RESET FORM

SBHC BEHAVIORAL HEALTH CLINICAL ASSESSMENT FORM

Student Name:	**Address:**	**Assigned Gender at Birth:** ☐ female ☐ male **Identified Gender:** ☐ female ☐ male self-identify	**Referral Date:**
Preferred Name:			
DOB:			**Assessment Date:**
Ethnicity:		**Language Preference:**	
Parent(s)/Guardian :	**Parent Phone:**	**Student Phone:**	**Contacted if under 14 Signed consent to contact if over 14:** ☐ Yes ☐ No

Referred by:	☐ Counselor	☐ Nurse	☐ Teacher	☐ Self-Referral	☐ Parent	☐ Other

Insurance:	☐ Molina Centennial Care	☐ Presbyterian Centennial Care	☐ United Health Care Centennial Care	☐ Blue Cross/Blue Shield Centennial Care	☐ Medicaid Exempt	☐ CYFD	☐ Other (specify)

Presenting Concern(s):	Include source of concern, precipitating events, and symptoms (onset, frequency, and duration)

MEDICAL/NUTRITIONAL/SLEEP/PAIN: (check all that apply)**:**

☐ Surgery	☐ Major illness	☐ Change in eating habits	☐ Insomnia
☐ Head injury	☐ Major injury	☐ Special diet:	☐ Sleeping more than usual
☐ Loss of consciousness	☐ Diabetes	☐ Bingeing/purging	☐ Change in sleep pattern
☐ Seizure	☐ Weight change	☐ Inadequate fluid intake	☐ Limitations to physical activity
☐ Other			
Allergies: (specify with reaction)	☐ Food:	☐ Medication:	☐ Environment:

Referral has been made for: ☐ **NA** ☐ **Medical** ☐ **Nutritional** ☐ **Pain** **Last Physical Exam Date:**

FAMILY/INTERPERSONAL CONCERNS AFFECTING STUDENT: (choose all that apply)

☐ Parent child conflict	☐ Sibling conflict	☐ Perpetrator of physical or sexual abuse
☐ Absent parent	☐ Death of a family member	☐ Mental health problems of family member
☐ Cultural concern	☐ Religious concern	☐ Victim of physical abuse
☐ Financial concern	☐ Legal problems	☐ Victim of sexual abuse
☐ Unemployment	☐ Homelessness	☐ Victim of neglect
☐ Intimate partner violence	☐ Community/school violence	☐ Medical concerns of family member
☐ Peer abuse	☐ Educational stressors	☐ Witness of domestic violence

Other Information:

Name of other children/siblings:	Age	Sex	Residence (where they live)

 ***Form to precede the Treatment Plan which is to be developed by the third visit.**

Student Name: DOB: ID#:

FAMILY LIVING SITUATION/PHYSICAL CUSTODY:
Student Lives with:

WHO HAS LEGAL CUSTODY?
☐ Mother ☐ Father ☐ Emancipated Minor ☐ Other:

IS STUDENT A PARENT/EXPECTANT PARENT? ☐ Yes ☐ No
If yes, please explain:

STUDENT'S EDUCATION:
Does student have a: ☐ 504 ☐ IEP ☐ NA
If yes, please explain:

Is student currently receiving educational support services outside of school? ☐ Yes ☐ No
If yes, please explain:

How many schools have you attended in the last two years?
Have you repeated any grade level? ☐ Yes ☐ No If so, which grade(s):

Usual grades achieved: ☐ A ☐ B ☐ C ☐ D ☐ F

Are there any educational or behavioral concerns? (choose all that apply)
☐ Physically Aggressive Behavior ☐ Verbally Aggressive Behavior ☐ Grades Declining ☐ Suspension/Expulsion

☐ Peer Conflicts ☐ Teacher/Administrator Conflict ☐ Attendance/Tardiness Challenges

What do you like best about school?

What do you like least about school?

Are there any extracurricular activities and/or school activities in which you participate?

What are your educational goals?

HAS STUDENT EVER BEEN INVOLVED WITH?

☐ Family Assistance	☐ Past	☐ Current	Name of Case Worker:
☐ Child Protective Services	☐ Past	☐ Current	Name of Social Worker:
☐ Tribal Child Protective Services	☐ Past	☐ Current	Name of Social Worker:
☐ Juvenile Justice	☐ Past	☐ Current	Name of JPPO/JPO:
☐ Out of home placements:	☐ Past	☐ Current	Location:

STUDENT SUBSTANCE USE HISTORY (Refer to SHQ) (Onset, Frequency, Duration, Severity) (Individualize Substances)

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STUDENT'S BEHAVIORAL HEALTH TREATMENT HISTORY: (if checked, describe with dates)**:**					
☐ None	☐ In patient	☐ Out patient	☐ Out of Home Placement (TFC or Group Home)	☐ RTC	☐ Other

If other, please explain:

Name of Treatment Facility:

Duration?

Reason for Treatment:

Requested Release of Information: ☐ Yes ☐ No ☐ N/A

PSYCHIATRIC HISTORY (continued and current status)

Is student prescribed psychotropic medication: Past: ☐ Yes ☐ No Current: ☐ Yes ☐ No

If yes describe name, dosage, frequency, and indication.

Is/was student medication compliant? ☐ Yes ☐ No

Prescribing Provider Information: ROI Obtained? ☐ Yes ☐ No

Hallucinations: Past: ☐ Yes ☐ No Current: ☐ Yes ☐ No

If yes describe (Type, Onset, Frequency, Duration, Severity):

Delusions: Past: ☐ Yes ☐ No Current: ☐ Yes ☐ No

If yes describe:

Homicidal Ideation: Past: ☐ Yes ☐ No Current: ☐ Yes ☐ No

Plan: ☐ Yes ☐ no Means to carry out plan? ☐ Yes ☐ No

If yes describe:

Violent Acts (fighting both physical or verbal with others, cruelty to animals): ☐ Yes ☐ No

If yes, explain:

Destruction to property, especially fire setting: ☐ Yes ☐ No

If yes, explain:

SUICIDE

Suicidal Ideation: Past: ☐ Yes ☐ No When: Current: ☐ Yes ☐ No

Describe Plan? Means to carry out plan? ☐ Yes ☐ No

Suicide Attempt: ☐ Yes ☐ No When: Method:

Outcome:

Current Ideation: Is safety plan completed? ☐ Yes ☐ No

Family History of Suicide Attempt/Completion (include anniversary dates):

MENTAL STATUS EXAM: (Clinician Observation. Check all that apply)

Grooming/Appearance:	☐ Well groomed	☐ Disheveled	☐ Malodorous	☐ Age appropriate		
Orientation:	☐ Alert and oriented	☐ Confused	☐ Disoriented	☐ Drowsy/sleepy		
Behavior:	☐ Lethargic	☐ Hyperactive	☐ Hostile	☐ Appropriate	☐ Inappropriate	
	☐ Threatening	☐ Calm	☐ Agitated	☐ Cooperative		
Speech:	☐ Slowed	☐ Loud	☐ Soft	☐ Normal rate	☐ Normal tone	☐ Pressured	☐ Monotone
Thought Process	☐ Coherent	☐ Linear	☐ Disorganized	☐ Incoherent	☐ Grandiose	
	☐ Paranoid	☐ Concrete	☐ Flight of ideas	☐ Delusional		
Mood/Affect:	☐ Dysphoric	☐ Depressed	☐ Euphoric	☐ Apathetic	☐ Euthymic	
	☐ Hostile	☐ Labile	☐ Fearful	☐ Restricted	☐ Broad	
	☐ Anxious	☐ Irritable	☐ Sad	☐ Flat	☐ Tearful	
	☐ Alert	☐ Appropriate	☐ Inappropriate			
Cognitive Functioning:	☐ Intact memory	☐ Intelligence WNL	☐ Impaired attention			
	☐ Memory impairment	☐ Impaired intelligence	☐ Impaired concentration			
Insight/Judgment:	☐ Adequate	☐ Impairment				

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Describe area(s) of concern (for any area of mental status exam/SHQ):

STUDENT STRENGTHS/RESOURCES:

Individual/Family:

Social/Culture Support:

PROVIDER FORMULATION/ASSESSMENT(Summary of presenting problem, area(s) of concern, symptoms supporting diagnosis, strengths):

Diagnosis (Include DSM-5 Diagnosis):

Therapist Signature/Credentials	**Printed Name**	**Date**
Supervisor Signature/Credentials(if applicable)	**Printed Name**	**Date**

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