special Education</td>
</tr>
<tr>
<td>□ Attended or is attending undergraduate college</td>
</tr>
<tr>
<td>□ College graduate</td>
</tr>
</tbody>
</table>

**HIGHEST GRADE**

- □ Preschool
- □ Day Care Center
- □ Head Start
- □ Early On
- □ Home Day Center

**CURRENT SCHOOL/SCHOOL DISTRICT:**

- □ In Special Education?
  - □ Yes  □ No

**DATE OF FSP**

**DATE OF LAST IEPC**

**AT AGE-APPROPRIATE GRADE LEVEL?**

- □ Yes  □ No

**IF NO, EXPLAIN:**

- □ Expelled

**LIMITED ENGLISH PROFICIENCY?**

- □ Yes  □ No

**IF YES, EXPLAIN:**

### MOTHER'S EDUCATION

<table>
<thead>
<tr>
<th>EDUCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Not Applicable</td>
</tr>
</tbody>
</table>

| □ Literacy Issues |

### FATHER'S EDUCATION

<table>
<thead>
<tr>
<th>EDUCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Not Applicable</td>
</tr>
</tbody>
</table>

| □ Literacy Issues |

### DOES THE CHILD/INDIVIDUAL NEED ASSISTANCE TO ACHIEVE EDUCATION/WORK GOALS?

- □ Yes  □ No

**IF YES, EXPLAIN:**
DOES THE FAMILY NEED ASSISTANCE TO HELP WITH INDIVIDUAL ACHIEVING EDUCATION AND/OR WORK GOALS?

- Yes
- No

IF YES, EXPLAIN:

**EMPLOYMENT**

**EMPLOYMENT STATUS**

- Employed full time (30 hours or more per week) competitively or self-employed.
- Employed part time (less than 30 hours per week) in competitively or self-employed.
- Unemployed - looking for work, and/or on layoff from job
- Sheltered workshop or work services participant in non-integrated setting
- In unpaid work (e.g. volunteering, internship, community service)
- Self-employed (e.g. micro-enterprise).
- In enclaves/mobile crews, agency-owned transitional employment.
- Participates in facility-based activity program where an array of specialty supports and services are provided to assist an individual in achieving his/her non-work related goals
- Not in the competitive labor force-includes homemaker, child, student age 18 and over, retired from work, resident of an institution (including nursing home), or incarcerated.

**EARNED WAGE IS MINIMUM WAGE OR GREATER**

- Yes
- No
- N/A - Person is not working

**CULTURE/SPIRITUALITY/RELIGION**

DOES THE INDIVIDUAL IDENTIFY CULTURAL, SPIRITUAL, OR RELIGIOUS VALUES THAT PLAY A ROLE IN THEIR LIFE WHERE THEY WOULD PREFER SERVICES SPECIFIC TO THEIR CULTURE VALUES?

- Yes
- No

IF YES, PLEASE EXPLAIN:

**CURRENT LIVING ARRANGEMENTS**

**RESIDENTIAL LIVING ARRANGEMENT**

FOSTER CARE FACILITY / LICENSE #
DESCRIBE ANY CONCERNS/ISSUES WITH CURRENT LIVING SITUATION (INDICATE APPROPRIATENESS, MOBILITY, RESTRICTIVENESS, ACCESSIBILITY, CAREGIVER CONCERNS)

DO YOU HAVE ANYONE LIVING IN YOUR HOME WHO IS DEPENDENT ON YOU?

☐ Yes  ☐ No

IF YES, PLEASE LIST AGE, RELATION, AND NAME OF PERSON(S).

TRANSPORTATION

ARE THERE ANY CONCERNS OR PROBLEMS RELATED TO TRANSPORTATION?

☐ Yes  ☐ No

ASSESSMENT OF TRANSPORTATION NEEDS:

EXPLAIN IF NECESSARY

MENTAL STATUS

IS INDIVIDUAL ORIENTED TO: (CHECK ALL THAT APPLY):

<table>
<thead>
<tr>
<th>INDIVIDUAL</th>
<th>PLACE</th>
<th>TIME</th>
<th>SITUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes</td>
<td>☐ Yes</td>
<td>☐ Yes</td>
<td>☐ Yes</td>
</tr>
</tbody>
</table>

EXPLAIN IF NECESSARY

GROOMING

☐ Excellent  ☐ Good  ☐ Marginal  ☐ Poor

HYGIENE

☐ Excellent  ☐ Good  ☐ Marginal  ☐ Poor

DRESS

☐ Inappropriate to Weather  ☐ Unkempt  ☐ Unusual  ☐ Unremarkable

MEMORY

☐ Impaired Immediate  ☐ Impaired Recent  ☐ Impaired Remote  ☐ Not Determined

EXPLAIN IF NECESSARY
<table>
<thead>
<tr>
<th>AWARENESS</th>
<th>Alert</th>
<th>Dull</th>
<th>Stupor</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXPLAIN IF NECESSARY</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CONCENTRATION</th>
<th>Normal</th>
<th>Able to Focus</th>
<th>Distractible</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXPLAIN IF NECESSARY</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>JUDGMENT</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXPLAIN IF NECESSARY</td>
<td></td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>INSIGHT</th>
<th>None</th>
<th>Limited</th>
<th>Insightful</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXPLAIN IF NECESSARY</td>
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</table>

<table>
<thead>
<tr>
<th>HALLUCINATIONS: (CHECK ALL THAT APPLY)</th>
<th>N/A</th>
<th>Auditory</th>
<th>Visual</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXPLAIN IF NECESSARY</td>
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</table>

<table>
<thead>
<tr>
<th>THOUGHT PROCESS: (CHECK ALL THAT APPLY)</th>
<th>Unremarkable</th>
<th>Obsessions</th>
<th>Compulsions</th>
<th>Paranoid</th>
<th>Irrational</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peculiar</td>
<td>Loosely Organized</td>
<td>Illogical</td>
<td>Other (explain)</td>
<td></td>
<td></td>
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<tr>
<td>EXPLAIN IF NECESSARY</td>
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</table>

<table>
<thead>
<tr>
<th>STREAM OF MENTAL ACTIVITY:</th>
<th>Normal</th>
<th>Delayed Reponse</th>
<th>Perseverating</th>
<th>Circumstantial</th>
<th>Tangential</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flight of Ideas</td>
<td>Slowed</td>
<td>Racing</td>
<td>Blocked</td>
<td>Other (explain)</td>
<td></td>
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<tr>
<td>EXPLAIN IF NECESSARY</td>
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</table>

<table>
<thead>
<tr>
<th>CHARACTERISTICS OF SPEECH:</th>
<th>Unremarkable</th>
<th>Soft</th>
<th>Loud</th>
<th>Pressured</th>
<th>Nonverbal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stuttering</td>
<td>Incoherent</td>
<td>Other (explain)</td>
<td></td>
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<td></td>
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<tr>
<td>EXPLAIN IF NECESSARY</td>
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<table>
<thead>
<tr>
<th>PRESENTATION DURING THE INTERVIEW:</th>
<th>Unremarkable</th>
<th>Embarrassed</th>
<th>Seductive</th>
<th>Impulsive</th>
<th>Dramatic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needy</td>
<td>Guarded</td>
<td>Other (explain)</td>
<td></td>
<td></td>
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</tbody>
</table>
EXPLAIN IF NECESSARY

EMOTIONAL STATE / AFFECT / REACTION:

☐ Appropriate  ☐ Inappropriate  ☐ Irritable
☐ Sad  ☐ Depressed  ☐ Anxious
☐ Angry  ☐ Calm
☐ Absence of Emotions  ☐ Unstable Emotions
☐ Emotions are Incongruent with Thought Content
☐ Other (explain)

EXPLAIN IF NECESSARY

MOOD AS STATED BY THE INDIVIDUAL:

CLINICAL IMPRESSIONS

CLINICAL SUMMARY

RECOMMENDATIONS
### DIAGNOSTIC SUMMARY

#### AXIS I

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
<th>Description</th>
<th>Status Date</th>
<th>Status</th>
</tr>
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<tbody>
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#### AXIS II

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
<th>Description</th>
<th>Status Date</th>
<th>Status</th>
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#### AXIS III

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
<th>Description</th>
<th>Status Date</th>
<th>Status</th>
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<tbody>
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</table>

#### AXIS IV

- Economic problems
- Problem accessing healthcare
- Educational problems
- Occupational problems
- Housing problems

- Problem with primary support group
- Problem related to social environment
- Problem related to interaction with legal system
- Other psychosocial and environmental problems
- Behavioral / Personality issues

#### AXIS V

<table>
<thead>
<tr>
<th>CURRENT GAF</th>
<th>GAF DATE</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

### Diagnostic Summary

**CO-OCCURRING CONSUMER QUADRANT**

- Mild Psychopathology with Substance Abuse (Psych. Low/Substance Low)
- Psychiatically Complicated Substance Dependence (Psych. Low/Substance High)
- Serious & Persistent Mental Illness with Substance Abuse (Psych. High/Substance Low)
- Serious & Persistent Mental Illness with Substance Dependence (Psych. High/Substance High)

**DIAGNOSIS MADE BY (NAME/CREDS)**

**DIAGNOSIS EFFECTIVE DATE**

### DD PROXY

For purposes of these data elements, when the term 'support' is used, it means support from a paid or un-paid person or technological support needed to enable the individual to achieve his/her desired future. The kinds of support a person might need are:

- 'Limited' means the person can complete approximately 75% or more of the activity without support and the caregiver provides support for approximately 25% or less of the activity.
- 'Moderate' means the person can complete approximately 50% of the activity and the caregiver supports the other 50%.
• ‘Extensive’ means the person can complete approximately 25% of the activity and relies on the caregiver to support 75% of the activity.

• ‘Total’ means the person is unable to complete the activity and the caregiver is providing 100% of support.

### PREDOMINANT COMMUNICATION STYLE

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ English language spoken by the individual</td>
<td></td>
</tr>
<tr>
<td>☐ Assistive technology used</td>
<td>Includes computer, other electronic devices or symbols such as Bliss board, or other ‘low tech’ communication devices.</td>
</tr>
<tr>
<td>☐ Interpreter used</td>
<td>This includes a foreign language or American Sign Language (ASL) interpreter, or someone who knows the individual well enough to interpret speech or behavior.</td>
</tr>
<tr>
<td>☐ Alternative language used</td>
<td>This includes a foreign language, or sign language without an interpreter.</td>
</tr>
<tr>
<td>☐ Non-language forms of communication used</td>
<td>Gestures, vocalizations or behavior.</td>
</tr>
<tr>
<td>☐ No ability to communicate</td>
<td></td>
</tr>
<tr>
<td>☐ Unknown (Missing Value)</td>
<td></td>
</tr>
</tbody>
</table>

### ABILITY TO MAKE SELF UNDERSTOOD

Ability to communicate needs, both verbal and non-verbal, to family, friends, or staff.

*For reporting children 5 or younger—Report ‘Rarely or Never Understood’ when understanding is limited to interpretation of every person-specific sounds or body language and/or a child age 5 or younger is not yet using verbal or non-verbal communication.

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Always Understood</td>
<td>Expresses self without difficulty</td>
</tr>
<tr>
<td>☐ Usually Understood</td>
<td>Difficulty communicating BUT if given time and/or familiarity can be understood, little or no prompting required</td>
</tr>
<tr>
<td>☐ Often Understood</td>
<td>Difficulty communicating AND prompting usually required</td>
</tr>
<tr>
<td>☐ Sometimes Understood</td>
<td>Ability is limited to making concrete requests or understood only by a very limited number of people</td>
</tr>
<tr>
<td>☐ Rarely or Never Understood</td>
<td>Understanding is limited to interpretation of very person-specific sounds or body language</td>
</tr>
<tr>
<td>☐ Unknown (Missing Value)</td>
<td></td>
</tr>
</tbody>
</table>

### SUPPORT WITH MOBILITY

*For reporting children 5 or younger—Report ‘Moderate Support’ if a child scoots, crawls, creeps on hands and knees, or walks a few steps independently or when holding hands with caregiver. Report ‘Extensive Support’ if a child is primarily carried or transported by a caregiver.

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Independent</td>
<td>Able to walk (with or without an assistive device) or propel wheelchair and move about</td>
</tr>
<tr>
<td>☐ Guidance/Limited Support</td>
<td>Able to walk (with or without an assistive device) or propel wheelchair and move about with guidance, prompting, reminders, stand by support, or with limited physical support</td>
</tr>
<tr>
<td>☐ Moderate Support</td>
<td>May walk very short distances with support but uses wheelchair as primary method of mobility, needs moderate physical support to transfer, move the chair, and/or shift positions in chair or bed</td>
</tr>
<tr>
<td>☐ Extensive Support</td>
<td>Uses wheelchair exclusively, needs extensive support to transfer, move the wheelchair, and/or shift positions in chair or bed</td>
</tr>
<tr>
<td>☐ Total Support</td>
<td>Uses wheelchair with total support to transfer, move the wheelchair, and/or shift positions or may be unable to sit in a wheelchair; needs total support to shift positions throughout the day</td>
</tr>
<tr>
<td>☐ Unknown (Missing Value)</td>
<td></td>
</tr>
</tbody>
</table>

### MODE OF NUTRITIONAL INTAKE

*For reporting children 5 or younger—Report ‘Modified independent’ if child is bottle fed or eats foods specially prepared by the caregiver to accommodate current developmental needs.

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Normal</td>
<td>Swallows all types of foods</td>
</tr>
<tr>
<td>☐ Modified independent</td>
<td>e.g., liquid is sipped, takes limited solid food, need for modification may be unknown</td>
</tr>
<tr>
<td>☐ Requires diet modification to swallow solid food</td>
<td>e.g., mechanical diet (e.g., puree, minced) or only able to ingest specific foods</td>
</tr>
<tr>
<td>☐ Requires modification to swallow liquids</td>
<td>e.g., thickened liquids</td>
</tr>
<tr>
<td>☐ Can swallow only pureed solids AND thickened liquids</td>
<td></td>
</tr>
<tr>
<td>☐ Combined oral and parenteral or tube feeding</td>
<td></td>
</tr>
<tr>
<td>☐ Enteral feeding into stomach</td>
<td>e.g., G-tube or PEG tube</td>
</tr>
<tr>
<td>☐ Enteral feeding into jejunum</td>
<td>e.g., J-tube or PEG-J tube</td>
</tr>
<tr>
<td>☐ Parenteral feeding only</td>
<td></td>
</tr>
<tr>
<td>☐ Unknown (Missing Value)</td>
<td></td>
</tr>
</tbody>
</table>
Includes all types of parenteral feedings, such as total parenteral nutrition (TPN)

- Unknown (Missing Value)

### SUPPORT WITH PERSONAL CARE

Ability to complete personal care, including bathing, toileting, hygiene, dressing and grooming tasks, including the amount of help required by another person to assist. This measure is an overall estimation of the person’s ability in the category of personal care. If the person requires guidance only for all tasks but bathing, where he or she needs extensive support, score ‘Guidance/Limited Support’ to reflect the overall average ability. The person may or may not use assistive devices like shower or commode chairs, long-handled brushes, etc. Note: assistance with medication should NOT be included.

- **Independent**
  - Able to complete all personal care tasks without physical support

- **Guidance/Limited Support**
  - Able to perform personal care tasks with guidance, prompting, reminding or with limited physical support for less than 25% of the activity

- **Moderate Physical Support**
  - Able to perform personal care tasks with moderate support of another person

- **Extensive Support**
  - Able to perform personal care tasks with extensive support of another person

- **Total Support**
  - Requires full support of another person to complete personal care tasks (unable to participate in tasks)

- Unknown (Missing Value)

### RELATIONSHIPS

Indicate whether or not the individual has ‘natural supports’ defined as persons outside of the mental health system involved in his/her life who provide emotional support or companionship.

- **Extensive involvement, such as daily emotional support/companionship**
- **Moderate involvement, such as several times a month up to several times a week**
- **Limited involvement, such as intermittent or up to once a month**
- **Involved in planning or decision-making, but does not provide emotional support/companionship**
- **No involvement**

- Unknown (Missing Value)

### STATUS OF FAMILY/FRIEND SUPPORT SYSTEM

Indicate whether current (unpaid) family/friend caregiver status is at risk in the next 12 months; including instances of caregiver disability/illness, aging, and/or re-location. ‘At risk’ means caregiver will likely be unable to continue providing the current level of help, or will cease providing help altogether but no plan for replacing the caregiver’s help is in place.

- **Caregiver status is not at risk**
- **Caregiver is likely to reduce current level of help provided**
- **Caregiver is likely to cease providing help altogether**
- **Family/friends do not currently provide care**
- **Information unavailable**

- Unknown (Missing Value)

### SUPPORT FOR ACCOMMODATING CHALLENGING BEHAVIORS

Indicate the level of support the individual needs, if any, to accommodate challenging behaviors. ‘Challenging behaviors’ include those that are self-injurious, or place others at risk of harm. (Support includes direct line of sight supervision)

- **No challenging behaviors, or no support needed**
- **Limited Support, such as support up to once a month**
- **Moderate Support, such as support once a week**
- **Extensive Support, such as support several times a week**
- **Total Support - Intermittent, such as support once or twice a day**
- **Total Support - Continuous, such as full-time support**

- Unknown (Missing Value)

### PRESENCE OF A BEHAVIOR PLAN

Indicate the presence of a behavior plan during the past 12 months.

- **No Behavior Plan**
- **Positive Behavior Support Plan or Behavior Treatment Plan without restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee**
- **Behavior Treatment Plan with restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee**

- Unknown (Missing Value)
USE OF PSYCHOTROPIC MEDICATIONS
Fill in the number of anti-psychotic and other psychotropic medications the individual is prescribed. See the codebook for further definition of ‘anti-psychotic’ and ‘other psychotropic’ and a list of the most common medications.

<table>
<thead>
<tr>
<th>NUMBER OF ANTIPSYCHOTIC MEDICATIONS</th>
<th>NUMBER OF OTHER PSYCHOTROPIC MEDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric medications primarily used to manage psychosis.</td>
<td>Includes anti-convulsant, anti-anxiety, anti-depressant, ADHD, Bi-Polar, OCD and other psychiatric medications prescribed.</td>
</tr>
</tbody>
</table>

MAJOR MENTAL ILLNESS (MMI) DIAGNOSIS
This measure identifies major mental illnesses characterized by psychotic symptoms or severe affective symptoms. Indicate whether or not the individual has one or more of the following major mental illness diagnoses: Schizophrenia, Schizophreniform Disorder, or Schizoaffective Disorder (ICD code 295.xx); Delusional Disorder (ICD code 297.1); Psychotic Disorder NOS (ICD code 298.9); Psychotic Disorder due to a general medical condition (ICD codes 293.81 or 293.82); Dementia with delusions (ICD code 294.42); Bipolar I Disorder (ICD codes 296.0x, 296.4x, 296.5x, 296.6x, or 296.7); or Major Depressive Disorder (ICD codes 296.2x and 296.3x). The ICD code must match the codes provided above. Note: Any digit or no digit at all, may be substituted for each ‘x’ in the codes.

☐ One or more MMI diagnosis present
☐ No MMI diagnosis present
☒ Unknown (Missing Value)

LEVEL OF CARE/CARE RECOMMENDATION
INDICATE RECOMMENDED LEVEL OF CARE

INDICATE ESTIMATED LENGTH OF TREATMENT

SIGNATURES
STAFF SIGNATURE / CREDENTIALS

06/11/2015
Detroit Wayne Mental Health Authority
Integrated BioPsychosocial Assessment

IDENTIFYING INFORMATION

NAME
DOB
MEMBER ID
GENDER

ADDRESS

ASSESSMENT DATE
START TIME
AGE

CASE STATUS
□ New  □ Readmission
INTERVIEW TYPE
□ Face to Face  □ Phone

ASSESSMENT TYPE
□ Initial  □ Quarterly  □ Annual  □ Other

IDENTIFYING INFORMATION

□ SBIRT (screening, brief intervention & treatment) consumer

MEMBER ID
DATE OF BIRTH
DATE OF DEATH

GENDER
□ Female  □ Male  □ Transgender/Transsexual  □ Intersex  □ Questioning

FIRST NAME
MIDDLE NAME
LAST NAME
SSN

ALIASES AND OTHER IDENTIFYING INFORMATION

MEDICAID ID #
MI CHILD ID #

HOME ADDRESS
HOME PHONE
ALTERNATE PHONE
COUNTY OF RESIDENCE

PRIMARY SPOKEN LANGUAGE
COMMUNICATION PREFERENCE

REFERRAL SOURCE
RELIGION

RACE / ETHNIC ORIGIN 1
RACE / ETHNIC ORIGIN 2

RACE / ETHNIC ORIGIN 3
ETHNICITY

HISPANIC OR LATINO / LATINA
□ Yes  □ No  □ Unknown

MARITAL STATUS

□ Divorced  □ Married  □ Never Married
□ Widowed

MAIDEN NAME

PARENTAL STATUS

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

□ Yes  □ No

VETERAN STATUS

□ Yes  □ No  □ Unknown

CHILDREN & FAMILIES

Is Consumer a Child enrolled in Early On
Wraparound Service

□ Yes  □ No

DEPARTMENT OF HUMAN SERVICES

Is Consumer a Child served by DHS for abuse and neglect

□ Yes  □ No

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<table>
<thead>
<tr>
<th><strong>Is Consumer a Child served by another DHS program</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>ADOPTION SUBSIDY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>GUARDIAN OR LEGAL REPRESENTATION</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>WHO IS RESPONSIBLE FOR MAKING DECISIONS REGARDING CARE FOR THE INDIVIDUAL?</td>
</tr>
<tr>
<td>☐ Individual ☐ Parent ☐ Guardian or Legal Representative ☐ Power of Attorney</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PRIMARY GUARDIAN INFORMATION</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>LAST NAME</td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>RELATIONSHIP TO CONSUMER</td>
</tr>
<tr>
<td>☐ Mother</td>
</tr>
<tr>
<td>☐ Child</td>
</tr>
<tr>
<td>☐ Spouse</td>
</tr>
<tr>
<td>☐ Sibling</td>
</tr>
</tbody>
</table>

| ☐ CHECK IF ADDRESS IS SAME AS CONSUMER |
|-----------|----------------|
| PHONE NUMBER | ALTERNATIVE PHONE |

<table>
<thead>
<tr>
<th><strong>ADDITIONAL GUARDIAN NOTES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>DOES THE INDIVIDUAL HAVE AN ADVANCE DIRECTIVE?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No ☐ N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PRESENTING NEEDS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>BRIEFLY DESCRIBE THE PRESENTING NEEDS OF THE INDIVIDUAL (E.G., WHAT BROUGHT THE PERSON IN FOR SERVICES TODAY? HOW DOES THE PERSON VIEW THE REFERRAL? WHAT LED TO THE REFERRAL?)</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

| WHAT SUPPORTS/SERVICES ARE BEING REQUESTED TO HELP WITH THE PRESENTING NEEDS? |
### SOCIAL/NATURAL SUPPORTS

Please indicate the supports in the person's daily life (family, friends, parent, others, etc.):

<table>
<thead>
<tr>
<th>Name of Support</th>
<th>Relationship</th>
<th>State how this person helps the individual achieve their goals</th>
</tr>
</thead>
</table>

- **No Natural Supports**

- **IS THE INDIVIDUAL SATISFIED WITH THEIR SUPPORTS?**
  - Yes
  - No

- **IS THERE A NEED TO CHANGE OR INCREASE SUPPORTS?**
  - Yes
  - No

- **DOES THE INDIVIDUAL HAVE A SIGNIFICANT OTHER/FRIEND/SPouse CURRENTLY?**
  - Yes
  - No

- **HAS THE INDIVIDUAL LOST OR SEPARATED FROM A SIGNIFICANT OTHER/SPouse?**
  - Yes
  - No

- **HAS THE INDIVIDUAL LOST ANY CLOSE RELATIVES/FAMILY MEMBERS/FRIENDS?**
  - Yes
  - No

- **HAS THE INDIVIDUAL LOST ANY PETS/ANIMALS?**
  - Yes
  - No

- **WHAT WERE THE INDIVIDUALS LIVING ARRANGEMENTS AS A CHILD?**

### COMMUNITY INVOLVEMENT

WHAT DOES THE INDIVIDUAL DO DURING A TYPICAL DAY? HOW DOES THE INDIVIDUAL SPEND THEIR DAY?

WHAT ACTIVITIES/HOBBIES DOES THE INDIVIDUAL ENJOY?

WOULD THE INDIVIDUAL LIKE TO INCREASE COMMUNITY INVOLVEMENTS OR DAILY ACTIVITIES?

- Yes
  - No

### MENTAL HEALTH SYMPTOMS

DURING THE PAST MONTH, HAVE YOU FELT DEPRESSED, SAD, OR HOPELESS MOST DAYS?

- Yes
  - No
HAVE YOU LOST INTEREST IN OR GOT LESS PLEASURE FROM THE THINGS YOU USED TO ENJOY?
☐ Yes  ☐ No

DO YOU FEEL YOU ARE A NERVOUS PERSON?
☐ Yes  ☐ No

IS IT HARD FOR YOU TO CONTROL YOUR WORRY?
☐ Yes  ☐ No

DO YOU FEEL HYPER OR HIGH (LIKE ON DRUGS) EVEN THOUGH YOU HAVEN'T TAKEN ANY?
☐ Yes  ☐ No

DO YOU HAVE TIMES WHEN YOUR THOUGHTS RACE OR YOU HAVE LESS NEED FOR SLEEP LASTING MORE THAN A WEEK?
☐ Yes  ☐ No

HAVE YOU HAD THOUGHTS OR PLANS TO HURT YOURSELF OR OTHERS DURING THE PAST TWO WEEKS?
☐ Yes  ☐ No

DO YOU FEEL YOU ARE IN CRISIS AND MAY NEED TO BE IN THE HOSPITAL?
☐ Yes  ☐ No

HAVE YOU EVER BELIEVED THAT PEOPLE WERE SPYING ON YOU, OR THAT SOMEONE WAS PLOTTING AGAINST YOU, OR TRYING TO HURT YOU?
☐ Yes  ☐ No

HAVE YOU EVER FELT LIKE OTHERS COULD READ YOUR MIND OR CONTROL YOUR THOUGHTS?
☐ Yes  ☐ No

HAVE YOU EVER HEARD VOICES OR SEEN THINGS THAT OTHER PEOPLE COULD NOT HEAR OR SEE?
☐ Yes  ☐ No

HAVE YOU EVER BELIEVED YOU WERE BEING SENT SPECIAL MESSAGES THROUGH THE TV, RADIO, OR NEWSPAPER?
☐ Yes  ☐ No

Please indicate which screening tool was used and provide score:
Adult Screening - SCORE:  

SUBSTANCE USE HISTORY

IS THERE A FAMILY HISTORY OF SUBSTANCE USE?
☐ Yes  ☐ No

ALCOHOL USE

DO YOU SOMETIMES USE BEER, WINE, OR OTHER ALCOHOL WHERE YOU OR SOMEONE CLOSE TO YOU FEELS THERE IS A PROBLEM OR THERE HAVE BEEN LEGAL CONSEQUENCES?
☐ Yes  ☐ No

ABOUT HOW MANY TIMES IN THE PAST THREE MONTHS HAVE YOU HAD 4 OR MORE DRINKS CONTAINING ALCOHOL A DAY?

DRUG USE

DO YOU SOMETIMES USE ANY DRUGS FOR RECREATIONAL USE (SUCH AS MARIJUANA, COCAINE, CRACK, HEROIN) OR TAKE PRESCRIPTION MEDICATION MORE OFTEN THAN PRESCRIBED?
☐ Yes  ☐ No

ABOUT HOW MANY TIMES IN THE PAST THREE MONTHS HAVE YOU USED ANY DRUGS OR MISUED ANY PRESCRIPTION MEDICATIONS?

If above questions are positive for alcohol or drug use, complete full screening tool and provide score:
AUDIT (Alcohol) Score:  
DAST (Drug Use) Score:  

CLIENT SUBSTANCES

Key
Drug of Choice:  
1 = First Choice - 10 = Last Choice
Number of Days used in the Last 30 Days:  
0 = Not Used; 1-29 = No. of Days; 30 = Daily
Method Of Current Dosing:  
1 = Oral; 2 = Smoking; 3 = Snorting; 4 = IV; 5 = Other

<table>
<thead>
<tr>
<th>Type of Drug and Name</th>
<th>Drug of Choice</th>
<th>Age First Use</th>
<th>Age Problematic use</th>
<th>Init. Rx</th>
<th>1) Heaviest Amount Consumed and When</th>
<th>2) Current Consumption</th>
<th>Approx. Date of Last Use</th>
<th>Number of days drug used in the last 30 days</th>
<th>Method of Dosing</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

ASAM CRITERIA

☐ Section N/A
### Dimension 1: Acute Intoxication and/or Withdrawal Potential
- **Low**
- **Moderate**
- **High**

### Dimension 2: Biomedical Conditions and Complications
- **Low**
- **Moderate**
- **High**

### Dimension 3: Emotional, Behavioral/Cognitive Conditions and Complications
- **Low**
- **Moderate**
- **High**

### Dimension 4: Readiness to Change
- **Low**
- **Moderate**
- **High**

### Dimension 5: Relapse, Continued Use, or Continued Problem Potential
- **Low**
- **Moderate**
- **High**

### Dimension 6: Recovery Environment
- **Low**
- **Moderate**
- **High**

---

**Does the individual attend any support-type meetings, such as AA, NA, or DRA?**
- **Yes**
- **No**

**Is there a family history of alcohol or drug use?**
- **Yes**
- **No**

---

**GAMBLING**

**Have you ever gambled, like lottery, cards, dice, or horses?**
- **Yes**
- **No**

**Have you ever tried to stop or cut back on how much or how often you gamble?**
- **Yes**
- **No**

---

**Risk and Safety Assessment**

**Any at-risk behaviors?**
- **Yes**
- **No**

**Explain**

**Any physical or verbal aggression?**
- **Yes**
- **No**

**Explain**
ANY SELF-INJURIOUS BEHAVIORS?
☐ Yes  ☐ No
EXPLAIN

ANY RISK OR SAFETY ISSUES WITH SCHOOL (FOR CHILDREN)?
☐ Yes  ☐ No
EXPLAIN

ANY RISK OR SAFETY ISSUES WITH COMMUNITY?
☐ Yes  ☐ No
EXPLAIN

ANY RISK OR SAFETY ISSUES WITH HOME ENVIRONMENT?
☐ Yes  ☐ No
EXPLAIN

ANY RISK OR SAFETY ISSUES WITH WORK ENVIRONMENT?
☐ Yes  ☐ No
EXPLAIN

ANY PHYSICAL ACTIVITIES THAT PUT THE INDIVIDUAL AT RISK?
☐ Yes  ☐ No
EXPLAIN

ARE THERE ANY WEAPONS IN THE HOME?
☐ Accessible  ☐ Locked  ☐ No
EXPLAIN

DOES THE INDIVIDUAL HAVE ACCESS TO ANY OTHER WEAPONS?
☐ Yes  ☐ No
EXPLAIN

IS THERE A HISTORY OF SUICIDAL IDEATION?
☐ Yes  ☐ No
EXPLAIN

IS A CRISIS SCREENING NEEDED IMMEDIATELY?
☐ Yes  ☐ No
IS IMMEDIATE INTERVENTION FOR RISK/SAFETY NEEDED? IF YES, PLAN?
☐ Yes  ☐ No
EXPLAIN

IS THERE A CRISIS PLAN?
☐ Yes  ☐ No
EXPLAIN

IS THERE A HISTORY OF HOMICIDAL IDEATION?
☐ Yes  ☐ No
EXPLAIN

INTELLECTUAL/DEVELOPMENTAL HISTORY
☐ No reported history of intellectual/developmental disability

BRIEFLY DESCRIBE THE PRESENTING SYMPTOM(S) OF THE INTELLECTUAL/DEVELOPMENTAL DISABILITY:

WHAT YEAR AND AT WHAT AGE WAS THE INDIVIDUAL INITIALLY DETERMINED TO HAVE AN INTELLECTUAL/DEVELOPMENTAL DISABILITY?

WHERE DID THE EVALUATION DETERMINATION OCCUR AND WHY?
WHAT WAS THE ORIGINAL DIAGNOSIS?

BEHAVIOR TREATMENT PLAN

DOES THE INDIVIDUAL REQUIRE A REFERRAL FOR A BEHAVIORAL ASSESSMENT?
☐ Yes  ☐ No

IF YES, EXPLAIN AND PROVIDER REFERRAL INFORMATION:

HAS THE INDIVIDUAL EVER HAD A BEHAVIOR TREATMENT PLAN?
☐ Yes  ☐ No  ☐ N/A

BRIEFLY DESCRIBE HISTORY IF APPLICABLE:
### TRAUMA HISTORY

**Have you ever been involved in a traumatic event that caused you to fear for your life? (E.g., sexual assault, physical attack, military combat, robbery, severe car accident, or sexual assault as a child)**
- [ ] Yes    [ ] No
  - [ ] Child
  - [ ] Adult
  - [ ] Ongoing

**Explain if needed**

**History of emotional abuse? (E.g., someone repeatedly made you feel bad through harsh words)**
- [ ] Yes    [ ] No
  - [ ] Child
  - [ ] Adult
  - [ ] Ongoing

**Explain if needed**

**History of physical abuse? (E.g., someone repeatedly caused you physical harm)**
- [ ] Yes    [ ] No
  - [ ] Child
  - [ ] Adult
  - [ ] Ongoing

**Explain if needed**

**History of sexual abuse? (E.g., someone forced sexual advances or acts)**
- [ ] Yes    [ ] No
  - [ ] Child
  - [ ] Adult
  - [ ] Ongoing

**Explain if needed**

**History of neglect? (E.g., a caretaker denied basic needs, such as adequate food, clothes, and supervision)**
- [ ] Yes    [ ] No
  - [ ] Child
  - [ ] Adult
  - [ ] Ongoing

**Explain if needed**

**History of violence? (E.g., the use of physical force against oneself, another person, or a community, which has a high likelihood of resulting in injury, death, or psychological harm)**
- [ ] Yes    [ ] No
  - [ ] Child
  - [ ] Adult
  - [ ] Ongoing

**Explain if needed**

**History of domestic violence? (E.g., a pattern of abusive behavior in an intimate relationship, which is used by one partner to gain or maintain power and control over another partner)**
- [ ] Yes    [ ] No
  - [ ] Child
  - [ ] Adult
  - [ ] Ongoing

**Explain if needed**

**History of bullying? (E.g., unwanted and repeated aggressive behavior among school aged children that involves a real or perceived power imbalance. Includes verbal and/or physical abuse)**
- [ ] Yes    [ ] No
### HISTORY OF PRIOR TREATMENT SERVICES

List of hospitals, CMH providers, DHS involvement

<table>
<thead>
<tr>
<th>Treatment Provider</th>
<th>Location</th>
<th>Reason</th>
<th>Date/LOS</th>
<th>Did the individual find the treatment helpful?</th>
</tr>
</thead>
</table>

### PHYSICAL HEALTH HISTORY

**INDIVIDUAL’S REPORTED CURRENT HEALTH STATUS:**
- [ ] Excellent
- [ ] Good
- [ ] Fair
- [ ] Poor

**DOES THE INDIVIDUAL HAVE ANY DIAGNOSED PHYSICAL ILLNESS OR CONDITION(S)? CHECK ALL THAT APPLY.**

- [ ] Allergies
- [ ] Chronic fatigue
- [ ] Endometriosis
- [ ] Heart disease
- [ ] Multiple sclerosis
- [ ] Ulcers

- [ ] Anemia
- [ ] Chronic pain
- [ ] Fibromyalgia
- [ ] Hepatitis
- [ ] Renal failure

- [ ] Arrhythmias
- [ ] COPD
- [ ] Gastritis
- [ ] Hernia
- [ ] Sleep apnea

- [ ] Arthritis
- [ ] Crohns disease
- [ ] Gout
- [ ] HIV/AIDS
- [ ] Stroke

- [ ] Cancer
- [ ] Eating Disorder
- [ ] Headache/migraines
- [ ] Menopause
- [ ] Tuberculosis

- [ ] Other

**HAVE ANY OF THE INDIVIDUAL’S IMMEDIATE FAMILY MEMBERS OR DECEASED RELATIVES (PARENTS, SIBLINGS) HAD ANY OF THE FOLLOWING CONDITIONS? CHECK ALL THAT APPLY.**

- [ ] Asthma
- [ ] Allergies
- [ ] Heart Disease
- [ ] Hypertension
- [ ] Substance use

- [ ] Cancer
- [ ] COPD
- [ ] Stroke
- [ ] Suicide

- [ ] Diabetes
- [ ] Mental health

### ADVERSE REACTIONS

<table>
<thead>
<tr>
<th>DRUG / ALLERGEN</th>
<th>REPORTED BY</th>
<th>SEVERITY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>[ ] Not Assessed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Mild</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Severe</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Life-Threatening</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] This is an Allergy</td>
</tr>
</tbody>
</table>

**NOTES**

START

### HEALTH INDICATORS AND OTHER CONDITIONS FOR ALL POPULATIONS

### HEARING

**ABILITY TO HEAR (WITH HEARING APPLIANCE NORMALLY USED)**

- [ ] Adequate
  - No difficulty in normal conversation, social interaction, listening to TV
- [ ] Minimal difficulty
  - Difficulty in some environments (e.g., when person speaks softly or is more than 6 feet away)
- [ ] Moderate difficulty

---

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**Problem hearing normal conversation, requires quiet setting to hear well**

- [ ] Severe difficulty
  - Difficulty in all situations (e.g., speaker has to talk loudly or speak very slowly; or person reports that all speech is mumbled)
- [ ] No hearing

**HEARING AID USED**
- [ ] Yes
- [ ] No

### VISION

**ABILITY TO SEE IN ADEQUATE LIGHT (WITH GLASSES OR WITH OTHER VISUAL APPLIANCE NORMALLY USED)**

- [ ] Adequate
  - Sees fine detail, including regular print in newspapers/books or small items in pictures
- [ ] Minimal difficulty
  - Sees large print, but not regular print in newspapers/books or cannot identify large objects in pictures
- [ ] Moderate difficulty
  - Limited vision; not able to see newspaper headlines or small items in pictures, but can identify objects in his/her environment
- [ ] Severe difficulty
  - Object identification in question, but the person's eyes appear to follow objects, or the person sees only light, colors, shapes
- [ ] No vision
  - Eyes do not appear to follow objects; absence of sight

**VISUAL APPLIANCE**
- [ ] Yes
- [ ] No

### HEALTH CONDITIONS

Indicate whether or not the individual had the presence of each of the following health conditions, as reported by the individual, a health care professional or family member, in the past 12 months.

**PNEUMONIA (2 OR MORE TIMES) - INCLUDING ASPIRATION PNEUMONIA**
- [ ] Never present
- [ ] History of condition, but not treated for the condition within the past 12 months
- [ ] Treated for the condition within the past 12 months
- [ ] Information unavailable

**ASTHMA**
- [ ] Never present
- [ ] History of condition, but not treated for the condition within the past 12 months
- [ ] Treated for the condition within the past 12 months
- [ ] Information unavailable

**UPPER RESPIRATORY INFECTIONS (3 OR MORE TIMES WITHIN PAST 12 MONTHS)**
- [ ] Never present
- [ ] History of condition, but not treated for the condition within the past 12 months
- [ ] Treated for the condition within the past 12 months
- [ ] Information unavailable

**GASTROESOPHAGEAL REFLUX, OR GERD**
- [ ] Never present
- [ ] History of condition, but not treated for the condition within the past 12 months
- [ ] Treated for the condition within the past 12 months
- [ ] Information unavailable

**CHRONIC BOWEL IMPACTIONS**
- [ ] Never present
- [ ] History of condition, but not treated for the condition within the past 12 months
- [ ] Treated for the condition within the past 12 months
- [ ] Information unavailable

**SEIZURE DISORDER OR EPILEPSY**
- [ ] Never present
- [ ] History of condition, but not treated for the condition within the past 12 months
- [ ] Treated for the condition within the past 12 months and seizure free
- [ ] Treated for the condition within the past 12 months, but still experience occasional seizures (less than one per month)
- [ ] Treated for the condition within the past 12 months, but still experience frequent seizures
- [ ] Information unavailable

**PROGRESSIVE NEUROLOGICAL DISEASE, INCLUDE, ALZHEIMER'S AND PARKINSON'S DISEASE**
- [ ] Not present
- [ ] Treated for the condition within the past 12 months
- [ ] Information unavailable

**DIABETES**
- [ ] Never present
- [ ] History of condition, but not treated for the condition within the past 12 months
- [ ] Treated for the condition within the past 12 months
- [ ] Information unavailable

**HYPERTENSION**
- [ ] Never present
- [ ] History of condition, but not treated for the condition within the past 12 months

06/11/2015
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Treated for condition within the past 12 months and blood pressure is stable</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Treated for condition within the past 12 months, but blood pressure remains high or unstable</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Information is unavailable</strong></td>
<td></td>
</tr>
<tr>
<td><strong>OBESITY</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Not present</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Medical diagnosis of obesity present or Body Mass Index (BMI) &gt; 30</strong></td>
<td></td>
</tr>
</tbody>
</table>

**DO YOU HAVE A PRIMARY CARE DOCTOR/FAMILY PHYSICIAN/PEDIATRICIAN THAT YOU ARE SEEING?**
- Yes
- No

**PRIMARY CARE PHYSICIAN**

**WHEN WAS THE LAST TIME THE INDIVIDUAL SAW A PRIMARY CARE DOCTOR/FAMILY PHYSICIAN/PEDIATRICIAN?**

**IS A REFERRAL NEEDED TO GET THE INDIVIDUAL SET UP WITH A PHYSICAL HEALTH DOCTOR?**
- Yes
- No

**WHEN WAS THE LAST TIME THE INDIVIDUAL SAW A DENTIST?**

**WHEN WAS THE LAST TIME THE INDIVIDUAL HAD AN EYE EXAM?**

**IS THE INDIVIDUAL CURRENT ON ALL VACCINES/IMMUNIZATIONS?**
- Yes
- No
- Referral Needed

**HISTORY OF CHRONIC PAIN**

**HAVE YOU HAD CHRONIC PAIN (I.E., PAIN FOR MORE THAN 6 MONTHS)?**
- Yes
- No
- Current
- Past

**WHERE IS THE PAIN LOCATED?**

**HOW LONG HAVE YOU HAD THIS PAIN? WHEN DID THE PAIN FIRST START?**

**HOW OFTEN DO YOU EXPERIENCE THE PAIN? (I.E., WEEKLY, DAILY, 2-3 TIMES PER DAY, ETC.)?**

**HOW LONG, DURING A TYPICAL DAY WHEN YOU EXPERIENCE PAIN, DOES THE PAIN LAST FOR?**

**HOW SEVERE IS THE PAIN (ON A SCALE FROM 0 TO 10, WITH 10 BEING THE WORSE)?**

**HOW DO YOU MANAGE THIS PAIN? PLEASE LIST ALL SOURCES (E.G., MEDICATION, EXERCISE, RELAXATION, ACUPUNCTURE, ETC.)**

**DIET AND EXERCISE**

**DO YOU THINK YOU EAT A HEALTHY DIET (REGULAR MEALS, FRUITS, VEGETABLES, MINIMUM TAKEOUT/RESTAURANTS)?**
- Yes
- No

**DO YOU THINK YOU TAKE PART IN ANY PHYSICAL ACTIVITY OR EXERCISE (INCLUDING WALKING, CYCLING, GARDENING)?**
- Yes
- No

**HOW OFTEN DO YOU EXERCISE OR ENGAGE IN PHYSICAL ACTIVITY DURING A TYPICAL WEEK (INDICATE HOW MANY TIMES PER WEEK, AND MINUTES/HOURS PER WEEK)?**

**SMOKING HABITS**

**DO YOU SMOKE CIGARETTES OR TOBACCO?**
- Yes
- No

**IF YES, HOW MUCH DO YOU SMOKE PER DAY? (AMOUNT)**

**AND HOW LONG HAVE YOU SMOKED FOR? (MONTHS/YEARS)**

**IF NO, HAVE YOU EVER SMOKED IN THE PAST?**
- Yes
- No

**IF YES, FOR HOW LONG? (MONTHS/YEARS)**

**HAVE YOU TRIED TO STOP SMOKING IN THE PAST?**
- Yes
- No

**DO YOU WANT TO STOP SMOKING NOW?**
- Yes
- No

**SEXUAL ACTIVITIES**

**ARE YOU SEXUALLY ACTIVE?**
- Yes
- No
- Prefer Not To Answer
<table>
<thead>
<tr>
<th>ARE YOU USING A METHOD OF PROTECTION DURING SEXUAL ACTIVITIES TO REDUCE YOUR RISK OF SEXUALLY TRANSMITTED INFECTIONS AND/OR PREGNANCY (E.G., CONDOMS, DENTAL DAMS, CONTRACEPTIVES, ETC.)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No ☐ Prefer Not To Answer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ARE YOU AWARE OF THE RISKS OF SEXUALLY TRANSMITTED INFECTIONS SUCH AS HEPATITIS, HIV/AIDS, SYPHILIS, ETC.?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No ☐ Prefer Not To Answer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HAVE YOU EVER HAD UNPROTECTED SEX OR ENGAGED IN SEXUAL BEHAVIORS (ORAL, ANAL, GENITAL) WITH A PERSON WHOSE HIV, HEPATITIS, OR STI STATUS WAS UNKNOWN TO YOU (SUCH AS SEX WHEN DRUNK OR HIGH WITH SOMEONE YOU DID NOT KNOW VERY WELL)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No ☐ Unsure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HAVE YOU EVER ENGAGED IN SEXUAL BEHAVIORS WITH ANYONE WHO HAS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No ☐ Unsure</td>
</tr>
<tr>
<td>INJECTED DRUGS?</td>
</tr>
<tr>
<td>☐ Yes ☐ No ☐ Unsure</td>
</tr>
<tr>
<td>TRADED SEX FOR DRUGS?</td>
</tr>
<tr>
<td>☐ Yes ☐ No ☐ Unsure</td>
</tr>
<tr>
<td>MANY SEXUAL PARTNERS?</td>
</tr>
<tr>
<td>☐ Yes ☐ No ☐ Unsure</td>
</tr>
<tr>
<td>HIV/AIDS?</td>
</tr>
<tr>
<td>☐ Yes ☐ No ☐ Unsure</td>
</tr>
<tr>
<td>HEPATITIS?</td>
</tr>
<tr>
<td>☐ Yes ☐ No ☐ Unsure</td>
</tr>
<tr>
<td>STI'S?</td>
</tr>
<tr>
<td>☐ Yes ☐ No ☐ Unsure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HAVE YOU EVER EXPERIENCED OTHER FORMS OF BLOOD-TO-BLOOD OR BODILY FLUID CONTACT (FOR EXAMPLE, BLOOD TRANSFUSIONS, HEMOPHILIA TREATMENTS, EMPLOYMENT IN MEDICAL FIELD, ETC.) AND HAVE CONCERNS ABOUT YOUR RISK FOR HIV, HEPATITIS, OR STI'S?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No ☐ Unsure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WOULD THE INDIVIDUAL LIKE FURTHER INFORMATION ON ANY SEXUAL HEALTH ISSUES?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VITALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>COLLECTION INFORMATION</td>
</tr>
<tr>
<td>COLLECTION DATE</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GENERAL INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEIGHT:</td>
</tr>
<tr>
<td>WEIGHT:</td>
</tr>
<tr>
<td>WAIST CIRCUMFERENCE:</td>
</tr>
<tr>
<td>BMI:</td>
</tr>
<tr>
<td>COMMENTS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REPRODUCTIVE HEALTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREGNANT:</td>
</tr>
<tr>
<td>☐ Yes ☐ No ☐ N/A</td>
</tr>
<tr>
<td>LAST MONTHLY PERIOD DATE</td>
</tr>
<tr>
<td>BIRTH CONTROL METHOD</td>
</tr>
<tr>
<td>IF OTHER, EXPLAIN:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TOBACCO USE</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMOKING STATUS:</td>
</tr>
<tr>
<td>☐ Declined</td>
</tr>
</tbody>
</table>
OTHER TOBACCO USE:

**PROVIDED CONSUMER WITH ADVICE TO QUIT SMOKING OR TOBACCO USE, OR RECOMMENDED OR DISCUSSED SMOKING OR TOBACCO USE CESSATION, MEDICATIONS, METHODS, OR STRATEGIES**

- Yes
- No

### TEMPERATURE

**VALUE:**

- Declined
- No Information Collected

**SITE:**

- Axillary
- Rectal
- Non-invasive thermometer
- Oral
- Temporal
- Tympanic

**COMMENTS**

### PULSE

**VALUE:**

- Declined
- No Information Collected

**RHYTHM:**

- Irregular
- Regular

**FORCE:**

- Bounding
- Normal
- Thready
- Weak

**METHOD USED:**

- Machine
- Manual

**SITE:**

- Apical (over heart)
- Femoral (inner thigh)
- Brachial (upper arm)
- Popliteal (behind knee)
- Cartoid (neck)
- Radial (wrist)

**COMMENTS**

### RESPIRATION

**VALUE:**

- Declined
- No Information Collected

**LUNG SOUNDS:**

- Clear
- Rales
- Rhonchi
- Wheeze
- Other

**COMMENTS**

### BLOOD PRESSURE

**Sitting**

- **Systolic** mmHg
- **Diastolic** mmHg

**Standing**

- **Systolic** mmHg
- **Diastolic** mmHg

**METHOD USED:**

- Machine
- Manual

**COMMENTS**

06/11/2015
### RESULTS OF BREATHALYZER & URINE DRUG SCREEN (UDS)

**BAC (BLOOD ALCOHOL CONTENT):**

**URINE DRUG SCREEN RESULTS**

**BLOOD GLUCOSE RESULTS**

- Declined
- No Information Collected

**COMMENTS**

### REACTION:

- Cooperative
- Declined
- Resisted (Uncooperative)

**COMMENTS**

### PRESCRIBED MEDICATIONS

### OTHER MEDICATIONS

**DO YOU HAVE ANY PROBLEMS WITH ANY OF THESE MEDICATIONS (SIDE EFFECTS)?**

- Yes
- No

**IF YES, PLEASE EXPLAIN:**

### LEGAL ISSUES

### CORRECTIONS RELATED STATUS
Most Recent Offense

<table>
<thead>
<tr>
<th>JUDGE NAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>COURT:</td>
</tr>
<tr>
<td>CMO AGENCY NAME:</td>
</tr>
<tr>
<td>PAROLE OFFICER NAME:</td>
</tr>
<tr>
<td>PROBATION OFFICER NAME:</td>
</tr>
</tbody>
</table>

RETURNING CITIZEN (RELEASE FROM INCARCERATION - NO PROBATION/PAROLE)?

☐ Yes  ☐ No

CMO CONTACT INFORMATION:

---

EDUCATION

☐ Not Applicable

EDUCATION HISTORY

☐ Unreported
☐ Completed less than high school
☐ Completed special education, high school, or GED
☐ In school - Kindergarten through 12th grade
☐ In training program
☐ In Special Education
☐ Attended or is attending undergraduate college
☐ College graduate

HIGHEST GRADE

---

DOES THE CHILD/INDIVIDUAL NEED ASSISTANCE TO ACHIEVE EDUCATION/WORK GOALS?

☐ Yes  ☐ No

IF YES, EXPLAIN:

---

DOES THE FAMILY NEED ASSISTANCE TO HELP WITH INDIVIDUAL ACHIEVING EDUCATION AND/OR WORK GOALS?

☐ Yes  ☐ No

IF YES, EXPLAIN:
### EMPLOYMENT

<table>
<thead>
<tr>
<th>EMPLOYMENT STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Employed full time (30 hours or more per week) competitively or self-employed.</td>
</tr>
<tr>
<td>□ Employed part time (less than 30 hours per week) in competitively or self-employed.</td>
</tr>
<tr>
<td>□ Unemployed - looking for work, and/or on layoff from job</td>
</tr>
<tr>
<td>□ Sheltered workshop or work services participant in non-integrated setting</td>
</tr>
<tr>
<td>□ In unpaid work (e.g. volunteering, internship, community service)</td>
</tr>
<tr>
<td>□ Self-employed (e.g. micro-enterprise).</td>
</tr>
<tr>
<td>□ In enclaves/mobile crews, agency-owned transitional employment.</td>
</tr>
<tr>
<td>□ Participates in facility-based activity program where an array of specialty supports and services are provided to assist an individual in achieving his/her non-work related goals</td>
</tr>
<tr>
<td>□ Not in the competitive labor force - includes homemaker, child, student age 18 and over, retired from work, resident of an institution (including nursing home), or incarcerated.</td>
</tr>
</tbody>
</table>

**EARNED WAGE IS MINIMUM WAGE OR GREATER**

- □ Yes
- □ No
- □ N/A - Person is not working

### CULTURE/SPirituality/RELIGION

**DOES THE INDIVIDUAL IDENTIFY CULTURAL, SPIRITUAL, OR RELIGIOUS VALUES THAT PLAY A ROLE IN THEIR LIFE WHERE THEY WOULD PREFER SERVICES SPECIFIC TO THEIR CULTURE VALUES?**

- □ Yes
- □ No

**IF YES, PLEASE EXPLAIN:**

### CURRENT LIVING ARRANGEMENTS

**RESIDENTIAL LIVING ARRANGEMENT**

- FOSTER CARE FACILITY / LICENSE #

**DESCRIBE ANY CONCERNS/ISSUES WITH CURRENT LIVING SITUATION (INDICATE APPROPRIATENESS, MOBILITY, RESTRICTIVENESS, ACCESSIBILITY, CAREGIVER CONCERNS)**
DO YOU HAVE ANYONE LIVING IN YOUR HOME WHO IS DEPENDENT ON YOU?
☐ Yes  ☐ No
IF YES, PLEASE LIST AGE, RELATION, AND NAME OF PERSON(S).

TRANSPORTATION
ARE THERE ANY CONCERNS OR PROBLEMS RELATED TO TRANSPORTATION?
☐ Yes  ☐ No
ASSESSMENT OF TRANSPORTATION NEEDS:
EXPLAIN IF NECESSARY

MENTAL STATUS
IS INDIVIDUAL ORIENTED TO: (CHECK ALL THAT APPLY):

<table>
<thead>
<tr>
<th>INDIVIDUAL</th>
<th>PLACE</th>
<th>TIME</th>
<th>SITUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
</tbody>
</table>
EXPLAIN IF NECESSARY

GROOMING
☐ Excellent  ☐ Good  ☐ Marginal  ☐ Poor

HYGIENE
☐ Excellent  ☐ Good  ☐ Marginal  ☐ Poor

DRESS
☐ Inappropriate to Weather  ☐ Unkempt  ☐ Unusual  ☐ Unremarkable

MEMORY
☐ Impaired Immediate  ☐ Impaired Recent  ☐ Impaired Remote  ☐ Not Determined
EXPLAIN IF NECESSARY

AWARENESS
☐ Alert  ☐ Dull  ☐ Stupor
EXPLAIN IF NECESSARY

CONCENTRATION
☐ Normal  ☐ Able to Focus  ☐ Distractible
EXPLAIN IF NECESSARY

JUDGMENT
☐ Good  ☐ Fair  ☐ Poor

EXPLAIN IF NECESSARY

INSIGHT
☐ None  ☐ Limited  ☐ Insightful

EXPLAIN IF NECESSARY

HALLUCINATIONS: (CHECK ALL THAT APPLY)
☐ N/A  ☐ Auditory  ☐ Visual  ☐ Other

EXPLAIN IF NECESSARY

THOUGHT PROCESS: (CHECK ALL THAT APPLY)
☐ Unremarkable  ☐ Obsessions  ☐ Compulsions  ☐ Paranoid  ☐ Irrational
☐ Peculiar  ☐ Loosely Organized  ☐ Illogical  ☐ Other (explain)

EXPLAIN IF NECESSARY

STREAM OF MENTAL ACTIVITY:
☐ Normal  ☐ Delayed Reponse  ☐ Perseverating  ☐ Circumstantial  ☐ Tangential
☐ Flight of Ideas  ☐ Slowed  ☐ Racing  ☐ Blocked  ☐ Other (explain)

EXPLAIN IF NECESSARY

CHARACTERISTICS OF SPEECH:
☐ Unremarkable  ☐ Soft  ☐ Loud  ☐ Pressured  ☐ Nonverbal
☐ Stuttering  ☐ Incoherent  ☐ Other (explain)

EXPLAIN IF NECESSARY

PRESENTATION DURING THE INTERVIEW:
☐ Unremarkable  ☐ Embarrassed  ☐ Seductive  ☐ Impulsive  ☐ Dramatic
☐ Needy  ☐ Guarded  ☐ Other (explain)

EXPLAIN IF NECESSARY

EMOTIONAL STATE / AFFECT / REACTION:
☐ Appropriate  ☐ Inappropriate  ☐ Irritable  ☐ Angry  ☐ Calm
☐ Sad  ☐ Depressed  ☐ Anxious  ☐ Absence of Emotions  ☐ Unstable Emotions
☐ Emotions are Incongruent with Thought Content  ☐ Other (explain)
**AXIS II**

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
<th>Description</th>
<th>Status Date</th>
<th>Status</th>
</tr>
</thead>
</table>

**AXIS III**

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
<th>Description</th>
<th>Status Date</th>
<th>Status</th>
</tr>
</thead>
</table>

**AXIS IV**

- Economic problems
- Problem accessing healthcare
- Educational problems
- Occupational problems
- Problem with primary support group
- Problem related to social environment
- Problem related to interaction with legal system
- Problem accessing healthcare
- Problem related to social environment
- Problem related to interaction with legal system
- Problem related to interaction with legal system
- Problem related to social environment
- Limited
- Moderate
- Extensive
- Total

**AXIS V**

<table>
<thead>
<tr>
<th>CURRENT GAF</th>
<th>GAF DATE</th>
</tr>
</thead>
</table>

**Diagnostic Summary**

**Additional Information**

- Mild Psychopathology with Substance Abuse (Psych. Low/Substance Low)
- Psychiatrically Complicated Substance Dependence (Psych. Low/Substance High)
- Serials & Persistent Mental Illness with Substance Abuse (Psych. High/Substance Low)
- Serials & Persistent Mental Illness with Substance Dependence (Psych. High/Substance High)

**DIAGNOSIS MADE BY (NAME/CREDENTIALS) | DIAGNOSIS EFFECTIVE DATE**

**DD PROXY**

For purposes of these data elements, when the term 'support' is used, it means support from a paid or un-paid person or technological support needed to enable the individual to achieve his/her desired future. The kinds of support a person might need are:

- 'Limited' means the person can complete approximately 75% or more of the activity without support and the caregiver provides support for approximately 25% or less of the activity.
- 'Moderate' means the person can complete approximately 50% of the activity and the caregiver supports the other 50%.
- 'Extensive' means the person can complete approximately 25% of the activity and relies on the caregiver to support 75% of the activity.
- 'Total' means the person is unable to complete the activity and the caregiver is providing 100% of support.

**PREDOMINANT COMMUNICATION STYLE**

- English language spoken by the individual
- Assistive technology used
  - Includes computer, other electronic devices or symbols such as Bliss board, or other 'low tech' communication devices.

06/11/2015
### Ability to Make Self Understood

Ability to communicate needs, both verbal and non-verbal, to family, friends, or staff.

- **Always Understood**: Expresses self without difficulty
- **Usually Understood**: Difficulty communicating but if given time and/or familiarity can be understood, little or no prompting required
- **Often Understood**: Difficulty communicating AND prompting usually required
- **Sometimes Understood**: Ability is limited to making concrete requests or understood only by a very limited number of people
- **Rarely or Never Understood**: Understanding is limited to interpretation of very person-specific sounds or body language
- **Unknown (Missing Value)**

### Support with Mobility

*For reporting children 5 or younger.*

- **Independent**: Able to walk (with or without an assistive device) or propel wheelchair and move about
- **Guidance/Limited Support**: Able to walk (with or without an assistive device) or propel wheelchair and move about with guidance, prompting, reminders, stand by support, or with limited physical support
- **Moderate Support**: May walk very short distances with support but uses wheelchair as primary method of mobility, needs moderate physical support to transfer, move the chair, and/or shift positions in chair or bed
- **Extensive Support**: Uses wheelchair exclusively, needs extensive support to transfer, move the wheelchair, and/or shift positions in chair or bed
- **Total Support**: Uses wheelchair with total support to transfer, move the wheelchair, and/or shift positions or may be unable to sit in a wheelchair; needs total support to shift positions throughout the day
- **Unknown (Missing Value)**

### Mode of Nutritional Intake

*For reporting children 5 or younger.*

- **Normal**: Swallows all types of foods
- **Modified independent**: e.g., liquid is sipped, takes limited solid food, need for modification may be unknown
- **Requires diet modification to swallow solid food**: e.g., mechanical diet (e.g., puree, minced) or only able to ingest specific foods
- **Requires modification to swallow liquids**: e.g., thickened liquids
- **Can swallow only pureed solids AND thickened liquids**
- **Combined oral and parenteral or tube feeding**
  - e.g., G-tube or PEG tube
- **Enteral feeding into jejunum**
  - e.g., J-tube or PEG-J tube
- **Parenteral feeding only**
  - Includes all types of parenteral feedings, such as total parenteral nutrition (TPN)
- **Unknown (Missing Value)**

### Support with Personal Care

Ability to complete personal care, including bathing, toileting, hygiene, dressing and grooming tasks, including the amount of help required by another person to assist. This measure is an overall estimation of the person’s ability in the category of personal care. If the person requires guidance only for all tasks but bathing, where he or she needs extensive support, score “Guidance/Limited Support” to reflect the overall average ability. The person may or may not use assistive devices like shower or commode chairs, long-handled brushes, etc. Note: assistance with medication should NOT be included.

- **Independent**: Able to complete all personal care tasks without physical support
- **Guidance/Limited Support**
<table>
<thead>
<tr>
<th><strong>Able to perform personal care tasks with guidance, prompting, reminding or with limited physical support for less than 25% of the activity</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Moderate Physical Support</td>
</tr>
<tr>
<td>□ Extensive Support</td>
</tr>
<tr>
<td>□ Total Support</td>
</tr>
<tr>
<td>□ Unknown (Missing Value)</td>
</tr>
</tbody>
</table>

### RELATIONSHIPS

Indicate whether or not the individual has 'natural supports' defined as persons outside of the mental health system involved in his/her life who provide emotional support or companionship.

- □ Extensive involvement, such as daily emotional support/companionship
- □ Moderate involvement, such as several times a month up to several times a week
- □ Limited involvement, such as intermittent or up to once a month
- □ Involved in planning or decision-making, but does not provide emotional support/companionship
- □ No involvement
- □ Unknown (Missing Value)

### STATUS OF FAMILY/FRIEND SUPPORT SYSTEM

Indicate whether current (unpaid) family/friend caregiver status is at risk in the next 12 months; including instances of caregiver disability/illness, aging, and/or re-location. 'At risk' means caregiver will likely be unable to continue providing the current level of help, or will cease providing help altogether but no plan for replacing the caregiver's help is in place.

- □ Caregiver status is not at risk
- □ Caregiver is likely to reduce current level of help provided
- □ Caregiver is likely to cease providing help altogether
- □ Family/friends do not currently provide care
- □ Information unavailable
- □ Unknown (Missing Value)

### SUPPORT FOR ACCOMMODATING CHALLENGING BEHAVIORS

Indicate the level of support the individual needs, if any, to accommodate challenging behaviors. 'Challenging behaviors' include those that are self-injurious, or place others at risk of harm. (Support includes direct line of sight supervision)

- □ No challenging behaviors, or no support needed
- □ Limited Support, such as support up to once a month
- □ Moderate Support, such as support once a week
- □ Extensive Support, such as support several times a week
- □ Total Support - Intermittent, such as support once or twice a day
- □ Total Support - Continuous, such as full-time support
- □ Unknown (Missing Value)

### PRESENCE OF A BEHAVIOR PLAN

Indicate the presence of a behavior plan during the past 12 months.

- □ No Behavior Plan
- □ Positive Behavior Support Plan or Behavior Treatment Plan without restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee
- □ Behavior Treatment Plan with restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee
- □ Unknown (Missing Value)

### USE OF PSYCHOTROPIC MEDICATIONS

Fill in the number of anti-psychotic and other psychotropic medications the individual is prescribed. See the codebook for further definition of 'anti-psychotic' and 'other psychotropic' and a list of the most common medications.

<table>
<thead>
<tr>
<th>NUMBER OF ANTIPSYCHOTIC MEDICATIONS</th>
<th>NUMBER OF OTHER PSYCHOTROPIC MEDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Includes anti-convulsant, anti-anxiety, anti-depressant, ADHD, Bi-Polar, OCD and other psychiatric medications prescribed.</td>
<td></td>
</tr>
</tbody>
</table>

### MAJOR MENTAL ILLNESS (MMI) DIAGNOSIS

This measure identifies major mental illnesses characterized by psychotic symptoms or severe affective symptoms. Indicate whether or not the individual has one or more of the following major mental illness diagnoses: Schizophrenia, Schizoaffective Disorder, or Schizophreniform Disorder (ICD code 295.xx); Delusional Disorder (ICD code 297.1); Psychotic Disorder NOS (ICD code 298.9); Psychotic Disorder due to a general medical condition (ICD codes 293.81 or 293.82); Dementia with delusions (ICD code 294.42); Bipolar I Disorder (ICD codes 296.0x, 296.4x, 296.5x, 296.6x, or 296.7); or Major Depressive Disorder (ICD codes 296.2x and 296.3x). The ICD code must match the codes provided above. Note: Any digit or no digit at all, may be substituted for each ‘x’ in the codes.

- □ One or more MMI diagnosis present
- □ No MMI diagnosis present
<table>
<thead>
<tr>
<th>LEVEL OF CARE/CARE RECOMMENDATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>INDICATE RECOMMENDED LEVEL OF CARE</td>
</tr>
</tbody>
</table>

| INDICATE ESTIMATED LENGTH OF TREATMENT |

<table>
<thead>
<tr>
<th>SIGNATURES</th>
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<tr>
<td>STAFF SIGNATURE / CREDENTIALS</td>
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**Detroit Wayne Mental Health Authority**  
Integrated BioPsychosocial Assessment

<table>
<thead>
<tr>
<th>IDENTIFYING INFORMATION</th>
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<tbody>
<tr>
<td>NAME</td>
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<thead>
<tr>
<th>ASSESSMENT DATE</th>
<th>START TIME</th>
<th>AGE</th>
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<tr>
<th>CASE STATUS</th>
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<th>ASSESSMENT TYPE</th>
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<tr>
<td>New</td>
<td>Face to Face</td>
<td>Initial</td>
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<tr>
<td>Readmission</td>
<td>Phone</td>
<td>Quarterly</td>
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<table>
<thead>
<tr>
<th>IDENTIFYING INFORMATION</th>
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<tbody>
<tr>
<td>☐ SBIRT (screening, brief intervention &amp; treatment) consumer</td>
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</table>

<table>
<thead>
<tr>
<th>MEMBER ID</th>
<th>DATE OF BIRTH</th>
<th>DATE OF DEATH</th>
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<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>GENDER</th>
<th>FIRST NAME</th>
<th>MIDDLE NAME</th>
<th>LAST NAME</th>
<th>SSN</th>
<th>MEDICAID ID #</th>
<th>MI CHILD ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Female</td>
<td>☐ Male</td>
<td>☐ Transgender/Transsexual</td>
<td>☐ Intersex</td>
<td>☐ Questioning</td>
<td></td>
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<table>
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<tr>
<th>ALIASES AND OTHER IDENTIFYING INFORMATION</th>
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<tbody>
<tr>
<td>HOME ADDRESS</td>
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<tr>
<td>--------------</td>
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<tr>
<th>PRIMARY SPOKEN LANGUAGE</th>
<th>COMMUNICATION PREFERENCE</th>
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<th>REFERRAL SOURCE</th>
<th>RELIGION</th>
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<table>
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<tr>
<th>RACE / ETHNIC ORIGIN 1</th>
<th>RACE / ETHNIC ORIGIN 2</th>
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<th>RACE / ETHNIC ORIGIN 3</th>
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<tr>
<td></td>
<td>HISPANIC OR LATINO / LATINA</td>
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<tr>
<td></td>
<td>☐ Yes</td>
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<table>
<thead>
<tr>
<th>MARITAL STATUS</th>
<th>MAIDEN NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Divorced</td>
<td></td>
</tr>
<tr>
<td>☐ Married</td>
<td></td>
</tr>
<tr>
<td>☐ Never Married</td>
<td></td>
</tr>
<tr>
<td>☐ Separated</td>
<td></td>
</tr>
<tr>
<td>☐ Widowed</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>PARENTAL STATUS</th>
<th>VETERAN STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHILDREN &amp; FAMILIES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Is Consumer a Child enrolled in Early On</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>Wraparound Service</td>
<td>☐ Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DEPARTMENT OF HUMAN SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is Consumer a Child served by DHS for abuse and neglect</td>
</tr>
</tbody>
</table>
Is Consumer a Child served by another DHS program

☐ Yes  ☐ No

ADOPTION SUBSIDY

☐ Yes  ☐ No

GUARDIAN OR LEGAL REPRESENTATION

WHO IS RESPONSIBLE FOR MAKING DECISIONS REGARDING CARE FOR THE INDIVIDUAL?

☐ Individual  ☐ Parent  ☐ Guardian or Legal Representative  ☐ Power of Attorney

PRIMARY GUARDIAN INFORMATION

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>TYPE OF GUARDIANSHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

RELATIONSHIP TO CONSUMER

☐ Mother  ☐ Father
☐ Child  ☐ Unrelated
☐ Spouse  ☐ Other
☐ Sibling

☐ CHECK IF ADDRESS IS SAME AS CONSUMER

PHONE NUMBER

ALTERNATIVE PHONE

ADDITIONAL GUARDIAN NOTES

DOES THE INDIVIDUAL HAVE AN ADVANCE DIRECTIVE?

☐ Yes  ☐ No  ☐ N/A

PRESENTING NEEDS

BRIEFLY DESCRIBE THE PRESENTING NEEDS OF THE INDIVIDUAL (E.G., WHAT BROUGHT THE PERSON IN FOR SERVICES TODAY? HOW DOES THE PERSON VIEW THE REFERRAL? WHAT LED TO THE REFERRAL?)

WHAT SUPPORTS/SERVICES ARE BEING REQUESTED TO HELP WITH THE PRESENTING NEEDS?
SOCIAL/NATURAL SUPPORTS

Please indicate the supports in the person's daily life (family, friends, parent, others, etc.):

<table>
<thead>
<tr>
<th>Name of Support</th>
<th>Relationship</th>
<th>State how this person helps the individual achieve their goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ No Natural Supports</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

IS THE INDIVIDUAL SATISFIED WITH THEIR SUPPORTS?
☐ Yes  ☐ No

IS THERE A NEED TO CHANGE OR INCREASE SUPPORTS?
☐ Yes  ☐ No

HAS THE INDIVIDUAL LOST ANY CLOSE RELATIVES/FAMILY MEMBERS/FRIENDS?
☐ Yes  ☐ No

HAS THE INDIVIDUAL LOST ANY PETS/ANIMALS?
☐ Yes  ☐ No

WHAT WERE THE INDIVIDUALS LIVING ARRANGEMENTS AS A CHILD?

PARENTING SUPPORT

WHO IS PRESENT WITH THE CHILD TODAY?
☐ Parent  ☐ Legal Guardian  ☐ N/A

PARENTS' TOTAL NUMBER OF DEPENDENTS (INCLUDING THIS CHILD):

CHILD SERVED BY DEPARTMENT OF HUMAN SERVICES?
☐ Yes  ☐ No

PARENTS' VIEW OF PARENTING NEEDS?

ASSESSMENT OF PARENTING SKILLS/KNOWLEDGE?

SOURCES OF PARENTING SUPPORT?

STATUS OF MENTAL HEALTH AFFECTING PARENT?

CONCERNS/ISSUES RELATED TO PARENT-CHILD RELATIONSHIP?

DOES THE PARENT/GUARDIAN HAVE ANY OF THE FOLLOWING CONCERNS? (CHECK ALL THAT APPLY)

TIME SPENT ON COMPUTER
☐ Yes  ☐ No

TIME SPENT WATCHING TV
☐ Yes  ☐ No

TIME SPENT WITH FRIENDS
☐ Yes  ☐ No

INTERACTION DIFFICULTIES
☐ Child  ☐ Parent  ☐ N/A

COGNITIVE
☐ Child  ☐ Parent  ☐ N/A

SUBSTANCE USE
☐ Child  ☐ Parent  ☐ N/A

LEARNING/LITERACY PROBLEMS
☐ Child  ☐ Parent  ☐ N/A
Mental Health Symptoms

During the past month, have you felt down, depressed, irritable, or hopeless most days?
- Yes
- No

Have you lost interest in or got less pleasure from the things you used to enjoy?
- Yes
- No

Have you had thoughts or plans to hurt yourself or others during the past two weeks?
- Yes
- No

Do you feel you are in crisis and may need to be in the hospital?
- Yes
- No

Does the child feel/act hyper or high (like on drugs) even though she/he hasn't taken any?
- Yes
- No

Does the child have times when his/her thoughts race or does she/he need less sleep, lasting more than a week?
- Yes
- No

Has the child ever believed that people were spying on him/her, or that someone was plotting against him/her, or trying to hurt him/her?
- Yes
- No

Has the child ever felt like others could read his/her mind or control his/her thoughts?
- Yes
- No

Has the child ever heard voices or seen things that other people could not hear or see?
- Yes
- No

Can the child be described as nervous or overly fearful?
- Yes
- No
DOES THE CHILD FREQUENTLY ARGUE WITH PARENTS OR PEOPLE IN AUTHORITY?
☐ Yes  ☐ No

DOES THE CHILD OPENLY DISREGARD RULES OR LIMITS TO GET THEIR WAY?
☐ Yes  ☐ No

DOES THE CHILD HAVE PROBLEMS GETTING ALONG WITH OTHERS?
☐ Yes  ☐ No

DOES THE CHILD DO LESS WELL IN SCHOOL THAN YOU KNOW HE/SHE CAN?
☐ Yes  ☐ No

DOES THE CHILD HAVE MORE TROUBLE HANDLING CHANGE/STRESS THAN OTHER CHILDREN HIS/HER AGE?
☐ Yes  ☐ No

SUBSTANCE USE HISTORY

IS THERE A FAMILY HISTORY OF ALCOHOL OR DRUG USE?
☐ Yes  ☐ No

<table>
<thead>
<tr>
<th>When was the last time that...</th>
<th>Past Month</th>
<th>2 to 3 months ago</th>
<th>4 to 12 months ago</th>
<th>1+ years ago</th>
<th>Never</th>
</tr>
</thead>
</table>

SCORING

You used alcohol or drugs weekly or more often?
☐ ☐ ☐ ☐ ☐

You spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs (e.g., feeling sick)?
☐ ☐ ☐ ☐ ☐

You kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?
☐ ☐ ☐ ☐ ☐

Your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home, or social events?
☐ ☐ ☐ ☐ ☐

You had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or you used any alcohol or other drugs to stop being sick or to avoid withdrawal problems?
☐ ☐ ☐ ☐ ☐

CLIENT SUBSTANCES

Key

<table>
<thead>
<tr>
<th>Drug of Choice:</th>
<th>1 = First Choice - 10 = Last Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Days used in the Last 30 Days:</td>
<td>0 = Not Used; 1-29 = No. of Days; 30 = Daily</td>
</tr>
<tr>
<td>Method Of Current Dosing:</td>
<td>1 = Oral; 2 = Smoking; 3 = Snorting; 4 = IV; 5 = Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Drug and Name</th>
<th>Drug of Choice</th>
<th>Age First Use</th>
<th>Age Problematic use</th>
<th>Init. Rx</th>
<th>1) Heaviest Amount Consumed and When</th>
<th>Approx. Date of Last Use</th>
<th>Number of days drug used in the last 30 days</th>
<th>Method of Dosing</th>
</tr>
</thead>
</table>

RISK AND SAFETY ASSESSMENT

ANY AT-RISK BEHAVIORS?
☐ Yes  ☐ No

EXPLAIN

ANY PHYSICAL OR VERBAL AGGRESSION?
☐ Yes  ☐ No

EXPLAIN

ANY SELF-INJURIOUS BEHAVIORS?
☐ Yes  ☐ No
EXPLAIN

ANY RISK OR SAFETY ISSUES WITH SCHOOL (FOR CHILDREN)?
☐ Yes  ☐ No
EXPLAIN

ANY RISK OR SAFETY ISSUES WITH COMMUNITY?
☐ Yes  ☐ No
EXPLAIN

ANY RISK OR SAFETY ISSUES WITH HOME ENVIRONMENT?
☐ Yes  ☐ No
EXPLAIN

ANY RISK OR SAFETY ISSUES WITH WORK ENVIRONMENT?
☐ Yes  ☐ No
EXPLAIN

ANY PHYSICAL ACTIVITIES THAT PUT THE INDIVIDUAL AT RISK?
☐ Yes  ☐ No
EXPLAIN

ARE THERE ANY WEAPONS IN THE HOME?
☐ Accessible  ☐ Locked  ☐ No
EXPLAIN

DOES THE INDIVIDUAL HAVE ACCESS TO ANY OTHER WEAPONS?
☐ Yes  ☐ No
EXPLAIN

IS THERE A HISTORY OF SUICIDAL IDEATION?
☐ Yes  ☐ No
EXPLAIN

IS A CRISIS SCREENING NEEDED IMMEDIATELY?
☐ Yes  ☐ No
EXPLAIN
IS IMMEDIATE INTERVENTION FOR RISK/SAFETY NEEDED? IF YES, PLAN?
☐ Yes  ☐ No
EXPLAIN

IS THERE A CRISIS PLAN?
☐ Yes  ☐ No
EXPLAIN

IS THERE A HISTORY OF HOMICIDAL IDEATION?
☐ Yes  ☐ No
EXPLAIN

INTELLECTUAL/DEVELOPMENTAL HISTORY
☐ No reported history of intellectual/developmental disability
BRIEFLY DESCRIBE THE PRESENTING SYMPTOM(S) OF THE INTELLECTUAL/DEVELOPMENTAL DISABILITY:

WHAT YEAR AND AT WHAT AGE WAS THE INDIVIDUAL INITIALLY DETERMINED TO HAVE AN INTELLECTUAL/DEVELOPMENTAL DISABILITY?

WHERE DID THE EVALUATION DETERMINATION OCCUR AND WHY?
WHAT WAS THE ORIGINAL DIAGNOSIS?

CHILD / ADOLESCENT DEVELOPMENTAL HISTORY

DURING PREGNANCY, DID THE MOTHER EXPERIENCE ANY DEPRESSION, INCLUDING POST-PARTUM DEPRESSION?
☐ Yes ☐ No

DURING PREGNANCY, DID THE MOTHER EXPERIENCE ANY INFECTIONS?
☐ Yes ☐ No ☐ Unknown

DURING PREGNANCY, DID THE MOTHER HAVE ANY COMPLICATIONS?
☐ Yes ☐ No ☐ Unknown

DURING PREGNANCY, DID THE MOTHER USE TOBACCO, ALCOHOL, OR DRUGS?
☐ Yes ☐ No ☐ Unknown

DURING PREGNANCY, DID THE MOTHER INHALE OR EAT TOXIC AGENTS?
☐ Yes ☐ No ☐ Unknown

WERE THERE ANY COMPLICATIONS DURING DELIVERY?
☐ Yes ☐ No ☐ Unknown

DID THE MOTHER REPORT THE CHILD AS HAVING PHYSICAL MALFORMATIONS AT BIRTH?
☐ Yes ☐ No ☐ Unknown
DID THE MOTHER HAVE A FULL TERM PREGNANCY?
☐ Yes  ☐ No  ☐ Unknown
EXPLAIN

DID THE INFANT EXHIBIT ANY EATING PROBLEMS?
☐ Yes  ☐ No  ☐ Unknown
EXPLAIN

DID THE INFANT EXHIBIT ANY SLEEPING PROBLEMS?
☐ Yes  ☐ No  ☐ Unknown
EXPLAIN

WHAT WAS THE CHILD’S BIRTH WEIGHT?

WHAT WAS THE AGE OF THE MOTHER AT THE CHILD’S BIRTH?

AT WHAT AGE DID THE CHILD DO THE FOLLOWING ... (IF NEVER OCCURRED, INDICATE UNABLE)

Roll Over  AGE (in months)  ☐ Unable
Crawl  AGE (in months)  ☐ Unable
Sit Up On Own  AGE (in months)  ☐ Unable
Walk  AGE (in months)  ☐ Unable
Speak Words  AGE (in months)  ☐ Unable
Speak Sentences  AGE (in months)  ☐ Unable
Become Toilet Trained  AGE (in months)  ☐ Unable

IF THE INFORMATION IS UNKNOWN, INDICATE WHY:

FETAL ALCOHOL SYNDROME (FAS) PRE-SCREEN

FAS is a birth defect caused by alcohol use during pregnancy. FAS is a medical diagnosis. This pre-screen is not intended to take the place of a diagnostic evaluation. It is intended to make the proper referral for diagnosis and treatment.

1. HEIGHT AND WEIGHT SEEM SMALL FOR AGE?
   ☐ Yes  ☐ No

2. SIZE OF HEAD SEEMS SMALL FOR AGE?
   ☐ Yes  ☐ No

3. BEHAVIORAL CONCERNS (CHECK ALL THAT APPLY - ANY OF THESE QUALIFIES AS AN IDENTIFIER)
   ☐ Sleeping/eating problems  ☐ ID/IQ below familial expectations
   ☐ Attention problem/impulsive/restless  ☐ Learning disability
   ☐ Problem with reasoning and judgement  ☐ Speech and/or language delays
   ☐ Acts younger than children same age

4. FACIAL ABNORMALITIES?
   ☐ Yes  ☐ No

5. MATERNAL ALCOHOL USE DURING PREGNANCY?
   ☐ Yes  ☐ No

If YES to 2 or more above, the individual should be referred for a full FAS diagnostic evaluation.

Contact the nearest center to schedule a complete FAS diagnostic evaluation: Detroit 313-993-3891 Ann Arbor 734-936-9777
**BEHAVIOR TREATMENT PLAN**

**DOES THE INDIVIDUAL REQUIRE A REFERRAL FOR A BEHAVIORAL ASSESSMENT?**

- [ ] Yes
- [ ] No

*IF YES, EXPLAIN AND PROVIDER REFERRAL INFORMATION:*

**HAS THE INDIVIDUAL EVER HAD A BEHAVIOR TREATMENT PLAN?**

- [ ] Yes
- [ ] No
- [ ] N/A

*BRIEFLY DESCRIBE HISTORY IF APPLICABLE:*

**TRAUMA HISTORY**

**HAVE YOU EVER BEEN INVOLVED IN A TRAUMATIC EVENT THAT CAUSED YOU TO FEAR FOR YOUR LIFE? (E.G., SEXUAL ASSAULT, PHYSICAL ATTACK, MILITARY COMBAT, ROBBERY, SEVERE CAR ACCIDENT, OR SEXUAL ASSAULT AS A CHILD)**

- [ ] Yes
- [ ] No

- Child
- Adult
- Ongoing

*EXPLAIN IF NEEDED*

**HISTORY OF EMOTIONAL ABUSE? (E.G., SOMEONE REPEATEDLY MADE YOU FEEL BAD THROUGH HARSH WORDS)**

- [ ] Yes
- [ ] No

- Child
- Adult
- Ongoing

*EXPLAIN IF NEEDED*

**HISTORY OF PHYSICAL ABUSE? (E.G., SOMEONE REPEATEDLY CAUSED YOU PHYSICAL HARM)**

- [ ] Yes
- [ ] No

- Child
- Adult
- Ongoing

*EXPLAIN IF NEEDED*
HISTORY OF SEXUAL ABUSE? (E.G., SOMEONE FORCED SEXUAL ADVANCES OR ACTS)
☐ Yes ☐ No
☐ Child ☐ Adult ☐ Ongoing
EXPLAIN IF NEEDED

HISTORY OF NEGLECT? (E.G., A CARETAKER DENIED BASIC NEEDS, SUCH AS ADEQUATE FOOD, CLOTHES, AND SUPERVISION)
☐ Yes ☐ No
☐ Child ☐ Adult ☐ Ongoing
EXPLAIN IF NEEDED

HISTORY OF VIOLENCE? (E.G., THE USE OF PHYSICAL FORCE AGAINST ONESELF, ANOTHER PERSON, OR A COMMUNITY, WHICH HAS A HIGH LIKELIHOOD OF RESULTING INJURY, DEATH, OR PSYCHOLOGICAL HARM)
☐ Yes ☐ No
☐ Child ☐ Adult ☐ Ongoing
EXPLAIN IF NEEDED

HISTORY OF DOMESTIC VIOLENCE? (E.G., A PATTERN OF ABUSIVE BEHAVIOR IN AN INTIMATE RELATIONSHIP, WHICH IS USED BY ONE PARTNER TO GAIN OR MAINTAIN POWER AND CONTROL OVER ANOTHER PARTNER)
☐ Yes ☐ No
☐ Child ☐ Adult ☐ Ongoing
EXPLAIN IF NEEDED

HISTORY OF BULLYING? (E.G., UNWANTED AND REPEATED AGGRESSIVE BEHAVIOR AMONG SCHOOL AGED CHILDREN THAT INVOLVES A REAL OR PERCEIVED POWER IMBALANCE. INCLUDES VERBAL AND/OR PHYSICAL ABUSE)
☐ Yes ☐ No
☐ Child ☐ Adult ☐ Ongoing
EXPLAIN IF NEEDED

Trauma/Abuse/Stress Screening for Children

1. ARE YOU AWARE OF OR DO YOU SUSPECT THE CHILD HAS EXPERIENCED ANY OF THE FOLLOWING:
☐ Physical abuse
☐ Suspected neglectful home environment
☐ Emotional abuse
☐ Exposure to domestic violence
☐ Known or suspected exposure to drug activity aside from parental/caregiver use
☐ Known or suspected exposure to any other violence not already identified
☐ Parental/caregiver drug use/substance abuse
☐ Multiple separations from parent or caregiver
☐ Frequent and multiple moves or homelessness
☐ Sexual abuse or exposure
☐ Other
If you are not aware of a trauma history, but multiple concerns are present in the questions 2-5, then there may be a trauma history that has not come to your attention.

Note: Concerns in the following areas do not necessarily indicate trauma; however, there is a strong relationship.

2. DOES THE CHILD SHOW ANY OF THESE BEHAVIORS?
☐ Excessive aggression or violence towards self
Blank Integrated BioPsychosocial Assessment v2.0

1. Does the child exhibit any of the following behaviors?
   - Excessive aggression or violence towards others
   - Explosive behavior (going from 0-100 instantly)
   - Hyperactivity, distractibility, inattention
   - Very withdrawn or excessively shy
   - Oppositional and/or defiant behavior
   - Sexual behaviors not typical for a child's age
   - Peculiar patterns of forgetfulness
   - Inconsistency in skills
   - Other

2. Does the child exhibit any of the following emotions or moods?
   - Excessive mood swings
   - Chronic sadness, doesn't seem to enjoy any activities
   - Very flat affect or withdrawn behavior
   - Quick, explosive anger
   - Other

3. Is the child having problems at school?
   - Low or failing grades
   - Inadequate performance
   - Difficulty with authority
   - Attention or memory problems
   - Other

4. Will trauma history be a goal of PCP?
   - Yes
   - No

HISTORY OF PRIOR TREATMENT SERVICES
List of hospitals, CMH providers, DHS involvement

<table>
<thead>
<tr>
<th>Treatment Provider</th>
<th>Location</th>
<th>Reason</th>
<th>Date/LOS</th>
<th>Did the individual find the treatment helpful?</th>
</tr>
</thead>
</table>

PHYSICAL HEALTH HISTORY

Individual's reported current health status:
- Excellent
- Good
- Fair
- Poor

Does the individual have any diagnosed physical illness or condition(s)? Check all that apply.
- Allergies
- Anemia
- Arrhythmias
- Arthritis
- Cancer
- Chronic fatigue
- Chronic pain
- COPD
- Crohns disease
- Eating Disorder
- Endometriosis
- Fibromyalgia
- Gastritis
- Gout
- Headache/migraines
- Heart disease
- Hepatitis
- Hernia
- HIV/AIDS
- Menopause
- Multiple sclerosis
- Renal failure
- Sleep apnea
- Stroke
- Tuberculosis
- Ulcers
- Other

Have any of the individual's immediate family members or deceased relatives (parents, siblings) had any of the following conditions? Check all that apply.
- Asthma
- Allergies
- Cancer
- COPD
- Diabetes
- Heart Disease
- Hypertension
- Stroke
- Suicide
- Mental health
- Substance use
- Developmental disability

ADVERSE REACTIONS

<table>
<thead>
<tr>
<th>Drug/Allergen</th>
<th>Reported by</th>
<th>Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Not Assessed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mild</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Severe</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Life-Threatening</td>
</tr>
<tr>
<td></td>
<td></td>
<td>This is an Allergy</td>
</tr>
</tbody>
</table>

NOTES

06/11/2015
DRUG / ALLERGEN

REPORTED BY

SEVERITY
☐ Not Assessed
☐ Mild
☐ Severe
☐ Life-Threatening
☐ This is an Allergy

NOTES

START

HEALTH INDICATORS AND OTHER CONDITIONS FOR ALL POPULATIONS

DATE REVIEWED

HEARING

ABILITY TO HEAR (WITH HEARING APPLIANCE NORMALLY USED)
☐ Adequate
   No difficulty in normal conversation, social interaction, listening to TV
☐ Minimal difficulty
   Difficulty in some environments (e.g., when person speaks softly or is more than 6 feet away)
☐ Moderate difficulty
   Problem hearing normal conversation, requires quiet setting to hear well
☐ Severe difficulty
   Difficulty in all situations (e.g., speaker has to talk loudly or speak very slowly; or person reports that all speech is mumbled)
☐ No hearing

HEARING AID USED
☐ Yes ☐ No

VISION

ABILITY TO SEE IN ADEQUATE LIGHT (WITH GLASSES OR WITH OTHER VISUAL APPLIANCE NORMALLY USED)
☐ Adequate
   Sees fine detail, including regular print in newspapers/books or small items in pictures
☐ Minimal difficulty
   Sees large print, but not regular print in newspapers/books or cannot identify large objects in pictures
☐ Moderate difficulty
   Limited vision; not able to see newspaper headlines or small items in pictures, but can identify objects in his/her environment
☐ Severe difficulty
   Object identification in question, but the person's eyes appear to follow objects, or the person sees only light, colors, shapes
☐ No vision
   Eyes do not appear to follow objects; absence of sight

VISUAL APPLIANCE
☐ Yes ☐ No

HEALTH CONDITIONS
Indicate whether or not the individual had the presence of each of the following health conditions, as reported by the individual, a health care professional or family member, in the past 12 months.

PNEUMONIA (2 OR MORE TIMES) - INCLUDING ASPIRATION PNEUMONIA
☐ Never present
☐ History of condition, but not treated for the condition within the past 12 months
☐ Treated for the condition within the past 12 months
☐ Information unavailable

ASTHMA
☐ Never present
☐ History of condition, but not treated for the condition within the past 12 months
☐ Treated for the condition within the past 12 months
☐ Information unavailable

UPPER RESPIRATORY INFECTIONS (3 OR MORE TIMES WITHIN PAST 12 MONTHS)
☐ Never present
☐ History of condition, but not treated for the condition within the past 12 months
☐ Treated for the condition within the past 12 months
☐ Information unavailable

GASTROESOPHAGEAL REFLUX, OR GERD
☐ Never present
☐ History of condition, but not treated for the condition within the past 12 months
☐ Treated for the condition within the past 12 months
☐ Information unavailable
<table>
<thead>
<tr>
<th><strong>CHRONIC BOWEL IMPACTIONS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Never present</td>
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<tr>
<td>☐ History of condition, but not treated for the condition within the past 12 months</td>
</tr>
<tr>
<td>☐ Treated for the condition within the past 12 months</td>
</tr>
<tr>
<td>☐ Information unavailable</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>SEIZURE DISORDER OR EPILEPSY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Never present</td>
</tr>
<tr>
<td>☐ History of condition, but not treated for the condition within the past 12 months</td>
</tr>
<tr>
<td>☐ Treated for the condition within the past 12 months and seizure free</td>
</tr>
<tr>
<td>☐ Treated for the condition within the past 12 months, but still experience occasional seizures (less than one per month)</td>
</tr>
<tr>
<td>☐ Treated for the condition within the past 12 months, but still experience frequent seizures</td>
</tr>
<tr>
<td>☐ Information unavailable</td>
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</tbody>
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<table>
<thead>
<tr>
<th><strong>PROGRESSIVE NEUROLOGICAL DISEASE, INCLUDE, ALZHEIMER’S AND PARKINSON’S DISEASE</strong></th>
</tr>
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<tbody>
<tr>
<td>☐ Not present</td>
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<tr>
<td>☐ Treated for the condition within the past 12 months</td>
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<td>☐ Information unavailable</td>
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<table>
<thead>
<tr>
<th><strong>DIABETES</strong></th>
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<tbody>
<tr>
<td>☐ Never present</td>
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<tr>
<td>☐ History of condition, but not treated for the condition within the past 12 months</td>
</tr>
<tr>
<td>☐ Treated for the condition within the past 12 months</td>
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<tr>
<td>☐ Information unavailable</td>
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<thead>
<tr>
<th><strong>HYPERTENSION</strong></th>
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<tr>
<td>☐ Never present</td>
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<tr>
<td>☐ History of condition, but not treated for the condition within the past 12 months</td>
</tr>
<tr>
<td>☐ Treated for condition within the past 12 months and blood pressure is stable</td>
</tr>
<tr>
<td>☐ Treated for condition within the past 12 months, but blood pressure remains high or unstable</td>
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<tr>
<td>☐ Information is unavailable</td>
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</tbody>
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<table>
<thead>
<tr>
<th><strong>OBESITY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Not present</td>
</tr>
<tr>
<td>☐ Medical diagnosis of obesity present or Body Mass Index (BMI) &gt; 30</td>
</tr>
</tbody>
</table>

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**DO YOU HAVE A PRIMARY CARE DOCTOR/FAMILY PHYSICIAN/PEDIATRICIAN THAT YOU ARE SEEING?**

- ☐ Yes
- ☐ No

**PRIMARY CARE PHYSICIAN**

- WHEN WAS THE LAST TIME THE INDIVIDUAL SAW A PRIMARY CARE DOCTOR/FAMILY PHYSICIAN/PEDIATRICIAN?
- IS A REFERRAL NEEDED TO GET THE INDIVIDUAL SET UP WITH A PHYSICAL HEALTH DOCTOR?

- WHEN WAS THE LAST TIME THE INDIVIDUAL SAW A DENTIST?
- WHEN WAS THE LAST TIME THE INDIVIDUAL HAD AN EYE EXAM?

- IS THE INDIVIDUAL CURRENT ON ALL VACCINES/IMMUNIZATIONS?

**HISTORY OF CHRONIC PAIN**

- HAVE YOU HAD CHRONIC PAIN (I.E., PAIN FOR MORE THAN 6 MONTHS)?
- WHERE IS THE PAIN LOCATED?

**DIET AND EXERCISE**

- DO YOU THINK YOU EAT A HEALTHY DIET (REGULAR MEALS, FRUITS, VEGETABLES, MINIMUM TAKEOUT/RESTAURANTS)?

- DO YOU THINK YOU TAKE PART IN ANY PHYSICAL ACTIVITY OR EXERCISE (INCLUDING WALKING, CYCLING, GARDENING)?
### HOW OFTEN DO YOU EXERCISE OR ENGAGE IN PHYSICAL ACTIVITY DURING A TYPICAL WEEK (INDICATE HOW MANY TIMES PER WEEK, AND MINUTES/HOURS PER WEEK)?

### SMOKING HABITS

**DO YOU SMOKE CIGARETTES OR TOBACCO?**
- [ ] Yes  
- [ ] No  

If yes, how much do you smoke per day? (Amount)

AND HOW LONG HAVE YOU SMOKED FOR? (MONTHS/YEARS)

If no, have you ever smoked in the past?
- [ ] Yes  
- [ ] No  

If yes, for how long? (MONTHS/YEARS)

Have you tried to stop smoking in the past?
- [ ] Yes  
- [ ] No  

Do you want to stop smoking now?
- [ ] Yes  
- [ ] No

### SEXUAL ACTIVITIES

- [ ] Section N/A

Are you sexually active?
- [ ] Yes  
- [ ] No  

Are you using a method of protection during sexual activities to reduce your risk of sexually transmitted infections and/or pregnancy (e.g., condoms, dental dams, contraceptives, etc.)?
- [ ] Yes  
- [ ] No  

Are you aware of the risks of sexually transmitted infections such as hepatitis, HIV/AIDS, syphilis, etc.?
- [ ] Yes  
- [ ] No  

Have you ever had unprotected sex or engaged in sexual behaviors (oral, anal, genital) with a person whose HIV, hepatitis, or STI status was unknown to you (such as sex when drunk or high with someone you did not know very well)?
- [ ] Yes  
- [ ] No  

Have you ever engaged in sexual behaviors with anyone who has:

- [ ] Injected drugs?
  - [ ] Yes  
  - [ ] No  
  - [ ] Unsure

- [ ] Traded sex for drugs?
  - [ ] Yes  
  - [ ] No  
  - [ ] Unsure

- [ ] Many sexual partners?
  - [ ] Yes  
  - [ ] No  
  - [ ] Unsure

- [ ] HIV/AIDS?
  - [ ] Yes  
  - [ ] No  
  - [ ] Unsure

- [ ] Hepatitis?
  - [ ] Yes  
  - [ ] No  
  - [ ] Unsure

- [ ] STIs?
  - [ ] Yes  
  - [ ] No  
  - [ ] Unsure

Have you ever experienced other forms of blood-to-blood or bodily fluid contact (for example, blood transfusions, hemophilia treatments, employment in medical field, etc.) and have concerns about your risk for HIV, hepatitis, or STIs?
- [ ] Yes  
- [ ] No  

Would the individual like further information on any sexual health issues?
- [ ] Yes  
- [ ] No

### VITALS

#### COLLECTION INFORMATION

<table>
<thead>
<tr>
<th>COLLECTION DATE</th>
<th>COLLECTION TIME</th>
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</table>

#### GENERAL INFORMATION

<table>
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<tr>
<th>Measurement</th>
<th>Information Provided</th>
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<tr>
<td>HEIGHT: ft</td>
<td>Declined</td>
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<tr>
<td></td>
<td>No Information Collected</td>
</tr>
<tr>
<td>WEIGHT: lbs</td>
<td>Declined</td>
</tr>
<tr>
<td></td>
<td>No Information Collected</td>
</tr>
<tr>
<td>WAIST CIRCUMFERENCE: in</td>
<td>Declined</td>
</tr>
<tr>
<td></td>
<td>No Information Collected</td>
</tr>
</tbody>
</table>
### REPRODUCTIVE HEALTH

- **Pregnant:**
  - □ Yes
  - □ No
  - □ N/A

- **Last Monthly Period Date:**

- **Birth Control Method:**
  - □ Yes
  - □ No
  - □ N/A

- **If Other, Explain:**

### TOBACCO USE

- **Smoking Status:**
  - □ Declined
  - □ No Information Collected

- **Effective:**

- **Other Tobacco Use:**
  - Provided consumer with advice to quit smoking or tobacco use, or recommended or discussed smoking or tobacco use cessation, medications, methods, or strategies
  - □ Yes
  - □ No

### TEMPERATURE

- **Value:**

- **Site:**
  - □ Axillary
  - □ Rectal
  - □ Non-invasive thermometer
  - □ Oral
  - □ Temporal
  - □ Tympanic

### PULSE

- **Value:**

- **Rhythm:**
  - □ Irregular
  - □ Regular

- **Force:**
  - □ Bounding
  - □ Normal
  - □ Thready
  - □ Weak

- **Method Used:**
  - □ Machine
  - □ Manual

- **Site:**
  - □ Apical (over heart)
  - □ Brachial (upper arm)
  - □ Cartoid (neck)
  - □ Femoral (inner thigh)
  - □ Popliteal (behind knee)
  - □ Radial (wrist)

### RESPIRATION

- **Value:**

- **Lung Sounds:**
  - □ Declined
  - □ No Information Collected
<table>
<thead>
<tr>
<th>Clear</th>
<th>Rales</th>
<th>Rhonchi</th>
<th>Wheeze</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMMENTS</td>
<td></td>
<td></td>
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**BLOOD PRESSURE**

<table>
<thead>
<tr>
<th></th>
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<th>No Information Collected</th>
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</table>

**COMMENTS**

<table>
<thead>
<tr>
<th>RESULTS OF BREATHALYZER &amp; URINE DRUG SCREEN (UDS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAC (BLOOD ALCOHOL CONTENT):</td>
</tr>
<tr>
<td>URINE DRUG SCREEN RESULTS</td>
</tr>
</tbody>
</table>

**BLOOD GLUCOSE RESULTS**

<table>
<thead>
<tr>
<th></th>
<th>Declined</th>
<th>No Information Collected</th>
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<tbody>
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</table>

**COMMENTS**

<table>
<thead>
<tr>
<th>REACTION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cooperative</td>
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</tbody>
</table>

**COMMENTS**

<table>
<thead>
<tr>
<th>PRESCRIBED MEDICATIONS</th>
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</thead>
<tbody>
<tr>
<td>OTHER MEDICATIONS</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>DO YOU HAVE ANY PROBLEMS WITH ANY OF THESE MEDICATIONS (SIDE EFFECTS)?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### LEGAL ISSUES

| CORRECTIONS RELATED STATUS |

<table>
<thead>
<tr>
<th>Most Recent Offense</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>JUDGE NAME:</td>
<td></td>
</tr>
<tr>
<td>COURT:</td>
<td></td>
</tr>
<tr>
<td>CMO AGENCY NAME:</td>
<td></td>
</tr>
<tr>
<td>PAROLE OFFICER NAME:</td>
<td>PHONE #:</td>
</tr>
<tr>
<td>PROBATION OFFICER NAME:</td>
<td>PHONE #:</td>
</tr>
</tbody>
</table>

RETURNS CITIZEN (RELEASE FROM INCARCERATION - NO PROBATION/PAROLE)?
- Yes
- No

CMO CONTACT INFORMATION:

### EDUCATION

| CHILD'S EDUCATION |

- Not Applicable
- Unreported
- Completed less than high school
- Completed special education, high school, or GED
- In school - Kindergarten through 12th grade
- In training program
- In Special Education
- Attended or is attending undergraduate college
- College graduate

| EDUCATION HISTORY |

- Preschool
- Day Care Center
- Head Start
- Early On
- Home Day Center

CURRENT SCHOOL/SCHOOL DISTRICT:

IN SPECIAL EDUCATION?
- Yes
- No

DATE OF FSP

IF YES, SERVICE TYPE PROVIDED:

DATE OF LAST IEPC
### AT AGE-APPROPRIATE GRADE LEVEL?

- **Yes**
- **No**

**IF NO, EXPLAIN:**
- **Excessive Absenteeism**

### LIMITED ENGLISH PROFICIENCY?

- **Yes**
- **No**

**IF YES, EXPLAIN:**

### MOTHER’S EDUCATION

- **Not Applicable**
- **Literacy Issues**

### FATHER’S EDUCATION

- **Not Applicable**
- **Literacy Issues**

### DOES THE CHILD/INDIVIDUAL NEED ASSISTANCE TO ACHIEVE EDUCATION/WORK GOALS?

- **Yes**
- **No**

**IF YES, EXPLAIN:**

### DOES THE FAMILY NEED ASSISTANCE TO HELP WITH INDIVIDUAL ACHIEVING EDUCATION AND/OR WORK GOALS?

- **Yes**
- **No**

**IF YES, EXPLAIN:**

### EMPLOYMENT

**EMPLOYMENT STATUS**

- Employed full time (30 hours or more per week) competitively or self-employed.
- Employed part time (less than 30 hours per week) in competitively or self-employed.
- Unemployed - looking for work, and/or on layoff from job
- Sheltered workshop or work services participant in non-integrated setting
- In unpaid work (e.g. volunteering, internship, community service)
- Self-employed (e.g. micro-enterprise).
- In enclaves/mobile crews, agency-owned transitional employment.
| Participates in facility-based activity program where an array of specialty supports and services are provided to assist an individual in achieving his/her non-work related goals |
| Not in the competitive labor force—includes homemaker, child, student age 18 and over, retired from work, resident of an institution (including nursing home), or incarcerated. |

| EARNED WAGE IS MINIMUM WAGE OR GREATER |
| ☐ Yes  ☐ No  ☐ N/A - Person is not working |

### CULTURE/SPIRITUALITY/RELIGION

**DOES THE INDIVIDUAL IDENTIFY CULTURAL, SPIRITUAL, OR RELIGIOUS VALUES THAT PLAY A ROLE IN THEIR LIFE WHERE THEY WOULD PREFER SERVICES SPECIFIC TO THEIR CULTURE VALUES?**  
☐ Yes  ☐ No

IF YES, PLEASE EXPLAIN: 

### CURRENT LIVING ARRANGEMENTS

#### RESIDENTIAL LIVING ARRANGEMENT

**FOSTER CARE FACILITY / LICENSE #**

DESCRIBE ANY CONCERNS/ISSUES WITH CURRENT LIVING SITUATION (INDICATE APPROPRIATENESS, MOBILITY, RESTRICTIVENESS, ACCESSIBILITY, CAREGIVER CONCERNS)

### TRANSPORTATION

**ARE THERE ANY CONCERNS OR PROBLEMS RELATED TO TRANSPORTATION?**  
☐ Yes  ☐ No

ASSESSMENT OF TRANSPORTATION NEEDS:
## Mental Status

### Is Individual Oriented To: (Check All That Apply):

<table>
<thead>
<tr>
<th>Individual</th>
<th>Place</th>
<th>Time</th>
<th>Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Yes</td>
<td>[ ] No</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
</tbody>
</table>

**Explain if necessary**

### Grooming

- [ ] Excellent
- [ ] Good
- [ ] Marginal
- [ ] Poor

### Hygiene

- [ ] Excellent
- [ ] Good
- [ ] Marginal
- [ ] Poor

### Dress

- [ ] Inappropriate to Weather
- [ ] Unkempt
- [ ] Unusual
- [ ] Unremarkable

### Memory

- [ ] Impaired Immediate
- [ ] Impaired Recent
- [ ] Impaired Remote
- [ ] Not Determined

**Explain if necessary**

### Awareness

- [ ] Alert
- [ ] Dull
- [ ] Stupor

**Explain if necessary**

### Concentration

- [ ] Normal
- [ ] Able to Focus
- [ ] Distractible

**Explain if necessary**

### Judgment

- [ ] Good
- [ ] Fair
- [ ] Poor

**Explain if necessary**

### Insight

- [ ] None
- [ ] Limited
- [ ] Insightful

**Explain if necessary**
Hallucinations: (Check all that apply)

- N/A
- Auditory
- Visual
- Other

Thought Process: (Check all that apply)

- Unremarkable
- Obsessions
- Compulsions
- Paranoid
- Irrational
- Peculiar
- Loosely Organized
- Illogical
- Other (explain)

Stream of Mental Activity:

- Normal
- Delayed Response
- Perseverating
- Circumstantial
- Tangential
- Flight of Ideas
- Slowed
- Racing
- Blocked
- Other (explain)

Characteristics of Speech:

- Unremarkable
- Soft
- Loud
- Pressured
- Nonverbal
- Stuttering
- Incoherent
- Other (explain)

Presentation during the Interview:

- Unremarkable
- Embarrassed
- Seductive
- Impulsive
- Dramatic
- Needy
- Guarded
- Other (explain)

Emotional State / Affect / Reaction:

- Appropriate
- Inappropriate
- Irritable
- Angry
- Calm
- Sad
- Depressed
- Anxious
- Absence of Emotions
- Unstable Emotions
- Emotions are Incongruent with Thought Content
- Other (explain)

Mood as Stated by the Individual:
### CLINICAL IMPRESSIONS

#### CLINICAL SUMMARY

#### RECOMMENDATIONS

### DIAGNOSTIC SUMMARY

#### DIAGNOSIS

<table>
<thead>
<tr>
<th>AXIS I</th>
<th>ICD-9</th>
<th>ICD-10</th>
<th>Description</th>
<th>Status Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<th>AXIS II</th>
<th>ICD-9</th>
<th>ICD-10</th>
<th>Description</th>
<th>Status Date</th>
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<th>AXIS III</th>
<th>ICD-9</th>
<th>ICD-10</th>
<th>Description</th>
<th>Status Date</th>
<th>Status</th>
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<tr>
<th>AXIS IV</th>
<th></th>
<th></th>
<th>Economic problems</th>
<th>Problem with primary support group</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Problem accessing healthcare</td>
<td>Problem related to social environment</td>
</tr>
</tbody>
</table>
Educational problems

Problem related to interaction with legal system

Occupational problems

Other psychosocial and environmental problems

Housing problems

Behavioral / Personality issues

AXIS V

CURRENT GAF

GAF DATE

Diagnostic Summary

Mild Psychopathology with Substance Abuse (Psych. Low/Substance Low)

Psychiatrically Complicated Substance Dependence (Psych. Low/Substance High)

Serious & Persistent Mental Illness with Substance Abuse (Psych. High/Substance Low)

Serious & Persistent Mental Illness with Substance Dependence (Psych. High/Substance High)

Additional Information

CO-OCCURRING CONSUMER QUADRANT

DIAGNOSIS MADE BY (NAME/CREDOENTS)

DIAGNOSIS EFFECTIVE DATE

PREDOMINANT COMMUNICATION STYLE

Indicate from the list below how the individual communicates most of the time

English language spoken by the individual

Assistive technology used

Includes computer, other electronic devices or symbols such as Bliss board, or other 'low tech' communication devices.

Interpreter used

This includes a foreign language or American Sign Language (ASL) interpreter, or someone who knows the individual well enough to interpret speech or behavior.

Alternative language used

This includes a foreign language, or sign language without an interpreter.

Non-language forms of communication used

Includes computer, other electronic devices or symbols such as Bliss board, or other 'low tech' communication devices.

No ability to communicate

Unknown (Missing Value)

ABILITY TO MAKE SELF UNDERSTOOD

Ability to communicate needs, both verbal and non-verbal, to family, friends, or staff.<br/>For reporting children 5 or younger:<br/>Report 'Rarely or Never Understood' when understanding is limited to interpretation of every person-specific sounds or body language and/or a child age 5 or younger is not yet using verbal or non-verbal communication.

Always Understood

Expresses self without difficulty

Usually Understood

Difficulty communicating BUT if given time and/or familiarity can be understood, little or no prompting required

Often Understood

Difficulty communicating AND prompting usually required

Sometimes Understood

Ability is limited to making concrete requests or understood only by a very limited number of people

For purposes of these data elements, when the term 'support' is used, it means support from a paid or un-paid person or technological support needed to enable the individual to achieve his/her desired future. The kinds of support a person might need are:

- 'Limited' means the person can complete approximately 75% or more of the activity without support and the caregiver provides support for approximately 25% or less of the activity.
- 'Moderate' means the person can complete approximately 50% of the activity and the caregiver supports the other 50%.
- 'Extensive' means the person can complete approximately 25% of the activity and relies on the caregiver to support 75% of the activity.
- 'Total' means the person is unable to complete the activity and the caregiver is providing 100% of support.
Rarely or Never Understood
Understanding is limited to interpretation of very person-specific sounds or body language
Unknown (Missing Value)

**SUPPORT WITH MOBILITY**

*For reporting children 5 or younger*:
- Report 'Moderate Support' if a child scoots, crawls, creeps on hands and knees, or walks a few steps independently or when holding hands with caregiver.
- Report 'Extensive Support' if a child is primarily carried or transported by a caregiver.

**Independent**
- Able to walk (with or without an assistive device) or propel wheelchair and move about

**Guidance/Limited Support**
- Able to walk (with or without an assistive device) or propel wheelchair and move about with guidance, prompting, reminders, stand by support, or with limited physical support

**Moderate Support**
- May walk very short distances with support but uses wheelchair as primary method of mobility, needs moderate physical support to transfer, move the chair, and/or shift positions in chair or bed

**Extensive Support**
- Uses wheelchair exclusively, needs extensive support to transfer, move the wheelchair, and/or shift positions in chair or bed

**Total Support**
- Uses wheelchair with total support to transfer, move the wheelchair, and/or shift positions or may be unable to sit in a wheelchair; needs total support to shift positions throughout the day
Unknown (Missing Value)

**MODE OF NUTRITIONAL INTAKE**

*For reporting children 5 or younger*:
- Report 'Modified independent' if child is bottle fed or eats foods specially prepared by the caregiver to accommodate current developmental needs.

**Normal**
- Swallows all types of foods

**Modified independent**
- e.g., liquid is sipped, takes limited solid food, need for modification may be unknown

**Requires diet modification to swallow solid food**
- e.g., mechanical diet (e.g., puree, minced) or only able to ingest specific foods

**Requires modification to swallow liquids**
- e.g., thickened liquids

**Can swallow only pureed solids AND thickened liquids**

**Requires combined oral and parenteral or tube feeding**

**Enteral feeding into stomach**
- e.g., G-tube or PEG tube

**Enteral feeding into jejunum**
- e.g., J-tube or PEG-J tube

**Parenteral feeding only**
- Includes all types of parenteral feedings, such as total parenteral nutrition (TPN)

Unknown (Missing Value)

**SUPPORT WITH PERSONAL CARE**

Ability to complete personal care, including bathing, toileting, hygiene, dressing and grooming tasks, including the amount of help required by another person to assist. This measure is an overall estimation of the person's ability in the category of personal care. If the person requires guidance only for all tasks but bathing, where he or she needs extensive support, score 'Guidance/Limited Support' to reflect the overall average ability. The person may or may not use assistive devices like shower or commode chairs, long-handled brushes, etc. Note: assistance with medication should NOT be included.

**Independent**
- Able to complete all personal care tasks without physical support

**Guidance/Limited Support**
- Able to perform personal care tasks with guidance, prompting, reminding or with limited physical support for less than 25% of the activity

**Moderate Physical Support**
- Able to perform personal care tasks with moderate support of another person

**Extensive Support**
- Able to perform personal care tasks with extensive support of another person

**Total Support**
- Requires full support of another person to complete personal care tasks (unable to participate in tasks)
Unknown (Missing Value)

**RELATIONSHIPS**

Indicate whether or not the individual has 'natural supports' defined as persons outside of the mental health system involved in his/her life who provide emotional support or companionship.

**Extensive involvement, such as daily emotional support/companionship**

**Moderate involvement, such as several times a month up to several times a week**

**Limited involvement, such as intermittent or up to once a month**

**Involved in planning or decision-making, but does not provide emotional support/companionship**

**No involvement**

Unknown (Missing Value)
## Status of Family/Friend Support System

Indicate whether current (unpaid) family/friend caregiver status is at risk in the next 12 months; including instances of caregiver disability/illness, aging, and/or re-location. 'At risk' means caregiver will likely be unable to continue providing the current level of help, or will cease providing help altogether but no plan for replacing the caregiver's help is in place.

- [ ] Caregiver status is not at risk
- [ ] Caregiver is likely to reduce current level of help provided
- [ ] Caregiver is likely to cease providing help altogether
- [ ] Family/friends do not currently provide care
- [ ] Information unavailable
- [ ] Unknown (Missing Value)

## Support for Accommodating Challenging Behaviors

Indicate the level of support the individual needs, if any, to accommodate challenging behaviors. 'Challenging behaviors' include those that are self-injurious, or place others at risk of harm. (Support includes direct line of sight supervision)

- [ ] No challenging behaviors, or no support needed
- [ ] Limited Support, such as support up to once a month
- [ ] Moderate Support, such as support once a week
- [ ] Extensive Support, such as support several times a week
- [ ] Total Support - Intermittent, such as support once or twice a day
- [ ] Total Support - Continuous, such as full-time support
- [ ] Unknown (Missing Value)

## Presence of a Behavior Plan

Indicate the presence of a behavior plan during the past 12 months.

- [ ] No Behavior Plan
- [ ] Positive Behavior Support Plan or Behavior Treatment Plan without restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee
- [ ] Behavior Treatment Plan with restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee
- [ ] Unknown (Missing Value)

## Use of Psychotropic Medications

Fill in the number of anti-psychotic and other psychotropic medications the individual is prescribed. See the codebook for further definition of 'anti-psychotic' and 'other psychotropic' and a list of the most common medications.

<table>
<thead>
<tr>
<th>NUMBER OF ANTIPSYCHOTIC MEDICATIONS</th>
<th>NUMBER OF OTHER PSYCHOTROPIC MEDICATIONS</th>
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<tbody>
<tr>
<td>Psychiatric medications primarily used to manage psychosis.</td>
<td>Includes anti-convulsant, anti-anxiety, anti-depressant, ADHD, Bi-Polar, OCD and other psychiatric medications prescribed.</td>
</tr>
</tbody>
</table>

## Major Mental Illness (MMI) Diagnosis

This measure identifies major mental illnesses characterized by psychotic symptoms or severe affective symptoms. Indicate whether or not the individual has one or more of the following major mental illness diagnoses: Schizophrenia, Schizophreniform Disorder, or Schizoaffective Disorder (ICD code 295.xx); Delusional Disorder (ICD code 297.1); Psychotic Disorder NOS (ICD code 298.9); Psychotic Disorder due to a general medical condition (ICD codes 293.81 or 293.82); Dementia with delusions (ICD code 294.42); Bipolar I Disorder (ICD codes 296.0x, 296.4x, 296.5x, 296.6x, or 296.7); or Major Depressive Disorder (ICD codes 296.2x and 296.3x). The ICD code must match the codes provided above. Note: Any digit or no digit at all, may be substituted for each ‘x’ in the codes.

- [ ] One or more MMI diagnosis present
- [ ] No MMI diagnosis present
- [ ] Unknown (Missing Value)

## Level of Care/Care Recommendation

Indicate recommended level of care
INDICATE ESTIMATED LENGTH OF TREATMENT

SIGNATURES

STAFF SIGNATURE / CREDENTIALS    DATE

06/11/2015
CONSENT TO SHARE BEHAVIORAL HEALTH INFORMATION
FOR CARE COORDINATION PURPOSES
Michigan Department of Health and Human Services

This form cannot be used for a release of information from any person or agency that has provided services for domestic violence, sexual assault or stalking. A separate consent form must be completed with the person or agency that provided those services. (See FAQ at www.michigan.gov/bhconsent to determine if this restriction applies to you or your agency.)

First Name  Middle Initial  Last Name  Date of Birth  Individual’s ID Number (Medicaid ID, Last 4 digits of SSN, other)

Under the Health Insurance Portability and Accountability Act (HIPAA), a health care provider or agency can use and share most of your health information in order to provide you with treatment, receive payment for your care, and manage and coordinate your care. However, your consent is needed to share certain types of health information. This form allows you to provide consent to share the following types of information.

• Behavioral and mental health services
• Referrals and treatment for an alcohol or substance abuse disorder

This information will be shared to help diagnose, treat, manage and get payment for your health needs. You can consent to share all of this information or just some information. (See FAQ at www.michigan.gov/bhconsent)

I. I consent to share my information among:

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

II. I consent to share:

☐ All of my behavioral health and substance use disorder information

☐ All of my behavioral health and substance use disorder information except: (List types of health information you do not want to share below)

I understand that HIPAA allows providers and other agencies to use and share much of my health information without my consent in order to provide me with treatment, receive payment for my care, and to manage and coordinate my care.

III. By signing this form I understand:

• I am giving consent to share my behavioral health and substance use disorder information. Behavioral health and substance use disorder information includes, but is not limited to, referrals and services for alcohol and substance use disorders.
• My information may be shared among each agency and person listed above.
• My information will be shared to help diagnose, treat, manage and pay for my health needs.
• My consent is voluntary and will not affect my ability to obtain mental health or medical treatment, payment for medical treatment, health insurance or benefits.
• My health information may be shared electronically.
• Other types of my information may be shared with my behavioral health and substance use disorder information. HIPAA allows my providers and other agencies to use and share most of my health information without my consent in order to provide me with treatment, receive payment for my care, and to manage and coordinate my care.
• The sharing of my health information will follow state and federal laws and regulations.
• This form does not give my consent to share psychotherapy notes as defined by federal law.
• I can withdraw my consent at any time; however, any information shared with or in reliance upon my consent cannot be taken back.
• I should tell all agencies and people listed on this form when I withdraw my consent.
• I can have a copy of this form.
• My consent will expire on the following date, event or condition unless I withdraw my consent. (If expiration date is left blank or is longer than one year, the consent will expire 1 year from the signature date.)

Expiration Date: 

Consent ID #: 

MDHHS-5515 (11-16)
I have read this form or have had it read to me in a language I can understand. I have had my questions about this form answered.

<table>
<thead>
<tr>
<th>Signature of person giving consent or legal representative</th>
<th>Date</th>
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<tr>
<th>Relationship to individual</th>
<th></th>
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<tbody>
<tr>
<td>☐ Self</td>
<td>☐ Parent</td>
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</tbody>
</table>

### WITHDRAW OF CONSENT

I understand that any information already shared with or in reliance upon my consent cannot be taken back.

I withdraw my consent to the sharing of my health information:

- ☐ Between any of the following persons or agencies:
  
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- ☐ For all persons and agencies:

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### Verbal Withdraw of Consent:

This consent was verbally withdrawn.

<table>
<thead>
<tr>
<th>Signature of person receiving verbal withdraw of consent</th>
<th>Date</th>
</tr>
</thead>
</table>

- ☐ Individual provided copy
- ☐ Individual declined copy

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**AUTHORITY:** This form is acceptable to the Michigan Department of Health and Human Services as compliant with HIPAA privacy regulations, 45 CFR Parts 160 and 164 as modified August 14, 2002, 42 CFR Part 2, PA 258 of 1974 and MCL 330.1748 and PA 368 of 1978, MCL 333.1101 et seq. and PA 129 of 2014, MCL 330.1141a.

**COMPLETION:** Is Voluntary, but required if disclosure is requested.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.