Mental Health Wellness INFORMATION NETWORK

Detroit Wayne Integrated Health Network

CCM Child Assessment

DWIHN Your Link to Holistic Healthcare

IDENTIFYING INFORMATION

NAME	DOB	MEMBER ID	GENDER

ADDRESS

DOCUMENT DATE

ASSESSMENT TYPE
☐ Initial ☐ Quarterly ☐ Other

CASE STATUS
☐ New ☐ Readmission ☐ Existing

CONSUMER INFORMATION

MEMBER ID | DATE OF BIRTH | DATE OF DEATH | GENDER

FIRST NAME | MIDDLE NAME | LAST NAME | SSN

ALIASES AND OTHER IDENTIFYING INFORMATION

MEDICAID ID #

MI CHILD ID #

MEDICARE ID

HOME ADDRESS

HOME PHONE

ALTERNATE PHONE

CELL PHONE

COUNTY OF RESIDENCE

PRIMARY SPOKEN LANGUAGE

COMMUNICATION PREFERENCE

REFERRAL SOURCE

RELIGION

RACE / ETHNIC ORIGIN

HISPANIC OR LATINO ETHNICITY

MARITAL STATUS

MAIDEN NAME

EMERGENCY CONTACT

Last Updated 11/04/2020

LAST NAME | FIRST NAME | PHONE NUMBER | ALT PHONE

RELATIONSHIP

☐ Mother ☐ Father
☐ Child ☐ Unrelated
☐ Spouse ☐ Sibling
☐ Other

☐ CHECK IF ADDRESS IS SAME AS CONSUMER
☐ DO NOT CONTACT

VETERAN / MILITARY INFORMATION

CONSUMER OR FAMILY MILITARY SERVICE

MOST RECENT MILITARY SERVICE ERA

BRANCH SERVED IN

CONSUMER/FAMILY ENROLLED IN/CONNECTED TO VA/VETERAN RESOURCES/OTHER SUPPORT & SERVICE ORGANIZATIONS

VETERAN STATUS

WHO IS RESPONSIBLE FOR MAKING DECISIONS REGARDING CARE FOR THE INDIVIDUAL?

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

PRIMARY GUARDIAN INFORMATION

LAST NAME | FIRST NAME | TYPE OF GUARDIANSHIP

RELATIONSHIP TO CONSUMER

- ☐ Mother
- ☐ Father
- ☐ Child
- ☐ Unrelated
- ☐ Spouse
- ☐ Other
- ☐ Sibling

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

SOCIAL DETERMINANTS OF HEALTH (SDOH)

ECONOMIC STABILITY & FOOD SECURITY

What is your source of income? Do you have enough money for food, rent, utilities and medications? Do you have a Bridge Card? Do you know where local food banks are located if needed? Do you have additional economic and food concerns?

EDUCATION

What is your highest level of schooling? Do you speak and/or understand English or another language? Do you require assistance to read or write English? Do you have additional educational concerns?

HEALTH AND HEALTHCARE

Do you have healthcare insurance and if so, what is the name of the insurance? Do you have a Primary Care Physician (PCP)? When is the last time you visited your PCP? Do you have additional healthcare providers (i.e. dentist, specialists, etc.)? When is the last time you visited an additional healthcare provider? If applicable: Are you linked to a Community Mental Health (CMH) agency and if so, what is the name of the agency? Do you know the name of your case manager/supports coordinator and know how to contact them? When is the last time you saw your psychiatrist? Do you have additional health & healthcare concerns?

SOCIAL & COMMUNITY

Do you have a place to live and what are your housing conditions? Do you feel safe at home and in your community? Do you have transportation to your PCP, therapy appointments (if applicable) and additional specialists? What are your social and community connections (i.e. religious services, neighborhood groups, educational services, and support and advocacy groups, etc.)? Are you utilizing these connections? Do you have additional social & community concerns?

INTRINSIC FACTORS

We are interested in honoring your values and beliefs. Tell me about any considerations that we should know about related to your religious beliefs/practices such as diet, prayer meditation? Is there anything you would like for us to know about how to help you to regain/maintain your health? Do you have mobility limitations? Are there any additional concerns?

DOES THE INDIVIDUAL HAVE AN ADVANCE DIRECTIVE?

☐ Yes ☐ No

DOES THE INDIVIDUAL HAVE A WILL OR LIVING WILL?

☐ Yes ☐ No

IF NOT, DOES INDIVIDUAL WANT MORE INFORMATION ABOUT OBTAINING AN ADVANCE DIRECTIVES OR OTHER LIFE PLANNING RESOURCES?

☐ Yes ☐ No

LIFE PLANNING RESOURCES PROVIDED, IF NO WHY NOT?

BRIEFLY DESCRIBE THE PRESENTING NEEDS OF THE INDIVIDUAL

(e.g., Why was the individual identified for or referred to Complex Case Management?)

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

SOCIAL / NATURAL SUPPORTS ☐ **No Natural Supports**

SUPPORTS		
Name	Relationship	State how this person helps the individual achieve their goals

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

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?

PARENTING SUPPORT [FOR ALL CHILDREN AGED 0-17 YEARS]

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

PARENT'S TOTAL NUMBER OF DEPENDENTS (INCLUDING THIS CHILD):

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

PARENT'S 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

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 PARENT'S 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

CHILD/YOUTH 11-17YRS

IS THERE A FAMILY HISTORY OF ALCOHOL OR DRUG USE?
☐ Yes ☐ No

When was the last time that...	Past Month	2-3 Months Ago	4-12 Months Ago	1+ Years Ago	Never
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 avoid withdrawal problems?	☐	☐	☐	☐	☐

Substance Rank	Substance	Route of Administration	Frequency of Use	Age at First Use

ADULT OR CHILD?

☐ PHQ-9 Adult ☐ PHQ-9 Modified for Adolescents ☐ Not Applicable / Under Age 11

OVER THE LAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS:	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things?	☐	☐	☐	☐
Feeling down, depressed, or hopeless?	☐	☐	☐	☐
Trouble falling or staying asleep, or sleeping too much?	☐	☐	☐	☐
Feeling tired or having little energy?	☐	☐	☐	☐
Poor appetite or overeating?	☐	☐	☐	☐
Feeling bad about yourself, or that you are a failure or have let yourself or your family down?	☐	☐	☐	☐
Trouble concentrating on things, such as reading the newspaper or watching television?	☐	☐	☐	☐
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual?	☐	☐	☐	☐
Thoughts that you would be better off dead or of hurting yourself in some way?	☐	☐	☐	☐

Total Score:

IN THE PAST YEAR HAVE YOU FELT DEPRESSED OR SAD MOST DAYS, EVEN IF YOU FELT OKAY SOMETIMES?

☐ Yes ☐ No

IF YOU CHECKED OFF ANY PROBLEMS, HOW DIFFICULT HAVE THESE PROBLEMS MADE IT FOR YOU TO DO YOUR WORK, TAKE CARE OF THINGS AT HOME, OR GET ALONG WITH OTHER PEOPLE?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

HAS THERE BEEN A TIME IN THE PAST MONTH WHEN YOU HAVE HAD SERIOUS THOUGHTS ABOUT ENDING YOUR LIFE?

☐ Yes ☐ No

HAVE YOU EVER IN YOUR WHOLE LIFE, TRIED TO KILL YOURSELF OR MADE A SUICIDE ATTEMPT?
☐ Yes ☐ No

PHQ-9 SCORES AND PROPOSED TREATMENT ACTIONS		
PHQ-9 Score	Depression Severity	Proposed Treatment Actions
0-4	None-Minimal	None/Ongoing monitoring
5-9	Mild	Watchful Waiting; repeat PHQ-9 at follow-up
10-14	Moderate	Treatment plan, considering counseling, Psychiatric follow-up/or pharmacotherapy
15-19	Moderately Severe	Active treatment psychiatrist and therapy
20-27	Severe	Immediate review and treatment by psychiatrist

WHO-DAS

DATE

In the past 30 Days, how much difficulty did you have in?

1. STANDING FOR LONG PERIODS SUCH AS 30 MINUTES?
☐ No Difficulty
☐ Mild Difficulty
☐ Moderate Difficulty
☐ Severe Difficulty
☐ Extreme Difficulty or Can't Do

2. TAKING CARE OF YOUR HOUSEHOLD RESPONSIBILITIES?
☐ No Difficulty
☐ Mild Difficulty
☐ Moderate Difficulty
☐ Severe Difficulty
☐ Extreme Difficulty or Can't Do

3. LEARNING A NEW TASK, FOR EXAMPLE, LEARNING HOW TO GET TO A NEW PLACE?
☐ No Difficulty
☐ Mild Difficulty
☐ Moderate Difficulty
☐ Severe Difficulty
☐ Extreme Difficulty or Can't Do

4. HOW MUCH OF A PROBLEM DID YOU HAVE IN JOINING COMMUNITY ACTIVITIES (FOR EXAMPLE, FESTIVITIES, RELIGIOUS OR OTHER ACTIVITIES) IN THE SAME WAY AS EVERYONE ELSE?
☐ No Difficulty
☐ Mild Difficulty
☐ Moderate Difficulty
☐ Severe Difficulty
☐ Extreme Difficulty or Can't Do

5. HOW MUCH HAVE YOU BEEN EMOTIONALLY AFFECTED BY YOUR HEALTH PROBLEMS?
☐ No Difficulty
☐ Mild Difficulty
☐ Moderate Difficulty
☐ Severe Difficulty
☐ Extreme Difficulty or Can't Do

6. CONCENTRATING ON DOING SOMETHING FOR TEN MINUTES?
☐ No Difficulty
☐ Mild Difficulty
☐ Moderate Difficulty
☐ Severe Difficulty
☐ Extreme Difficulty or Can't Do

7. WALKING A LONG DISTANCE SUCH AS HALF A MILE?
☐ No Difficulty
☐ Mild Difficulty
☐ Moderate Difficulty
☐ Severe Difficulty
☐ Extreme Difficulty or Can't Do

8. WASHING YOUR WHOLE BODY?
☐ No Difficulty
☐ Mild Difficulty

☐ Moderate Difficulty
☐ Severe Difficulty
☐ Extreme Difficulty or Can't Do

9. GETTING DRESSED?
☐ No Difficulty
☐ Mild Difficulty
☐ Moderate Difficulty
☐ Severe Difficulty
☐ Extreme Difficulty or Can't Do

10. DEALING WITH PEOPLE YOU DO NOT KNOW?
☐ No Difficulty
☐ Mild Difficulty
☐ Moderate Difficulty
☐ Severe Difficulty
☐ Extreme Difficulty or Can't Do

11. MAINTAINING A FRIENDSHIP?
☐ No Difficulty
☐ Mild Difficulty
☐ Moderate Difficulty
☐ Severe Difficulty
☐ Extreme Difficulty or Can't Do

12. YOUR DAY-TO-DAY WORK/SCHOOL?
☐ No Difficulty
☐ Mild Difficulty
☐ Moderate Difficulty
☐ Severe Difficulty
☐ Extreme Difficulty or Can't Do

TOTAL SCORE

13. OVERALL, IN THE LAST 30 DAYS, HOW MANY DAYS WERE THESE DIFFICULTIES PRESENT?

14. IN THE PAST 30 DAYS, FOR HOW MANY DAYS WERE YOU TOTALLY UNABLE TO CARRY OUT YOUR USUAL ACTIVITIES BECAUSE OF ANY HEALTH CONDITION?

15. IN THE PAST 30 DAYS, NOT COUNTING THE DAYS YOU WERE TOTALLY UNABLE, FOR HOW MANY DAYS DID YOU CUT BACK OR REDUCE YOUR USUAL ACTIVITIES BECAUSE OF ANY HEALTH CONDITION?

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

IF YES, EXPLAIN

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

IF YES, EXPLAIN

DO YOU SOMETIMES FEEL UNSTEADY WHEN YOU WALK?
☐ Yes ☐ No

IF YES, EXPLAIN

DO YOU STEADY YOURSELF BY HOLDING ONTO FURNITURE WHEN WALKING?
☐ Yes ☐ No

IF YES, EXPLAIN

DO YOU TAKE ANY MEDICATIONS THAT MAKE YOU LIGHTHEADED OR MORE TIRED THAN USUAL?
☐ Yes ☐ No

IF YES, EXPLAIN

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

IF YES, EXPLAIN

IS IMMEDIATE INTERVENTION FOR RISK/SAFETY NEEDED?
☐ Yes ☐ No

IF YES, EXPLAIN PLAN

IS THERE A CRISIS PLAN?
☐ Yes ☐ No

IF YES, EXPLAIN

HAS THE CONSUMER HAD AN EPSDT SCREENING THE PAST 12 MONTHS?
☐ Yes ☐ No

IF YES, EXPLAIN

☐ No reported history of intellectual/developmental disability

DURING PREGNANCY, DID THE MOTHER..	
EXPERIENCE ANY DEPRESSION, INCLUDING POST-PARTUM DEPRESSION? ☐ Yes ☐ No ☐ Unknown	EXPLAIN
EXPERIENCE ANY INFECTIONS? ☐ Yes ☐ No ☐ Unknown	EXPLAIN
HAVE ANY COMPLICATIONS? ☐ Yes ☐ No ☐ Unknown	EXPLAIN
USE TOBACCO, ALCOHOL, OR DRUGS? ☐ Yes ☐ No ☐ Unknown	EXPLAIN
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

XPLAIN

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?
lbs oz

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 UNKNOWN)	
ROLL OVER	☐ Unknown
CRAWL	☐ Unknown
SIT UP ON OWN	☐ Unknown
WALK	☐ Unknown
SPEAK WORDS	☐ Unknown
SPEAK SENTENCES	☐ Unknown
BECOME TOILET TRAINED	☐ Unknown
IF 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. ☐ 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 judgment
   ☐ Acts younger than children the 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

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
TRAUMA CHILD EMOTIONAL OTHER EXPLAIN

4. Is the child having problems in school?

☐ Low or failing grades
☐ Inadequate performance
☐ Difficulty with authority
☐ Attention and or memory problems
☐ Trauma Child School Other

WILL TRAUMA HISTORY BE GOAL OF PCP?
☐ Yes ☐ No

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

HEIGHT
ft in

WEIGHT
lbs oz

BMI:

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

☐ None			
☐ Allergies	☐ Anemia	☐ Arrhythmias	☐ Arthritis
☐ Asthma	☐ Cancer	☐ Chronic Fatigue	☐ Chronic Pain
☐ Crohn's disease	☐ COPD	☐ Diabetes	☐ Eating Disorders
☐ Endometriosis	☐ Fibromyalgia	☐ Gastritis	☐ Gout
☐ Heart Disease	☐ Hepatitis	☐ Hernia	☐ HIV/AIDS
☐ Menopause	☐ Headaches/Migraines	☐ Multiple Sclerosis	☐ Renal Failure
☐ Sleep Apnea	☐ Stroke	☐ Tuberculosis	☐ Ulcers
☐ Hypertension	☐ Obesity	☐ Sickle Cell Anemia	
☐ Other			

ADVERSE REACTIONS

DRUG / ALLERGEN
REPORTED BY
SEVERITY
☐ Not Assessed
☐ Mild
☐ Severe
☐ Life-Threatening
☐ This is an Allergy
REACTIONS
NOTES
START

DRUG / ALLERGEN
REPORTED BY
SEVERITY
☐ Not Assessed
☐ Mild
☐ Severe
☐ Life-Threatening
☐ This is an Allergy
REACTIONS
NOTES
START

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

☐ None			
☐ Asthma	☐ Allergies	☐ Cancer	☐ COPD
☐ Diabetes	☐ Heart Disease	☐ Hypertension	☐ Stroke
☐ Suicide	☐ Mental Illness	☐ Substance Use	☐ Intellectual/Developmental Disability
☐ HIV	☐ Hepatitis	☐ Sickle Cell Anemia	

HEALTH INDICATORS AND OTHER CONDITIONS

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

OTHER HEALTH FACTORS

CURRENTLY PREGNANT?
☐ Yes ☐ No ☐ Don't Know

SELF-REPORTED MEDICATIONS

MEDICATION	DOSAGE	QTY
MEDICATION TYPE	START DATE	END DATE
INSTRUCTIONS	REASON	
PHYSICIAN NAME	PRESCRIBING PHYSICIAN TYPE	
MEDICATION	DOSAGE	QTY
MEDICATION TYPE	START DATE	END DATE
INSTRUCTIONS	REASON	
PHYSICIAN NAME	PRESCRIBING PHYSICIAN TYPE	

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

IF YES, PLEASE EXPLAIN

OVER THE PAST 7 DAYS, HOW MANY DAYS DID YOU MISS ANY OF YOUR MEDICATION PRESCRIBED FOR YOUR BEHAVIORAL HEALTH?

OVER THE PAST 7 DAYS, HOW MANY DAYS DID YOU MISS ANY OF YOUR MEDICATION PRESCRIBED FOR YOUR PHYSICAL HEALTH?

PRIMARY CARE PHYSICIAN

WHEN WAS THE LAST TIME THE INDIVIDUAL SAW A PRIMARY CARE DOCTOR / FAMILY PHYSICIAN / PEDIATRICIAN? (DATE OF LAST VISIT)

DO YOU HAVE OTHER DOCTORS OR SPECIALISTS YOU SEE FOR YOUR HEALTH CONDITIONS?
☐ Yes ☐ No

IF SO, PLEASE LIST THEM

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? (DATE OF LAST VISIT)

WHEN WAS THE LAST TIME THE INDIVIDUAL HAD AN EYE EXAM? (DATE OF LAST VISIT)

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

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

DIET AND EXERCISE

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

DO 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 USE OTHER TOBACCO PRODUCTS?
☐ Yes ☐ No

IF YES, HOW MUCH DO YOU USE 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

CORRECTIONS / LEGAL STATUS

CORRECTIONS RELATED STATUS

Most Recent Offense	Date

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

EDUCATION LEVEL

CURRENTLY IN MAINSTREAM SPECIAL EDUCATION SCHOOL ATTENDANCE STATUS

CURRENT SCHOOL/SCHOOL DISTRICT

DATE OF FSP DATE OF LAST IEPC

AT AGE-APPROPRIATE GRADE LEVEL?
☐ Yes ☐ No

IF NO, EXPLAIN

☐ Expelled ☐ Excessive Absenteeism

LIMITED ENGLISH PROFICIENCY?
☐ Yes ☐ No

IF YES, EXPLAIN

MOTHER'S EDUCATION ☐ Not Applicable

MOTHER'S EDUCATION LEVEL

☐ Literacy Issues

FATHER'S EDUCATION ☐ Not Applicable

FATHER'S EDUCATION LEVEL

☐ Literacy Issues

ISSUES OR CONCERNS WITH EDUCATION

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

RESIDENTIAL LIVING ARRANGEMENT

LIVING ARRANGEMENTS

DOES THE INDIVIDUAL HAVE A CAREGIVER?
☐ Yes ☐ No

IS THE CAREGIVER IN NEED OF RESOURCES?
☐ Yes ☐ No

IF SO, WHAT WILL BE PROVIDED?

ARE THERE ANY CONCERNS OR PROBLEMS RELATED TO TRANSPORTATION?
☐ Yes ☐ No

ASSESSMENT OF TRANSPORTATION NEEDS
☐ Independent Use of Public Transportation
☐ Needs Assistance with Use of Public Transportation
☐ Able to Drive Independently
☐ Dependent on Others to Drive

EXPLAIN IF NECESSARY

DOES THE INDIVIDUAL UNDERSTAND THE INSURANCE BENEFITS CURRENTLY AVAILABLE TO HIM OR HER?
☐ Yes ☐ No

ARE THERE BENEFITS THE INDIVIDUAL IS NOT USING BUT COULD BENEFIT FROM?
☐ Yes ☐ No

IS THE INDIVIDUAL CURRENTLY UTILIZING ANY COMMUNITY RESOURCES?
☐ Yes ☐ No

IF YES, PLEASE EXPLAIN

ARE THERE ADDITIONAL COMMUNITY RESOURCES THE INDIVIDUAL MAY BENEFIT FROM?
☐ Yes ☐ No

IF YES, PLEASE EXPLAIN

MENTAL STATUS EXAM

IS INDIVIDUAL ORIENTED TO: (CHECK ALL THAT APPLY)

☐ Individual ☐ Place ☐ Time ☐ Situation

EXPLAIN IF NECESSARY

GROOMING
☐ Excellent ☐ Good ☐ Marginal ☐ Poor

HYGIENE
☐ Excellent ☐ Good ☐ Marginal ☐ Poor

DRESS
☐ Inappropriate to weather ☐ Unkempt ☐ Unusual ☐ Unremarkable

MEMORY IS

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

EXPLAIN IF NECESSARY

AWARENESS IS

☐ Alert ☐ Dull ☐ Stupor

EXPLAIN IF NECESSARY

CONCENTRATION IS

☐ Normal ☐ Able to Focus ☐ Distractible

EXPLAIN IF NECESSARY

JUDGMENT IS

☐ 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 PROCESSES: (CHECK ALL THAT APPLY)

☐ Unremarkable ☐ Obsessions ☐ Compulsions ☐ Paranoid

☐ Irrational ☐ Peculiar ☐ Loosely Organized ☐ Illogical

☐ Other

EXPLAIN IF NECESSARY

STREAM OF MENTAL ACTIVITY

☐ Normal ☐ Delayed Response ☐ Perseverating ☐ Circumstantial

☐ Tangential ☐ Flight Of Ideas ☐ Slowed ☐ Racing ☐ Blocked

☐ Other

EXPLAIN IF NECESSARY

CHARACTERISTICS OF SPEECH

☐ Unremarkable ☐ Soft ☐ Loud ☐ Pressured

☐ Nonverbal ☐ Stuttering ☐ Incoherent

☐ Other

EXPLAIN IF NECESSARY

PRESENTATION DURING THE INTERVIEW

☐ Unremarkable ☐ Embarrassed ☐ Seductive ☐ Impulsive
☐ Dramatic ☐ Needy ☐ Guarded
☐ Other

EXPLAIN IF NECESSARY

EMOTIONAL STATE/AFFECT/REACTIONS

☐ Appropriate ☐ Inappropriate ☐ Irritable ☐ Angry
☐ Calm ☐ Sad ☐ Depressed ☐ Anxious
☐ Absense of Emotions ☐ Unstable Emotions ☐ Emotions are Incongruent with Thought Content
☐ Other

EXPLAIN IF NECESSARY

CLINICAL SUMMARY

RECOMMENDATIONS

DIAGNOSTIC SUMMARY

DIAGNOSIS

AXIS I		ICD-10	Description	Status Date	Status	

AXIS II		ICD-10	Description	Status Date	Status	

AXIS III		ICD-10	Description	Status Date	Status	

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

CURRENT GAF

GAF DATE

Diagnostic Summary

Additional Information

CO-OCCURRING CONSUMER QUADRANT

- ☐ Mild Psychopathology with Substance Abuse (Psych. Low/Substance Low)
- ☐ Serious & Persistent Mental Illness with Substance Abuse (Psych. High/Substance Low)
- ☐ Psychiatrically Complicated Substance Dependence (Psych. Low/Substance High)
- ☐ Serious & Persistent Mental Illness with Substance Dependence (Psych. High/Substance High)
- ☒ N/A

DIAGNOSIS MADE BY (NAME/CREDENTIALS)

DIAGNOSIS EFFECTIVE DATE

COMPLEX CASE MANAGEMENT

IS COMPLEX CASE MANAGEMENT RECOMMENDED?

☐ Yes ☐ No

IF NO, PLEASE DESCRIBE REASON FOR DENIAL

IF YES, WHAT INITIAL REFERRALS WILL BE MADE FOR THIS CONSUMER?

PLEASE DESCRIBE THE RELEVANT BARRIERS TO THE DEVELOPMENT AND ATTAINMENT OF CCM GOALS

IN WHAT WAYS WILL CCM HELP OVERCOME THE CONSUMER'S BARRIERS TO CARE?

THE NEXT SCHEDULED MEETING WITH THE CONSUMER IS ON

SIGNATURES

STAFF SIGNATURE / CREDENTIALS

DATE