CONTRA COSTA
BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

Clinical Assessment – 21 and Over

NAME / MRN

Billing Information

Program Name: _____ Fac/Prog: _____ Date: _____

Staff #: _____ Hours: _____ Min(s): _____ Code Activity ☐ **331** Assessment ☐ **580** Lockout

Telehealth consent obtained (if applicable): ☐ **Yes** ☐ **No** **Assessment Type:** ☐ Initial ☐ Annual

Is Client Pregnant? ☐ **Yes** ☐ **No** *Travel Time To/From included in above (if applicable) Hrs* _____ *Mins* _____

Location of Services (Please check one)

☐ Office	☐ Satellite	☐ Emergency Shelter	☐ Skilled nursing facility
☐ Field	☐ Inpatient Psychiatric	☐ Primary Care Health Clinic	☐ Mobile Service
☐ Phone	☐ Inpatient Health	☐ Res Tx Ctr (child)	☐ Job Site
☐ Home	☐ Emergency Room	☐ Res Tx Ctr (adult)	☐ Age Specialty Center
☐ School	☐ Jail	☐ Hospice	☐ Faith-Based Location
☐ Telehealth-Clt Home	☐ Telehealth-Other than Clt Home		

☐ Nontraditional Location ☐ Other _____ ☐ Unknown

Service Strategies (Please check up to three, if applicable)

☐ Peer/Fam Deliv Svcs	☐ Supportive Education	☐ Ptnrshp: Soc Svcs	☐ Integrated Svcs: MH-Dvlp Disabled
☐ Psych Education	☐ Prtnrshp: Law Enfcmt	☐ Ptnrshp: Subs Abuse	☐ Ethnic-Specific Service Strategy
☐ Family Support	☐ Ptnrshp: Health Care	☐ IntSvcs : MH / Aging	☐ Age-Spec Svc Strategy
☐ Unknown			

Referred By: _____

Identifying Information

Legal Name: _____ Age: _____ DOB: _____

Preferred Name: _____

Gender

☐ Male ☐ Female ☐ Transgender F-M ☐ Transgender M-F ☐ Nonbinary ☐ Other _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Widowed

Address: _____

Phone #: _____

Emergency Contact: _____ _____
Name Phone number

Language

Primary Language: _____ Other Languages spoken in home: _____

Language in which the service provided (other than English): ☐ Spanish ☐ Other _____

☐ Interpreter Name of Interpreter: _____

Client Name: _____ **Client MRN/ID:** _____

Client Information

Entitlements: ☐ M/C ☐ Medicare ☐ BHC ☐ Other Health Care Info _____
☐ No Health Insurance Coverage
☐ SSI ☐ SSDI Payee: _____

Monthly Income _____ Refer to a Financial Counselor? ☐ Yes ☐ No

Living Situation: ☐ Independent Living ☐ Immediate Family ☐ Extended Family ☐ Shared Housing
☐ Board & Care ☐ Residential Care Facility ☐ **Homeless** ☐ Other

Support System Contacts: _____

Other Agencies Involved: ☐ CC Provider Network ☐ CFS/APS ☐ Voc Services
☐ AOD ☐ Regional Center ☐ Homeless Services
☐ Other _____

Presenting Problem

What is the primary reason for current referral? Describe current precipitating event, primary stressors, primary symptoms, and functional impairment.

Functional Impairment: Comment on all that apply:

Food/Shelter:

Family Relations:

Social Relations

Mental Health Impact on Physical Health

Occupation/Education

Substance Use

Activities of Daily Living

Recreational/Leisure Activities

Trauma History

Exposure and Stress Reaction

Treatment History

List 1) Mental health symptoms / conditions, 2) Treatment (outpatient and crisis services, psychiatric hospitalizations, residential or day treatment, partial hospitalizations, and 3) any use of nontraditional or alternative healing practices.

Response to treatment:

Substance Use during the past 12 months:

Have you ever used alcohol or drugs? ☐ Yes ☐ No

Check all substances you have used in the last 12 months:

	FREQUENCY		FREQUENCY
☐ Alcohol	_____	☐ Amphetamine	_____
☐ Caffeine (energy drinks, sodas, coffee, etc.)	_____	☐ Cocaine/crack	_____
☐ Designer drugs (GHB, PCP, ectasy)	_____	☐ Inhalants (paint, gas, aerosols)	_____
☐ Marijuana	_____	☐ Opiates (heroin, opium, methadone)	_____
☐ Hallucinogens (LSD, mushrooms, peyote)	_____	☐ Tobacco	_____
☐ Pain killers (Oxy, Norco, Vicodin)	_____	☐ Fentanyl	_____
☐ Over the counter (list)	_____	☐ Other (list)	_____

Have you gone to anyone for help because of your drinking or drug use (such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program)? ☐ Yes ☐ No

Has drinking or drug use caused problems between you and your family or friends? ☐ Yes ☐ No

Comments:_____

Medical History: ☐ Not available

Are there any health concerns (medical illness, medical symptoms) regarding this client? ☐ No ☐ Yes (if so, please describe):

Allergic Reactions: ☐ No ☐ Yes (if so, please describe):

Medications currently taking and compliance issues:

Relevant Family/Social History: Summarize relevant data regarding significant interpersonal relationships, including parents and marital status, children, siblings, living situations, education, work, history, military history, current support system, family history of mental illness or substance abuse and major traumatic events/losses, adverse childhood experiences, cultural and language, sexual orientation and gender identity.
CHECK THIS BOX IF CLIENT IS HOMELESS ☐

Assessment of Strengths: Check all that apply:

☐ Optimism / Hope	☐ Sense of humor	☐ Sense of meaning
☐ Support relationship	☐ Faith / Spirituality	☐ Friendships
☐ Empathy	☐ Open to change	☐ Compassion
☐ Exercises regularly	☐ Resourcefulness	☐ Nutritional awareness
☐ Academic Accomplishments	☐ Understands mental illness/needs	☐ Daily Living Skills
☐ Participates in 12-step program	☐ Flexibility	☐ Partricipates in self-help groups

Risk Assessment

Danger to self (Intent, Plan, Means):

Danger to self (Past history):

Danger to others (Intent, Plan, Means):

Danger to others (Past history):

Additional Risk Factors: Check all that apply. Document details.

- ☐ Access to Firearms (family, friends)
- ☐ Animal Cruelty
- ☐ Emotional/Physical Neglect
- ☐ Fire Setting
- ☐ Impulsivity/Threatening Behavior
- ☐ Physical Abuse/Emotional Abuse
- ☐ Severe Hopelessness
- ☐ Substance Use
- ☐ Other (specify in comments)
- ☐ Adverse Childhood
- ☐ Behavior Influenced by Delusions or Hallucinations
- ☐ Family History of Suicide
- ☐ History of Domestic Violence
- ☐ Inappropriate Sexualized Behavior
- ☐ Self-Injurious Behavior
- ☐ Sexual Abuse
- ☐ Trauma or Loss in Family

Comments:

Criminal Justice History

☐ Probation ☐ Parole ☐ Diversion ☐ N/A

Probation/Parole Officer Contact: _____ ☐ Obtain Release (ROI)

Offense History (include jail/prison facility):

Mental Status Exam

Appearance/Grooming

Behavioral Relatedness

Motor Activity

Speech

Mood

Affect

Thought Process

Thought Content

Perceptual Content

_____

Cognition/Orientation

_____

Attention/Concentration

_____

Memory

_____

Abstract Reasoning

_____

Insight

_____

Judgment

_____

Diagnosis:

DSM-5 Diagnosis: _____ ICD-10 Code: _____ (Primary)

DSM-5 Narrative Diagnosis: _____

DSM-5 Diagnosis: _____ ICD-10 Code: _____ (Secondary)

DSM-5 Narrative Diagnosis: _____

_____

Medical Necessity

Client meets Specialty Mental Health Medical Necessity: ☐ Yes ☐ No If no, provide plan for transition

_____

Clinical Summary / Additional Comments

_____

Client Name: _____ **Client MRN/ID:** _____

Recommendations/Plans

Is this late documentation? ☐ Yes ☐ No

_____	_____	_____
Staff Signature/License	Printed Name	Date
_____	_____	_____
Co-Signature of Licensed Clinician	Printed Name	Date

_____
Data Entry Clerk Initials