BH Assessment Form

Client Name: J. Santos
MRN#: XXXX

Language in which client received services, if other than English: ☑ Spanish ☐ Vietnamese ☐ Other (Specify):
Interpreter Utilized? ☑ No ☐ Yes (Describe in Progress Note)

DOMAIN 1

Presenting Problems & Current Episode

Presenting Problem *(should include current sxs/bx's, intensity of sxs/bx's and duration of sxs/bx's*):

Use Cl's words, referral's description, and/or clinician's understanding of the problem. Include duration, severity, frequency, what makes it worse or better impact on Cl's life, Cl's perception, and Cl's understanding of problem

Client is a 9 year old Hispanic male. Client is currently is foster care and recently immigrated to the United States. Client is presenting with symptoms of having daily intrusive memories and flashbacks, nightmares, hoarding/hiding food at home and school, feels guilty and thinks "its my fault mom is not here", anger outburst that escalate into breaking things, crying and yelling, avoids dark places, is easily startled, hyper vigilance, some difficulty sitting still and has difficulty focusing/daydreams often. Client experienced various traumatic events during his immigration journey to the United States such as getting severely ill, experiencing extreme hunger and dehydration, being taken away from his mother and not seeing her again (mom was killed), being locked up in a dark and small space and witnessing violence during the trip. Client left Mexico because of increased threats to his family from a local cartel.

History of Presenting Problem:

Use Cl's words, referral's description, and/or clinician's understanding of the problem. Include duration, severity, frequency, what makes it worse or better impact on Cl's life, Cl's perception, and Cl's understanding of problem

Due to there being no contact with someone close to client before coming to the United States, no history of the problem was obtained however per client the "scary dreams" and "scary memories" began after the trip when he came to the United States. Foster parents were asked about his history of behaviors since coming into their care about 2 months ago and they reported the anger outburst, crying, yelling and hoarding have been becoming more frequent at home and seen more in the evening time.

Mental Status Exam

Appearance/Speech/Interaction/Eye Contact/Motor Activity

Appears

- ☑ Stated Age
- ☐ Older than stated age
- ☐ Younger than stated age

Manner of Dress

- ☑ Appropriate
- ☐ Inappropriate
- ☐ Seductive
- ☐ Odd
- ☐ Other: _____

Hygiene Level

- ☑ Normal
- ☐ Neat
- ☐ Poor
- ☐ Disheveled
- ☐ Malodorous
- ☐ Other: _____

Eye Contact

- ☐ Good
- ☑ Avoidant
- ☐ Stares into space
- ☐ Intense/ Fixed
- ☐ Poor
- ☐ Eyes shut
- ☐ Other:

Attitude & Rapport

☑ Cooperative ☐ Evasive ☐ Dependent ☐ Manipulative ☐ Responsive ☐ Apathetic ☐ Oppositional ☐ Eager to Please
☐ Pleasant ☐ Aggressive ☐ Demanding ☐ Passive ☐ Engaging ☐ Uncooperative ☐ Threatening ☐ Silly
☐ Impulsive ☑ Distant ☐ Dramatic ☑ Guarded ☐ Hostile ☐ Seductive ☐ Other: _____

Motor Activity

☐ Agitated ☐ Hyperactive ☑ Normal ☐ Slow ☐ Tics ☐ No Extrapyramidal Symptoms/ Tardive Dyskinesia
☐ Tremor ☐ Posturing ☐ Pacing ☐ Hand Wringing ☐ Buccolingual masticatory ☑ Other: some difficulty sitting still

MANDATORY

Emotional State

Mood

- ☐ Euthymic
- ☐ Euphoric
- ☐ Irritable
- ☐ Hostile
- ☐ Bland
- ☐ Expansive
- ☐ Fearful
- ☐ Other: _____
- ☐ Depressed
- ☐ Manic
- ☑ Anxious
- ☐ Anhedonic
- ☐ Agitated
- ☐ Elevated

Affect

- ☑ Appropriate
- ☐ Constricted
- ☐ Expansive
- ☐ Flat
- ☐ Inappropriate
- ☐ Blunted
- ☐ Labile
- ☐ Other: _____

Thought Process/Content/Perceptions

Process

- ☑ Normal
- ☐ Loose associations
- ☐ Blocking
- ☐ Poverty of thought
- ☐ Concrete
- ☐ Circumstantial
- ☐ Slow
- ☐ Perseverating
- ☐ Rambling
- ☐ Disorganized
- ☐ Tangential
- ☐ Illogical
- ☐ Other: _____

Content

- ☑ Mood congruent
- ☐ Mood incongruent
- ☐ Bizarre
- ☐ Systemized
- ☐ Poorly Organized
- ☐ Other: _____

Delusions

- ☑ None
- ☐ Thought broadcasting
- ☐ Guilt
- ☐ Paranoid
- ☐ Persecutory
- ☐ Grandiosity
- ☐ Jealousy
- ☐ Ideas of reference
- ☐ Erotomanic
- ☐ Being controlled
- ☐ Thought Insertion
- ☐ Hyper religiosity
- ☐ Hypochondriacal
- ☐ Somatic
- ☐ Other: _____

Hallucinations

- ☑ None
- ☐ Gustatory
- ☐ Auditory
- ☐ Somatic
- ☐ Visual
- ☐ Tactile
- ☐ Olfactory
- ☐ Command
- ☐ Other: _____

Themes of Preoccupation

- ☑ None
- ☐ Sexual
- ☐ Obsessions
- ☐ Somatic
- ☐ Compulsions
- ☐ Magical thinking
- ☐ Phobias
- ☐ Depression
- ☐ Other: _____

Somatic

- ☑ None
- ☐ Dizzy/unsteady
- ☐ Chills
- ☐ Muscle tension
- ☐ Lightheaded
- ☐ Hot Flashes
- ☐ Heart palpitation
- ☐ Numbness/tingling
- ☐ Other:
- ☐ Heart pounding
- ☐ Chest pain/discomfort
- ☐ Trembling
- ☐ Shortness of breath
- ☐ Choking Sensation
- ☐ Nausea/stomach distress

Sensorium/ Intellectual Functioning

Orientation

- ☑ Oriented x4
- ☐ Person
- ☐ Place
- ☐ Date
- ☐ Purpose/Environment/Situation
- ☐ None

Concentration & Memory

- ☑ Intact
- ☐ Impaired
- ☐ Poor
- ☐ Unable to assess

As Measured by

- ☐ Serial 7's/3's
- ☑ Immediate Recall
- ☐ Number of digits forward
- ☐ Recent recall
- ☐ Number of digits backward
- ☐ Remote recall
- ☐ Naming 3 items
- ☐ Other:
- ☐ Recall 3 items at 5 minutes

General Fund of Knowledge

- ☑ Average
- ☐ Above average
- ☐ Below average

Estimated Intellectual Functioning

- ☑ Average
- ☐ Above average
- ☐ Below average

Insight

- ☐ Good
- ☑ Fair
- ☐ Poor

Judgement

- ☐ Good
- ☑ Fair
- ☐ Poor

Areas of Immediate Concern

Current Thoughts of Self-Harm

- ☑ Denies
- ☐ Yes
- ☐ Refused to State
- ☐ Unable to assess

Self-Harm

- ☐ Thoughts
- ☐ Intent
- ☐ Plan
- ☐ Means

Method, Frequency & Triggers

n/a

MANDATORY

Current Suicidal Ideation

- ☐ Denies
- ☑ Yes
- ☐ Refused to State
- ☐ Unable to assess

Suicidal Ideation

- ☑ Thoughts
- ☐ Intent
- ☐ Plan
- ☐ Means

Specificity, Availability & Lethality

per foster parent client stated once about three weeks ago he "didn't want to live" Client was asked about it and stated he was really sad and was thinking about his mom but only said that once. When asked if he felt this way today, client said no.

Suicide Risk Indicators

☑ Current/previous S/I, S/A	☑ Recent loss (death, divorce, job)	☐ Hopelessness
☐ History of psychiatric hospitalization	☑ Significant life events/stressors	☐ Suicide Plans
☐ Means or access to means	☐ Chronic pain	☐ Intent to commit suicide
☐ Chronic physical illness	☐ Perceives self as burden to other	☐ Possession of a firearm
☐ Access to a firearm	☐ Sees no other option	☐ Prior use of violent meth
☐ History of impulsivity	☐ Major psychiatric diagnosis	☐ Command hallucination
☐ History of drug/alc use/abuse	☐ Preparations (will, give aways, goodbyes)	

Suicide Protective Factors/Consumer Strengths

☐ Hope and optimism about future	☑ Religiously/spiritually involved	☑ Resilient towards life stressors
☑ Future plans/goals	☐ Agrees to elimination of means	☐ Immediate, reliable support
☐ Purpose/meaning in life	☐ Agrees to 24-hour monitoring	☐ Able to follow thru w/safety planning
☑ Seeing a therapist	☐ Agrees to take psychiatric meds	☐ Agrees not to consume drugs/alcohol
☐ Will see psychiatrist in 24-48 hours	☐ Positive connection with family	
☐ Suicide not supported by current belief/values	☐ Other_____	

Current Homicidal Ideation

- ☑ Denies
- ☐ Yes
- ☐ Refused to State
- ☐ Unable to assess

Homicidal Ideation

- ☐ Thoughts
- ☐ Intent
- ☐ Plan
- ☐ Means

Specificity, Availability & Lethality

n/a

Danger to Others Risk Indicators

☐ History of violence	☐ History of impulsivity	☐ Preoccupation with violent fantasy
☐ Plans to harm or kill another	☐ Paranoid delusions about others	☐ Command halluc. involving violence
☐ Possession of a firearm	☐ Agitated easily	☐ Persecutory delusions
☐ Access to a firearm	☐ Prescription drug abuse	☐ Major psychiatric diagnosis
☐ Other means	☐ Obsessing about violence	☐ Sees no other option
☐ Intent to harm or kill another	☐ History of psychiatric hospitalization	☐ Identifiable/intended victim(s)
☐ Anger/rage/frustration	☐ History of drug/alcohol use/abuse	

Danger to Others Protective Factors/Consumer Strengths

☐ Hope and optimism about future	☐ Violence not supported by current belief/values
☑ Future plans/goals	☐ Religiously/spiritually involved
☑ Immediate, reliable support	☐ Resilient towards life stressors
☐ Purpose/meaning in life	☐ Agrees to elimination of means
☐ Positive connection with family	☐ Able to follow thru w/safety planning
☐ Seeing a therapist	☐ Agrees to 24 hr monitoring
☐ Agrees to take psychiatrist meds	☐ Agrees not to consumer drugs/alcohol
☐ Will see psychiatrist in 24-48 hrs	☐ Other:

MANDATORY

Current Grave Disability

- ☐ Yes
- ☑ No
- ☐ Unable to assess

Grave Disability/Self Neglect Risk Indicators

- ☐ Previous history of grave disability
- ☐ Refusing or failing to eat
- ☐ Major psychiatric diagnosis
- ☐ Refusing to take medications
- ☐ Poor hygiene
- ☐ Disoriented/confused
- ☐ Insufficient clothing
- ☐ Wandering aimlessly
- ☐ Lack of positive social support
- ☐ Paranoia related to food or shelter
- ☐ No plans for filling basic needs (food)
- ☐ Eviction/recent homelessness

Comments

n/a

Impulse Control

- ☐ Good
- ☑ Fair
- ☐ Poor

Impulse Control Narrative

Client is showing higher risk and inability to manage his impulse control as reported by the increase frequency and disregulation during his anger outburst

Activities of Daily Living (ADL's)

ADL's

	Descriptor	Independence	Requires Assistance
Personal Hygiene	Bathing/showering, grooming, nail care and oral care.	yes	
Dressing	Being able to make appropriate clothing decisions and physically dress and undress oneself.	yes	
Eating	The ability to obtain food, feed oneself.	yes	
Maintaining Continence	Being able to mentally and physically use a restroom. This includes the ability to get on and off the toilet and cleaning oneself.	yes	
Transferring/ Mobility	Being able to stand from a sitting position, as well as get in and out of bed. The ability to walk independently from one location to another.	yes	

Travel's Via

- ☐ Public Transportation
- ☐ Own Conveyance

Effectively communicates needs to others

- ☐ Yes
- ☑ Sometimes
- ☐ No
- ☐ Other_____

Instrumental Activities of Daily Living (IADL's)

	Independent	Requires Assistance
Ability to keep appointments	yes	
Housework	yes	
Meal Preparation	yes	
Managing Medication	yes	
Transportation	yes	

Is there an impairment in this area of Functioning in Daily Activities due to Mental Health? ☑**Yes** ☐**No**

If yes, Identify the DSM symptoms and behaviors resulting in the impairment/s:

Symptoms *LPHA or licensed waivered only*	**Behaviors**	**Impairments**
intrusive thoughts and memories, hyper vigilance	Client will daydream and have flashbacks. Client will be cautious and avoid things	limits clients ability to engage fully in age appropriate activities with other peers and foster family.

MANDATORY

DOMAIN 2

Abuse & Trauma

Any History of Abuse or Trauma?

☑ Yes
☐ No

(i.e., having experienced traumatic events including experiences such as having witnessed violence, having been a victim of crime or violence, having lived through a natural disaster, having been a combatant or civilian in a war zone, having witnessed or having been a victim of a severe accident or having been a victim of physical, emotional, or sexual abuse)

If yes, *please provide additional information regarding the history and exposure to trauma:*

client recently immigrated to the United states and had a traumatic immigration journey. Client witnessed violence to others during immigration, was separated from mother during the immigration trip where mother was taken and killed, client got extremely ill and had very little food and water during the trip. During the trip client was placed with others in a very small cargo space that made it difficult to breathe. Client had threats to his family made when in his homeland that resulted in them leaving.

As a child was the client:

PAST			CURRENT			Describe:
	Yes	No		Yes	No	client witnessed violence during immigration, was separated from mother during the immigration trip where mother was killed. Client had threats to his family made in his homeland.
Physically Abused?		X	Physically Abused?		X	
Neglected?		X	Neglected?		X	
Sexually abused or molested?		X	Sexually abused or molested?		X	
Witness to violent acts?	X		Witness to violent acts?		X	
Were there any other childhood events to note?	X		Were there any other events to note?		X	

If yes *to any items above, please describe any negative life circumstances (e.g., homelessness) or placements (e.g., foster care) which resulted from the past or current abuse or trauma: MANDATORY if Marked* ***Yes*** *to any items above*

Due to client's traumatic experiences he is experiencing difficulty adjusting to his placement with foster parents

DOMAIN 3

Psychiatric & Substance Abuse History

Psychiatric History

History of Mental Health Treatment? ☐ Yes ☐ No ☑ Unknown

If yes is selected then the Outpatient and Psychiatric Hospitalization Section, below is MANDATORY.

Age of Onset

Outpatient ☐ Yes ☑ No

If yes is selected, then the Outpatient Mental Health Treatment History Narrative is MANDATORY.

Outpatient Mental Health Treatment Narrative

per client he has never been in therapy

Previous treatment, including providers, therapeutic modality (i.e. medications, psychosocial treatment, and response).

Is there an impairment in the client's ability to manage their Mental Illness? ☐**Yes** ☑**No**
(i.e. Hospitalizations, dropping out of services, gap in services, stopping medications, missed appointments, etc.)

<u>If yes</u>, identify the DSM symptoms and behaviors resulting in the impairment/s:

Symptoms *LPHA or licensed waivered only*	**Behaviors**	**Impairments**
n/a		

MANDATORY

History of Psychiatric Hospitalization ☐Yes ☑No

If yes, how many times in past 12 months? n/a **How many times in past 36 months?** n/a

Psychiatric Hospitalization History Narrative: *(Previous hospitalizations and hospitalization patterns, including name of hospital, admit legal status, date of admit and length of stay)*

n/a

Substance Abuse & Recovery

Substance Abuse & Recovery Narrative: *(Please include current/past use, age first use, type of substance/s and previous SUD services in narrative)*

none reported

MANDATORY

Questions to consider:
Can you tell me a bit about your past and/or current substance use?
About how often did/do you use substances?
Do you think that substance use has led to any negative effects on your life? If so, can you explain those negative effects and which areas of your life have been affected?
Do you think that you use substances to cope with negative feelings or experiences?
Do you ever feel like you want to reduce or quit using substances?

Is there an impairment in this area of Substance Abuse due to Mental Health? (comorbidity) ☐**Yes** ☑**No**
(i.e., getting arrested due to substance use, relapse, frequent ER visits due to drug-induced psychosis, etc.)

<u>If yes</u>, identify the DSM symptoms and behaviors resulting in the impairment/s:

Symptoms *LPHA or licensed waivered only*	**Behaviors**	**Impairments**
n/a		

Medical, Developmental, Care Coordination

Medical Problems & Medications

Current & Past Medical Problems & Allergies as Reported by Client:

it was reported client became very ill, had little water or food during his immigration trip. Client did state they had to get off the train so he could "get better because mom didn't want me to die"

MANDATORY

Current & Past Medications as Reported by Client

none at this time

Is there an impairment in this area of Physical Health Care due to Mental Health? ☐ **Yes** ☑ **No**
(i.e. Not taking prescribed medications, refusing to see PCP, inability to manage chronic conditions, generally poor health care hx, etc.)

If yes, identify the DSM symptoms and behaviors resulting in the impairment/s:

Symptoms *LPHA or licensed waivered only*	**Behaviors**	**Impairments**
n/a		

Developmental History

MANDATORY

Is the client 20 years or younger? ☑ **Yes** ☐ **No** (*If no, then the remainder of Developmental History section does not need to be filled out)*
Were the client's developmental milestones achieved within normal limits? ☐ **Yes** ☐ **No** ☑ **Unable to assess**
If "No", please give a Developmental History Narrative:

During the mother's pregnancy did any of the following occur?

☐ Inadequate prenatal care ☐ Father used drugs or alcohol ☐ Mother smoked ☐ Mother was victim of violence
☐ Mother used caffeine ☐ Mother had medical problems ☐ Mother used drugs or alcohol ☐ Mother was hospitalized
☐ Mother used medications ☐ Mother had accident/injury ☐ Mother had emotional problems
☑ Unknown ☐ Other

During the client's birth, did any of the following perinatal problems or conditions occur?

☐ Child was premature ☐ Baby placed in incubator ☐ Fetal distress
☐ Complicated labor ☐ Baby remained in hospital after mother went home
☐ Breech, caesarian, or forceps delivery ☐ None reported ☐ Delayed crying
☐ Baby given oxygen or transfusion ☑ Unknown ☐ Other

Were there any special problems, delays, or events regarding the client's childhood?

☐ Holding head up ☐ Dressing independently ☐ Sleeping through the night ☐ Language delay ☑ Unknown
☐ Learning to bond ☐ Writing his or her name ☐ Cognitive delay ☐ Learning to sit up alone ☐ Other
☐ Learning to crawl ☐ Learning to walk ☐ Learning to talk ☐ Tying shoes
☐ Bowel or bladder training ☐ Feeding self with a spoon ☐ Unspecified motor delay ☐ None reported

Care Coordination

Health Plans

Does client have Medi-Cal/Health Insurance? ☑Yes ☐No

Have BHS staff offered client assistance in obtaining Medi-Cal/Health Insurance? ☐**Yes** ☑**No**

If yes, what was the Intervention/Outcome?

☐**Linked to Medi-Cal/Health Insurance** ☐**Referred to Medi-Cal Enrollment Counselor** ☐**Client Not Eligible**

☑**Other:** already linked ☐**Client Declined Assistance – Explain:** _____

PCP/ Other Health Care Providers

Does client have a Primary Care Physician (PCP) or other Health Care Providers? ☑Yes ☐No

If yes, Name of PCP Dr Mario Phone 714-123-4567 Email_____

Address: 121 Cura lane orange county

If "No", what was the Intervention/Outcome

☐Linked to PCP under Medi-Cal/Health Insurance

☐Linked to OC Community health Center (for clients without Health Insurance)

☐Other:

Please list all other Ancillary Service Providers ☑**None**

Ancillary Service Provider	Ancillary Service	Contact Info	Location	Comment
n/a				

DOMAIN 5

Family History, Education, Employment-Financial, Gender-Sexual Orientation, Legal, Cultural/Religious/Spirituality and Supplemental

Family History

Family History – For how many people age -17 is the Client the Primary Care Giver (50% or more of their time): none

For how many people age 18 or older is the Client the Primary Care Giver (50% or more of their time): none

Pertinent Family History to presenting problem:	☐Yes	☐No	☑Unknown	If yes, please explain:
Mental Health History:	☐Yes	☐No	☑Unknown	If yes, please explain:
Substance Use History:	☐Yes	☐No	☑Unknown	If yes, please explain:
Other Pertinent Medical Condition:	☐Yes	☑No	☐Unknown	If yes, please explain:

Family History (narrative for additional details)

Family History was obtained per client interview and information from social worker. Limited information is known due to inability to locate family members for client from Mexico. Client stated he has a father but did not see him often as mother would tell him he is working in the mountain area and "can't come home". Client stated when in Mexico he would play by the tree and river and sometimes a neighbor would watch him as his mom went to get food from the local town. Client talked about going to town with his mother to sell dolls made of string so they could have some money. Client was separated from mother during their immigration to the United states and mother was killed. Client has recently been placed in foster care. Client stated he has no siblings.

Education

Has the client ever had:	Yes	No	Unknown
Problems learning certain subjects			x
Problems with paying attention	x		
Problems getting along with teachers		x	
Problems with studying	x		
Problems with grades	x		
Problems with truancy		x	
Disruptive class behavior	x		
Suspensions or transfers		x	
Special education		x	
Special day classes			x
Tutoring	x		

Other Education Problems:
Highest Level of Education Completed: 3 years of schooling

Date Type	Event Date	Education Status	Attendance Level	Grades	Spec. Education Eligibility (Per IEP)	Special Ed Setting	Educational Goal (Adult)
enrolled 1/1/2023	n/a	enrolled	no attendance issue	low in all subjects	being assessed	yes, Migrant education program	n/a

Employment/Financial

Current Employment Status: n/a
Is Employment a goal? ☐Yes ☑No

MANDATORY

Employment Year	LOS	Employment Description	Avg Hrs per week	Reason for Leaving	Comment
n/a					

Is there an impairment in this area of Education/Employment due to Mental Health? *If "Yes", please fill out the symptom/behavior(s) and impairment(s) below:* ☑**Yes** ☐**No**

Symptoms *LPHA or licensed waivered only*	**Behaviors**	**Impairments**
difficulty focusing in class, possible flashback and intrusive memories while in class. inability to sit still in class, hyper vigilance	will daydream in class or be pensive. wants to get out of seat, be looking around	does not listen to subject being taught and will get low grades. getting out of his seat will disrupt classroom flow

Financial

Income Source: caretaker **Amount per month:** n/a

Assisted by and/or payee: n/a **Phone Number:** n/a

SSI/SSDI Status: n/a

Is there an impairment in this area of Financial/Money Management due to Mental Health? ☐**Yes** ☑**No**
If "Yes", please fill out the symptom/behavior(s) and impairment(s) below:

Symptoms *LPHA or licensed waivered only*	**Behaviors**	**Impairments**
n/a	n/a	n/a

Gender/Sexual Orientation

Sex assigned at birth
- ☑ Male
- ☐ Female
- ☐ Intersex
- ☐ Declined to State
- ☐ Unknown

Gender Identity
- ☑ Male
- ☐ Female
- ☐ Transgender: Male to Female
- ☐ Transgender: Female to Male
- ☐ Questioning or unsure of gender identity
- ☐ Other:
- ☐ Declined to State
- ☐ Unknown

Sexual Orientation
- ☐ Bisexual
- ☐ Gay
- ☑ Heterosexual
- ☐ Lesbian
- ☐ Questioning
- ☐ Declined to State
- ☐ Other:

Gender Identity/Sexual Orientation Narrative (if applicable):

Preferred Gender Pronouns

☑ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ Declined to State ☐ Other:

Coming out experience, if applicable:

n/a

Client's Relationship with their Family ☐ **Positive** ☐ **Negative** ☑ **Other:** _____

Describe how the client's relationship with their family, or lack thereof, contributes to the client's current mental health

client was recently placed with his foster parents. Client states he does likes the home however his behaviors are creating a strain in developing his relationship with his foster parents (anger outburst, etc).

If the client identifies as transgender, are they pursuing a medical transition process? ☐ **Yes** ☑ **No**

Does the client believe they would benefit from Trans Health Care resources (knowledge of the transition process, trans-friendly providers, support resources, etc.)? ☐ **Yes** ☑ **No**

Living Arrangement

Current Housing Assistance

	Yes	No	Unknown
Section 8		x	
Other Financial		x	
Continuum of Care		x	
IPF		x	
IHF		x	
Family Support		x	

Additional information (if applicable): n/a

Current Living Arrangement (MANDATORY): foster family home

For additional Living Arrangement information, please describe here:

Client has been living in his foster placement for around 2 months

Please include the length of time client has maintained current living arrangement and/or reason for leaving recent living arrangement and include facility name if applicable.

Is there an impairment in this area of functioning in Living Arrangement/Housing due to Mental Health? ☑ **Yes** ☐ **No**

If "Yes", please fill out the symptom/behavior(s) and impairment(s) below:

Symptoms *LPHA or licensed waivered only*	**Behaviors**	**Impairments**
Trauma abreactions, hoarding food	anger outburst at home include yelling, breaking things. Hoarding, is seen at home as client hiding food, stealing food at night and causes a foul oder in his room due to leaving food hidden under the bed.	anger outburst create a strain on client and foster parents relationship and puts his placement at risk. Hoarding creates unsanitary conditions and creates more stress for family

MANDATORY

Legal

Is there an impairment in this area of Legal Status due to Mental Health? ☐ **Yes** ☑ **No**

If "Yes", please fill out the symptom/behavior(s) and impairment(s) below:

Symptoms *LPHA or licensed waivered only*	**Behaviors**	**Impairments**
n/a		

Court Involvement - ☑ **Yes** ☐ **No**

If yes, please explain:

Client has an active immigration/asylum case. Next court hearing is TBD

Incarceration History - ☐ **Yes** ☑ **No**

If yes, please explain:

n/a

Culture, Religion, Spirituality

Please gather information for this section based on an interview with the client or, when clinically or developmentally appropriate, from the client's conservator/caregiver/parent.

Client's culture and how it may impact treatment recovery

Client is from the southern region of Mexcio, acculturation and assimilation issues might come up as treatment progresses however none are seen at time of assessment. Foster family is Hispanic, speak Spanish and English at home. Client is enrolled in a Migrant Education Program.

Client's religion and how it may impact treatment/recovery

Client stated he did not know but would go to church with his mother if they walked around the local town. Local church support might be a positive resource in clients recovery

Client's spirituality and how it may impact treatment/recovery

Client is spiritual and stated his mother is in heaven, "up there". Spirituality might be a strength area in continuing the grieving process for clients losses

MANDATORY

Caregivers

Conservator/Care Giver	Address	Phone	Fax	Email	Relationship
Roberto Cruz	1234 main street				foster father
Elvira Cruz	1234 main street				foster mother

DOMAIN 6

Harm Assessment, Suicide Attempts, Strengths

Self-Harm

Thoughts ☑ **No** ☐ **Yes**

If yes, please explain when and how and resulting treatment:

Suicidal Ideation ☐ **No** ☑ **Yes**

If yes, please explain when and how and resulting treatment:

client had one incident of suicidal ideation that client and foster parent reported. Client stated he wanted to "die" but when asked about it stated didn't really want to do it and did not have a plan or result in any hospitalization. Incident occurred about three weeks ago. Per client he said it when he was really sad and thinking about mom

Suicide Attempts ☑ **No** ☐ **Yes**

If yes, please explain when and how and resulting treatment in grid below:

Date Type	Date	How	Comments	Outpatient Tx	Hospitalization?

Homicidal Ideation/Thoughts of Hurting Others ☑ **No** ☐ **Yes**

If yes, please explain when and how and resulting treatment

n/a

History of Violence (Toward People, Animals, Objects) ☑ **No** ☐ **Yes**

If yes, please explain when and how and resulting treatment:

none reported

Safety Planning (specific Safety Plans to be used should risk behaviors arise and emergency contacts:

Please describe safety plan:

safety plan was developed in place after ideation incident was reported to social worker about 3 weeks ago. Foster parent is still aware of the plan

MANDATORY

Emergency Contact	Phone Number
Cristina Paz	714-123-4567

Was a support person informed about the Safety Plan: ☐ **No** ☑ **Yes**
If yes, who was informed and what is their role in the client's life? _____

Strengths, Social Relationships & Communication Skills *(strengths should help achieve objective and/or overcome barriers)*

Describe the client's overall strengths

client is resilient, funny, family oriented

MANDATORY

Please list client's strengths that may benefit client in treatment (i.e., social/family support, displays good verbal skills, etc.).

Describe the client's social relationships & communication skills

Per client and foster parent client does not have any friends in school and will play alone at times. When foster parents have had social outings with extended family or in the community its reported client is shy, slow to warm up, hesitates about things and will then engage and play with other children. It was reported client will sometimes play alone when other children are around. When assessing clients communication needs, client seems to have some difficulty communicating his needs in safe ways as it comes out behaviorally through anger outburst, crying and hoarding

Is there an impairment in this area of functioning in Social Relationship/ Communication Skills due to Mental Health? ☑ **Yes** ☐ **No**
If "Yes", please fill out the symptom/behavior(s) and impairment(s) below:

Symptoms *LPHA or licensed waivered only*	**Behaviors**	**Impairments**
trauma abreactions, feels insecure	client will yell and cry when upset showing difficulty regulating his emotions, hoarding	puts a strain on the family relationship, impairs client relationship to bond with foster family

DOMAIN 7

Clinical Narrative Summary & Differential Diagnosis

A clinical hypothesis / understanding / core theme regarding what drives the client's experience of illness and recovery, makes connections between themes and describes the provider's understanding of the "why."

Diagnostic/Clinical Impression:

Client is presenting with symptoms of Post Traumatic Stress Disorder (F43.10) due the presenting behaviors of daily intrusive memories and flashbacks, nightmares, hoarding/hiding food at home and school, feels guilty and thinks "its my fault mom is not here", will have anger outburst that escalates into breaking things, crying and yelling, avoids dark places, is easily startled, hyper vigilant, some difficulty sitting still and has difficulty focusing/daydreams often. Client has experienced various traumatic events during his immigration to the United States and most of his symptoms and diagnosis seem to be a result of it. Currently, client is placed in foster care and enrolled in school and his symptoms are creating impairments for client to be successful in various life domains. Other diagnosis were looked into at time of assessment such as depression, ADHD; however the diagnosis of PTSD best fits what client is currently presenting with.

Determination of medical necessity, level of care, access criteria

Client was referred for and met access criteria for a mental health assessment through his involvement in social services. Due to clients symptoms, behaviors, impairments and diagnosis, client meets medical necessity for Specialty mental health services. Client's involvement with social services and the courts qualifies client for Pathways to well-being and to receive Intensive Care Coordination and Intensive Home based services.

Treatment recommendations:

Client will be provided Specialty mental health services that include individual therapy to work on impairing symptoms such as flash backs, process guilt and trauma abreactions, play therapy and learn coping skills. Intensive care coordination to coordinate care with other services such as social services, school and Wraparound. Intensive home based services to work with client on learning coping skills to make more tolerable his behavioral symptoms such as anger outburst in addition to working with foster parents in learning skills to support clients behavioral goals at home. Client will be referred for medication to see if he is candidate for medication.

I have completed the assessment and am ready to add a diagnosis: ☑ **Yes**

MANDATORY

Problem List

Code	Descriptor (Use ICD10 codes only or Snomed codes verbatim - see https://snomed.terminology.tools/terminology-ui/index.html#/terminology#content)	Date Established	Date Ended	Responsible Provider
F43.10	Post Traumatic Stress Disorder	1/11/23		E.C LMFT
390790000	Asylum seeker	1/11/23		E.C LMFT
285849008	difficulty controlling anger	1/11/23		E.C LMFT
30871003	flashbacks	1/11/23		E.C LMFT
7571003	feeling of guilt	1/11/23		E.C LMFT
410279000	care taking/parenting skills education, guidance and counseling	1/11/23		E.C LMFT
248025009	Hoarding	1/11/23		E.C LMFT
224965009	grief finding	4/4/2023		E.C LMFT
F41.8	other specified anxiety disorder	4/4/2023		E.C LMFT

Print Name: E Ceja _____ **Date:** _____

Provider Signature: _____ **Credentials:** LMFT _____

Additional Signature if needed:
Print Name: _____ **Date:** _____

Provider Signature: _____ **Credentials:** _____

MANDATORY