

CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

Critical Population (choose all that apply)

Funding Source	Residential	Legal Involvement
<input type="checkbox"/> Food Stamp Recipient	<input type="checkbox"/> Homeless	<input type="checkbox"/> Protective Services (APS/CPS)
<input type="checkbox"/> TANF Recipient	<input type="checkbox"/> Shelter Resident	<input type="checkbox"/> Court Ordered Services
<input type="checkbox"/> SSI Recipient	<input type="checkbox"/> Long Term Care Eligibility	<input type="checkbox"/> On Probation
<input type="checkbox"/> SSDI Recipient	<input type="checkbox"/> Long Term Care Resident	<input type="checkbox"/> On Parole
<input type="checkbox"/> SSA (retirement) Recipient		<input type="checkbox"/> On Pre-Release
<input type="checkbox"/> Other Retirement Income		<input type="checkbox"/> Mandatory Monitoring
<input type="checkbox"/> Medicaid Recipient	Disability	
<input type="checkbox"/> Medicare Recipient	<input type="checkbox"/> Physical Disability	
<input type="checkbox"/> General Assistance	<input type="checkbox"/> Severely Mentally Ill	Other
	<input type="checkbox"/> SED	<input type="checkbox"/> Currently pregnant
	<input type="checkbox"/> Developmentally Disabled	<input type="checkbox"/> Woman w/dependents
	<input type="checkbox"/> Chronically Mentally Ill	
	<input type="checkbox"/> Regional Behavioral Health Authority	

Contact Information
(Secure consents for agency contacts, when possible)

Name of Caseworker	Agency	Phone number

Client's/Family's Presentation of the Problem:

Client's/Family's Expected Outcome:

Physical functioning

Allergies (Medication & Other):

Current Medical Conditions:

Current Medications (include herbs, vitamins, & over-the-counter):

Past Medications:

Past Medical History including hospitalizations/residential treatment (list all prior inpatient or outpatient treatment including RTC, group home, therapeutic foster care, aftercare, inpatient psychiatric, outpatient counseling):

Dates	Inpt/Outpt	Location	Reason	Completed? Y/N

Surgeries:

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Pain Questionnaire

Pain Management: Is the client in pain now? Yes No
 If yes, ask client to rate the pain on a scale of 1-10 (with 10 being the severest) and enter score here

Is the client receiving care for the pain? Yes No
 If no, would the client like a referral for pain management? Yes No

Nutrition

Nutritional Status: Current Weight		Current Height		BMI
Appetite: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor, please explain below				
<input type="checkbox"/> Recently gained/lost significant weight		<input type="checkbox"/> Binges/overeats to excess		
<input type="checkbox"/> Restricts food/Vomits/over-exercises to avoid weight gain		<input type="checkbox"/> Special dietary needs		
<input type="checkbox"/> Hiding/hording food		<input type="checkbox"/> Food allergies		
Comments				

Child/Adolescent Growth & Development

During pregnancy, did the biological mother have any of the following (select all that apply)?		
<input type="checkbox"/> Amniocentesis	<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes Mellitus
<input type="checkbox"/> Emotional Problems	<input type="checkbox"/> Excessive weight gain	<input type="checkbox"/> German Measles
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> High fever	<input type="checkbox"/> Kidney problems
<input type="checkbox"/> No prenatal care	<input type="checkbox"/> Placenta Previa	<input type="checkbox"/> Premature labor
<input type="checkbox"/> Vaginal bleeding	<input type="checkbox"/> Vaginal infection	<input type="checkbox"/> Other infection
<input type="checkbox"/> Unknown	<input type="checkbox"/> Other:	

During pregnancy, did the mother use any of the following (select all that apply)?

Tobacco Alcohol Street Drugs Unknown

Comments (frequency and intensity of use, participation in treatment, birth defects or malformations due to drug/alcohol use among siblings):

Any problems with labor &/or delivery?

Apgar Scores?

Did the baby have any of the following after delivery (select all that apply)?

<input type="checkbox"/> Anemia	<input type="checkbox"/> Apnea	<input type="checkbox"/> Birth defects	<input type="checkbox"/> Blood transfusions
<input type="checkbox"/> Bradycardia	<input type="checkbox"/> Cord around neck	<input type="checkbox"/> Eye problems	<input type="checkbox"/> Fever/low temperature
<input type="checkbox"/> Hernia	<input type="checkbox"/> Hydrocephalus	<input type="checkbox"/> Infection	<input type="checkbox"/> Intensive Care
<input type="checkbox"/> Intracranial bleed	<input type="checkbox"/> Jitteriness	<input type="checkbox"/> Physical injury	<input type="checkbox"/> Seizures
<input type="checkbox"/> Surfactant	<input type="checkbox"/> Trouble breathing	<input type="checkbox"/> Trouble sucking	<input type="checkbox"/> 1 of multiples (twin, etc)
<input type="checkbox"/> Use of Oxygen	<input type="checkbox"/> Ventilator	<input type="checkbox"/> Yellow Jaundice	<input type="checkbox"/> Other:

Developmental Milestones – please select any that the client did late or is still having trouble with:

<input type="checkbox"/> Rolling Over (2-6 months)	<input type="checkbox"/> Sitting (6-12 months)	<input type="checkbox"/> Standing (8-16 months)
<input type="checkbox"/> Walking (8-16 months)	<input type="checkbox"/> Engaging peers (24-36 months)	<input type="checkbox"/> Toileting (24-36 months)
<input type="checkbox"/> Dressing self (24-36 months)	<input type="checkbox"/> Feeding Self	<input type="checkbox"/> Sleeping alone
<input type="checkbox"/> Tolerating separation	<input type="checkbox"/> Playing cooperatively	<input type="checkbox"/> Speaking

Are immunizations up to date? Yes No

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Has the client had any of the following (select all that apply)?			
Blood Disorders: <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding <input type="checkbox"/> Bruising			
Brain Disorders: <input type="checkbox"/> Confusion <input type="checkbox"/> Headaches <input type="checkbox"/> Coordination Problems			
<input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Staring <input type="checkbox"/> Tremors			
<input type="checkbox"/> Tics (motor/vocal) <input type="checkbox"/> Head Injuries <input type="checkbox"/> Seizures			
GI Problems: <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Soiling <input type="checkbox"/> Vomiting			
Heart/Lung Problems: <input type="checkbox"/> Asthma <input type="checkbox"/> Chest Pain <input type="checkbox"/> Murmur <input type="checkbox"/> Surgery <input type="checkbox"/> Congenital Heart Disease			
Hormone Problems: <input type="checkbox"/> Obesity <input type="checkbox"/> Thyroid <input type="checkbox"/> Early Puberty <input type="checkbox"/> Late Puberty			
Infections: <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Measles <input type="checkbox"/> Sinus infections			
<input type="checkbox"/> Ear infections <input type="checkbox"/> Meningitis <input type="checkbox"/> Whooping Cough <input type="checkbox"/> Encephalitis			
<input type="checkbox"/> Mumps <input type="checkbox"/> High fevers <input type="checkbox"/> Pneumonia <input type="checkbox"/> Other:			
Injuries: <input type="checkbox"/> Broken Bones <input type="checkbox"/> Stitches			
Kidney Problems: <input type="checkbox"/> Bed wetting <input type="checkbox"/> Daytime wetting <input type="checkbox"/> Infections			
Muscle/Bone Problems: <input type="checkbox"/> Scoliosis <input type="checkbox"/> Spasticity <input type="checkbox"/> Other:			
Poisoning: <input type="checkbox"/> Chemicals <input type="checkbox"/> Lead <input type="checkbox"/> Other:			
Sensory Problems: <input type="checkbox"/> Hearing <input type="checkbox"/> Tactile <input type="checkbox"/> Vision			
Sexual Problems: <input type="checkbox"/> Birth Control <input type="checkbox"/> Masturbation <input type="checkbox"/> Promiscuity			
Skin Disorders: <input type="checkbox"/> Acne <input type="checkbox"/> Birth Marks <input type="checkbox"/> Eczema <input type="checkbox"/> Hair Loss			

Social

Supportive Social Network? (Rate the network using a scale of 1 Weak to 5 Strong)			
Immediate Family		Extended Family	
Friends		School	
Work		Community	
Religious		Other	
What percentage of this network are substance-abusing?			%
Comment:			
Living Situation:			
<input type="checkbox"/> Housing Adequate	<input type="checkbox"/> Housing Dangerous	<input type="checkbox"/> Housing Overcrowded	<input type="checkbox"/> Homeless
<input type="checkbox"/> Dependent Upon Others	<input type="checkbox"/> Incarcerated	<input type="checkbox"/> Ward of State/Tribal Court	
Additional Information:			
Employment: Currently Employed?			
<input type="checkbox"/> Yes	Employer		Length of Employment
<input type="checkbox"/> Satisfied	<input type="checkbox"/> Dissatisfied	<input type="checkbox"/> Supervisor Conflict	<input type="checkbox"/> Co-worker Conflict
<input type="checkbox"/> No	Last Employer:		Reason for Leaving:
<input type="checkbox"/> Never Employed	<input type="checkbox"/> Disabled	<input type="checkbox"/> Student	<input type="checkbox"/> Unstable Work History
Family Financial Situation:			
Presence or absence of financial difficulties: (Fields below are optional)			
<input type="checkbox"/> No Current Problems	<input type="checkbox"/> Large Indebtedness	<input type="checkbox"/> Relationship Conflicts Over Finances	
<input type="checkbox"/> Impulsive Spending	<input type="checkbox"/> Poverty or Below	<input type="checkbox"/> Financial Difficulties	
Family's Source of Income (choose all that apply)			
Employed: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		Unemployed: <input type="checkbox"/> Public Assistance	
<input type="checkbox"/> Seasonal <input type="checkbox"/> Temporary		<input type="checkbox"/> Actively seeking work	
<input type="checkbox"/> Self-Employed		<input type="checkbox"/> Not looking for work	
<input type="checkbox"/> Retirement	<input type="checkbox"/> SSD	<input type="checkbox"/> SSDI	<input type="checkbox"/> SSI
<input type="checkbox"/> Medical Disability via Employer		<input type="checkbox"/> Other:	
Sexual Orientation:			
<input type="checkbox"/> Heterosexual		<input type="checkbox"/> Bisexual	
<input type="checkbox"/> Homosexual		<input type="checkbox"/> Transgendered	
<input type="checkbox"/> N/A at this time		Comment:	

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Family Social History

Describe family relationships & desire for involvement in the treatment process:

Perceived level of support for treatment? (scale 1-5 with 5 being the most supportive)

Legal Status Screening

Past or current legal problems (select all that apply)?

<input type="checkbox"/> None	<input type="checkbox"/> Gangs	<input type="checkbox"/> DUI/DWI
<input type="checkbox"/> Arrests	<input type="checkbox"/> Conviction	<input type="checkbox"/> Detention
<input type="checkbox"/> Jail	<input type="checkbox"/> Probation	<input type="checkbox"/> Other

If yes to any of the above, please explain:

Any court-ordered treatment?	<input type="checkbox"/> Yes (explain below)	<input type="checkbox"/> No
Ordered by	Offense	Length of Time

Child/Adolescent Educational Assessment

Current educational setting:

<input type="checkbox"/> Public	<input type="checkbox"/> Tribal	<input type="checkbox"/> Boarding (starting at age)	<input type="checkbox"/> Charter
<input type="checkbox"/> Private	<input type="checkbox"/> Home	<input type="checkbox"/> BIA	<input type="checkbox"/> Vocational
<input type="checkbox"/> Alternate	<input type="checkbox"/> GED	<input type="checkbox"/> College	<input type="checkbox"/> Other

Current grade level: Skipped a grade or been held back?

Any testing for an IEP (Individualized Education Plan)? Yes No

History of /or current placement in special education? How many hours per day?

For learning problems? Yes No For behavior problems? Yes No

History of hyperactivity at school? Yes No Comment:

Ever been expelled or suspended? Yes No Reason:

School attendance problems: Yes No Comments:

Other education-related concerns:

Leisure & Recreation

Which of the following does the client do? (Select all that apply)

Spend Time with Friends	Sports/Exercise
Classes	Dancing
Time with Family	Hobbies
Work Part-Time	Watch Movies/TV
Go "Downtown"	Stay at Home
Listen to Music	Spend Time at Clubs/Bars
Go to Casinos	Other:

What limits the client's leisure/recreational activities?

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Functional Assessment

Is client able to care for him/herself? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, please explain:			
Living Situation:			
<input type="checkbox"/> Housing Adequate	<input type="checkbox"/> Housing Dangerous	<input type="checkbox"/> Housing Overcrowded	<input type="checkbox"/> Homeless
<input type="checkbox"/> Dependent Upon Others	<input type="checkbox"/> Incarcerated	<input type="checkbox"/> Ward of State/Tribal Court	
Additional Information:			
Uses or Needs assistive or adaptive devices (select all that apply):			
<input type="checkbox"/> None	<input type="checkbox"/> Glasses	<input type="checkbox"/> Walker	<input type="checkbox"/> Braille
<input type="checkbox"/> Hearing Aids	<input type="checkbox"/> Cane	<input type="checkbox"/> Crutches	<input type="checkbox"/> Wheelchair
<input type="checkbox"/> Translated Written Information	<input type="checkbox"/> Translator for Speaking	<input type="checkbox"/> Other:	

Psychological

History of Depressed Mood: <input type="checkbox"/> Yes <input type="checkbox"/> No	
History of irritability, anger or violence (tantrums, hurts others, cruel to animals, destroys property):	
Sleep Pattern: Number of hours per day _____ Time to onset of sleep? _____	
<input type="checkbox"/> Normal	<input type="checkbox"/> Sleeping too much <input type="checkbox"/> Sleeping too little
Ability to Concentrate: <input type="checkbox"/> Normal <input type="checkbox"/> Difficulty concentrating	
Energy Level: <input type="checkbox"/> Low <input type="checkbox"/> Average/Normal <input type="checkbox"/> High	
History of/Current symptoms of PTSD (re-experiencing, avoidance, increased arousal)? Select all that apply	
<input type="checkbox"/> Intrusive memories, thoughts, perceptions	<input type="checkbox"/> Nightmares <input type="checkbox"/> Flashbacks
<input type="checkbox"/> Avoiding thoughts, feelings, conversations	<input type="checkbox"/> Numbing/detachment <input type="checkbox"/> Restricted display of emotions
<input type="checkbox"/> Avoiding people, places, activities	<input type="checkbox"/> Poor sleep <input type="checkbox"/> Irritability
<input type="checkbox"/> Hypervigilance	<input type="checkbox"/> Other:
Any additional information:	

Bereavement/Loss & Spiritual Awareness

Please list significant losses, deaths, abandonments, traumatic incidents:	
Spiritual/Cultural Awareness & Practice	
Knowledgeable about traditions, spirituality, or religion? <input type="checkbox"/> Yes <input type="checkbox"/> No Comment:	
Practices traditions, spirituality, or religion? <input type="checkbox"/> Yes <input type="checkbox"/> No Comment:	
How does client describe his/her spirituality?	
Does client see a traditional healer? <input type="checkbox"/> Yes <input type="checkbox"/> No Comment:	

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Abuse/Neglect/Exploitation Assessment

History of neglect (emotional, nutritional, medical, educational) or exploitation?
If yes, please explain.

Has client been abused at any time in the past or present by family, significant others, or anyone else?) No Yes, explain:

Type of Abuse	By Whom	Client's Age(s)	Currently Occurring? Y/N
Verbal Putdowns			
Being threatened			
Made to feel afraid			
Pushed			
Shoved			
Slapped			
Kicked			
Strangled			
Hit			
Forced or coerced into sexual activity			
Other			

Was it reported? Yes No To whom?

Outcome

Has client ever witnessed abuse or family violence? No Yes, explain:

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Behavioral Assessment

Abuse/Addiction – Chemical & Behavioral				
Drug	Age First Used	Age Heaviest Use	Recent Pattern of Use (frequency & Amount, etc)	Date Last Used
Alcohol				
Cannabis				
Cocaine				
Stimulants (crystal, speed, amphetamines, etc)				
Methamphetamine				
Inhalants (gas, paint, glue, etc)				
Hallucinogens (LSD, PCP, mushrooms, etc)				
Opioids (heroin, narcotics, methadone, etc)				
Sedative/Hypnotics (Valium, Phenobarb, etc)				
Designer Drugs/Other (herbal, Steroids, cough syrup, etc)				
Tobacco (smoke, chew)				
Caffeine				
Ever injected Drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Which ones?				
Drug of Choice?				
Consequences as a Result of Drug/Alcohol Use (select all that apply)				
<input type="checkbox"/> Hangovers	<input type="checkbox"/> DTs/Shakes	<input type="checkbox"/> Blackouts	<input type="checkbox"/> Binges	
<input type="checkbox"/> Overdoses	<input type="checkbox"/> Increased Tolerance (need more to get high)	<input type="checkbox"/> GI Bleeding	<input type="checkbox"/> Liver Disease	
<input type="checkbox"/> Sleep Problems	<input type="checkbox"/> Seizures	<input type="checkbox"/> Relationship Problems	<input type="checkbox"/> Left School	
<input type="checkbox"/> Lost Job	<input type="checkbox"/> DUIs	<input type="checkbox"/> Assaults	<input type="checkbox"/> Arrests	
<input type="checkbox"/> Incarcerations	<input type="checkbox"/> Homicide	<input type="checkbox"/> Other:		
Longest Period of Sobriety?			How long ago?	
Triggers to use (list all that apply):				
Has client traded sex for drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes, explain:				
Has client been tested for HIV? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, date of last test:			Results:	
Has client had any of the following problem gambling behaviors? Select all that apply:				
<input type="checkbox"/> Gambled longer than planned	<input type="checkbox"/> Gambled until last dollar was gone			
<input type="checkbox"/> Lost sleep thinking of gambling	<input type="checkbox"/> Used income or savings to gamble while letting bills go unpaid			
<input type="checkbox"/> Borrowed money to gamble	<input type="checkbox"/> Made repeated, unsuccessful attempts to stop gambling			
<input type="checkbox"/> Been remorseful after gambling	<input type="checkbox"/> Broken the law or considered breaking the law to finance gambling			
<input type="checkbox"/> Other:	<input type="checkbox"/> Gambled to get money to meet financial obligations			
Risk Taking/Impulsive Behavior (current/past) – select all that apply:				
<input type="checkbox"/> Unprotected sex	<input type="checkbox"/> Shoplifting	<input type="checkbox"/> Reckless driving		
<input type="checkbox"/> Gang Involvement	<input type="checkbox"/> Drug Dealing	<input type="checkbox"/> Carrying/using weapon		
<input type="checkbox"/> Other:				

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Mental Status Exam

Category	Selections
GENERAL OBSERVATIONS	
Appearance	<input type="checkbox"/> Well groomed <input type="checkbox"/> Unkempt <input type="checkbox"/> Disheveled <input type="checkbox"/> Malodorous
Build	<input type="checkbox"/> Average <input type="checkbox"/> Thin <input type="checkbox"/> Overweight <input type="checkbox"/> Obese
Demeanor	<input type="checkbox"/> Cooperative <input type="checkbox"/> Hostile <input type="checkbox"/> Guarded <input type="checkbox"/> Withdrawn
	<input type="checkbox"/> Preoccupied <input type="checkbox"/> Demanding <input type="checkbox"/> Seductive
Eye Contact	<input type="checkbox"/> Average <input type="checkbox"/> Decreased <input type="checkbox"/> Increased
Activity	<input type="checkbox"/> Average <input type="checkbox"/> Decreased <input type="checkbox"/> Increased
Speech	<input type="checkbox"/> Clear <input type="checkbox"/> Slurred <input type="checkbox"/> Rapid <input type="checkbox"/> Slow
	<input type="checkbox"/> Pressured <input type="checkbox"/> Soft <input type="checkbox"/> Loud <input type="checkbox"/> Monotone
	Describe:
THOUGHT CONTENT	
Delusions	<input type="checkbox"/> None Reported <input type="checkbox"/> Grandiose <input type="checkbox"/> Persecutory <input type="checkbox"/> Somatic
	<input type="checkbox"/> Bizarre <input type="checkbox"/> Nihilist <input type="checkbox"/> Religious
Describe:	
Other	<input type="checkbox"/> None Reported <input type="checkbox"/> Poverty of Content <input type="checkbox"/> Obsessions <input type="checkbox"/> Compulsions
	<input type="checkbox"/> Phobias <input type="checkbox"/> Guilt <input type="checkbox"/> Anhedonia <input type="checkbox"/> Thought Insertion
	<input type="checkbox"/> Ideas of Reference <input type="checkbox"/> Thought Broadcasting
Describe:	
Self Abuse	<input type="checkbox"/> None Reported <input type="checkbox"/> Self Mutilization
	<input type="checkbox"/> Suicidal (assess lethality if present) <input type="checkbox"/> Intent <input type="checkbox"/> Plan
Aggressive	<input type="checkbox"/> None Reported <input type="checkbox"/> Aggressive (assess lethality of present)
	<input type="checkbox"/> Intent <input type="checkbox"/> Plan
PERCEPTION	
Hallucinations	<input type="checkbox"/> None Reported <input type="checkbox"/> Auditory <input type="checkbox"/> Visual
	<input type="checkbox"/> Olfactory <input type="checkbox"/> Gustatory <input type="checkbox"/> Tactile
	Describe:
Other	<input type="checkbox"/> None Reported <input type="checkbox"/> Illusions <input type="checkbox"/> Depersonalization <input type="checkbox"/> Derealization
THOUGHT PROCESS	
<input type="checkbox"/> Logical <input type="checkbox"/> Goal Oriented <input type="checkbox"/> Circumstantial <input type="checkbox"/> Tangential	
<input type="checkbox"/> Loose <input type="checkbox"/> Rapid Thoughts <input type="checkbox"/> Incoherent <input type="checkbox"/> Concrete	
<input type="checkbox"/> Blocked <input type="checkbox"/> Flight of Ideas <input type="checkbox"/> Pervasive <input type="checkbox"/> Derailment	
Describe:	
MOOD	
<input type="checkbox"/> Euthymic <input type="checkbox"/> Depressed <input type="checkbox"/> Anxious	
<input type="checkbox"/> Angry <input type="checkbox"/> Euphoric <input type="checkbox"/> Irritable	
AFFECT	
<input type="checkbox"/> Flat <input type="checkbox"/> Inappropriate <input type="checkbox"/> Labile <input type="checkbox"/> Blunted	
<input type="checkbox"/> Congruent with Mood <input type="checkbox"/> Full <input type="checkbox"/> Constricted	
BEHAVIOR	
<input type="checkbox"/> No behavior issues <input type="checkbox"/> Assaultive <input type="checkbox"/> Resistant	
<input type="checkbox"/> Aggressive <input type="checkbox"/> Agitated <input type="checkbox"/> Hyperactive	
<input type="checkbox"/> Restless <input type="checkbox"/> Sleepy <input type="checkbox"/> Intrusive	
MOVEMENT	
<input type="checkbox"/> Akathisia <input type="checkbox"/> Dystonia <input type="checkbox"/> Tardive Dyskinesia <input type="checkbox"/> Tics	
Describe:	
COGNITION	
Impairment of:	<input type="checkbox"/> None Reported <input type="checkbox"/> Orientation <input type="checkbox"/> Memory
	<input type="checkbox"/> Attention/Concentration <input type="checkbox"/> Ability to Abstract
	Describe:
Intelligence Estimate	<input type="checkbox"/> Mental Retardation <input type="checkbox"/> Borderline <input type="checkbox"/> Average <input type="checkbox"/> Above Average
IMPULSE CONTROL	<input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Absent
INSIGHT	<input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Absent
JUDGMENT	<input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Absent

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RISK ASSESSMENT				
Risk to Self	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High	<input type="checkbox"/> Chronic
Risk to Others	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High	<input type="checkbox"/> Chronic
Serious current risk of any of the following: (Immediate response needed)				
Abuse or Family Violence	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abuse or Family Violence	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Psychotic or Severely Psychologically Disabled	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Is there a handgun in the home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any other weapons?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Plan:				
Safety Plan Reviewed	<input type="checkbox"/> Yes <input type="checkbox"/> No			

Diagnoses and Interpretive Summary

Biopsychosocial formulation	
DSM IV-TR Provisional Diagnoses	
Axis I	
Axis II	
Axis III	
Axis IV	
Axis V	
Treatment Acceptance/Resistance	
Client accepts problem? <input type="checkbox"/> No <input type="checkbox"/> Yes Comment:	
Client recognizes need for treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes Comment:	
Client minimizes or blames others? <input type="checkbox"/> No <input type="checkbox"/> Yes Comment:	
External motivation is primary? <input type="checkbox"/> No <input type="checkbox"/> Yes Comment:	
Strengths/Resources (enter score if present) 1 = Adequate, 2 = Above Average, 3 = Exceptional	
Family Support	Social Support Systems
Intellectual/Cognitive Skills	Coping Skills & Resiliency
Socio-Economic Stability	Communication Skills
Maturity & Judgment Skills	Motivation for Help
	Relationship Stability
	Parenting Skills
	Insight & Sensitivity
	Other:
Comments:	
Describe appropriateness & level of need for the family's participation:	

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Preliminary Treatment Plan & Referrals

Preliminary Biopsychosocial Treatment Plan			
Biological:			
Psychological:			
Social/Environmental:			
Referrals			
<input type="checkbox"/> Psychiatrist	<input type="checkbox"/> Psychologist	<input type="checkbox"/> Medical Provider	<input type="checkbox"/> Spiritual Counselor
<input type="checkbox"/> Benefits Coordinator	<input type="checkbox"/> Nutritionist	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Vocational Counselor
<input type="checkbox"/> Social Worker	<input type="checkbox"/> Community Agency:	<input type="checkbox"/> Other:	

Physical Fitness (Optional)

Physical Activity (please select one of the following based on activity level for the past month):

Avoids walking or exertion, e.g. always uses elevator, drives whenever possible instead of walking.

Walks for pleasure, routinely uses stairs, occasionally exercises sufficiently to cause heavy breathing or perspiration.

Participates regularly in recreation or work requiring **modest physical activity** such as golf, horseback riding, calisthenics, gymnastics, table tennis, bowling, weight lifting, and yard work.

10-60 minutes per week

More than one hour per week

Participates regularly in **heavy physical exercise**, such as running, jogging, swimming, cycling, rowing, skipping rope, running in place or engaging in vigorous aerobic activity such as tennis, basketball or handball.

Runs less than a mile a week or engages in other exercise for less than 30 minutes per week

Runs 1-5 miles per week or engages in other exercise for 30-60 minutes per week

Runs 5-10 miles per week or engages in other exercise for 1-3 hours per week

Runs more than 10 miles per week or engages in other exercise for more than 3 hours per week