WestCoast Children's Clinic

Initial Assessment Summary

Client Name:
Birthdate:
Client ID No.:
Episode Opening Date:
Program RU#:
Other Agencies Involved:

Program:

Date(s) of Interview(s):	Informants: ☐ Client ☐ Other: ☐ Family/Guardian ☐ DSS/DHS/JPD ☐ School ☐ CWW	Location: ☐ Clinic - Fruitvale ☐ Foster Home ☐ Clinic - El Cerrito ☐ Group Home ☐ Assessment Center ☐ School ☐ MISSSEY ☐ Other:

Section I: Initial Assessment Summary

1. IDENTIFYING INFORMATION Prior Client: ☐ Y ☐ N

Age:		Gender:	Legal Guardian:

Ethnicity: Secondary Ethnicity:

Address: Phone:

Primary Language: Interpreter Needed? ☐ Y ☐ N
Other Languages in Home: What Language?

Primary living situation at time of referral:
☐ With parent(s) ☐ With extended family ☐ Foster home ☐ Group home ☐ NREFM ☐ Other:

Referral Source: ☐ Self ☐ Parent/Legal Guardian ☐ School ☐ Police ☐ Probation ☐ CFS ☐ Other:

☐ SOCIAL SERVICES: ☐ 300 ☐ Legal Guardianship ☐ Adoption ☐ Voluntary
Social Worker: Phone: County:

☐ PROBATION/JUVENILE JUSTICE: Court Mandated Treatment: ☐ Y ☐ N ☐ U History of Arrest: ☐ Y ☐ N ☐ U
☐ Court Ward (601, 602) Probation Officer: Phone:

School: Grade (highest completed): City:
Teacher/Counselor: ☐ Unk Phone:

☐ SPECIAL EDUCATION:
☐ AB3632 ☐ Shadow ☐ Mentor ☐ SDC ☐ RSP ☐ Unknown
☐ Wrap Around Services ☐ TBS ☐ Tutor ☐ CESDC ☐ Other:
Eligibility/Placement: Current IEP (date):

☐ OTHER SERVICES/SUPPORT:

☐ Family Involvement Team (FIT) Name: Phone:
☐ Family Mosaic Project (FMP) Name: Phone:
☐ Children's System of Care (CSOC) Name: Phone:

Names of people living in home	Age	Relation to Client

Comments: (Include information about any significant family members not living in current home. Include any significant family hx.)

2. PRESENTATION/HISTORY OF PRESENTING PROBLEM

Current presentation *(include symptoms, behaviors, onset, duration, severity, & family response to current situation):*

3. IMPACT ON FUNCTIONING

Describe impact on self-care, home, school, and community. Please note whether the impairments are due to symptoms/ behavior of the included DSM-IV diagnosis (Axis I):

4. RELEVANT HISTORY

Describe precipitating events and other significant life events leading to current situation:

5. CULTURAL FACTORS/SPECIAL NEEDS

Special Needs: ☐ Cultural ☐ Linguistic ☐ Physical ☐ Visual ☐ Hearing ☐ Other ☐ None Reported

Cultural factors or special needs which may influence presenting problems as viewed by child/youth/parent/caregiver and clinician:

6. RISK BEHAVIORS

Describe aggressive/violent behavior/danger to others *(include level of impairment [e.g., school suspension, law enforcement/ incarceration, crisis services, and hospitalization])*: **Date of onset:** ☐ N/A or Unk

Self-destructive/suicidal behavior/danger to self *(include level of impairment [e.g., ideation, plan, threats, attempts/gestures, crisis services, hospitalization])*. **Date of onset:** ☐ N/A or Unk

7. SUBSTANCE ABUSE/DISORDER

Describe substance/alcohol abuse (specify onset, type—including tobacco and caffeine, frequency and amount, and level of impairment [e.g., missing work/school, law enforcement/incarceration, family's level of concern and attempts to intervene]):

8. CHILD STRENGTHS and SUPPORTS/FAMILY STRENGTHS and NEEDS

A. Child Strengths

Describe child strengths and supports

B. Caregiver Strengths and Needs

Caregiver name: Caregiver Relationship to Child:

If Foster Caregiver:

Caregiver Relationship to child *(choose one):* ☐ Relative ☐ Non-relative extended family member ☐ Other Paid Caregiver

Family strengths & needs:

9. PSYCHIATRIC HISTORY *(include psychiatric hospitalization and residential treatment, etc.):* ☐ N/A

Date	Provider/Type	Reasons for Treatment	Outcome (was it helpful and why)

10. MEDICAL HISTORY

	Name	Phone	Contacted	Coordinating
Primary Physician:				
Other Provider:				
Alternative:				

Tobacco Use:

Counseled to Quit:

Past / current illnesses and medical conditions *(include previous hospitalizations)***:**

Alternative healing practice/date *(e.g., acupuncture, hypnosis, etc.):* ☐ N/A

Date	Provider/Type	Reasons for Treatment	Outcome (was is helpful and why)

Current medication/previous medication: ☐ N/A

Name	Dosage	Date Started	Last Dose	Effectiveness / Side Effects

10. MEDICAL HISTORY *(continued)*

Allergies/Adverse reactions to medication: ☐ Unk/None Reported

Date of last physical exam: ☐ Unk **Date of last dental exam:** ☐ Unk

11. DEVELOPMENTAL HISTORY

Describe significant events in prenatal/birth/early childhood stages, as well as enduring or pervasive developmental or cognitive difficulties

Describe significant events in Latency stage *(peer/sibling relations, extracurricular activities, delinquency)*:

Describe significant events in Adolescence *(include onset of puberty, extracurricular activities, teen parenthood, delinquency, gang involvement)*:

12. ABUSE / TRAUMA HISTORY

Abuse history *(include type, age, and details of any neglect, and/or physical, sexual, and emotional abuse)*:

13. PLACEMENT HISTORY ☐ Unable to obtain

14. EDUCATIONAL HISTORY ☐ Unable to obtain

Describe significant educational issues such as learning disabilities, school behavioral problems, etc.

15. MENTAL STATUS EXAM (Child and Adolescent)

16. CLINICAL FORMULATION

Target symptoms/focus of treatment:

Impairments and their relationship to symptoms:

Interventions and how they have reduced the impairment or symptoms:

Interventions to be used now, and why:

17. DSM-IV-TR DIAGNOSIS ***(Definition of problems/signs/symptoms that support diagnosis and impairment to functioning; context for presenting problems; if applicable include any relevant cultural factors):***

18. SERVICE NECESSITY

19. CLINICAL RATIONALE FOR COMMUNITY-BASED TREATMENT

CANS: Developmental Needs (DD) Module

This module is intended to describe any needs that might involve services for Developmental Disabilities including services provided through the Department of Developmental Disabilities.

COGNITIVE

DEVELOPMENTAL

COMMUNICATION

SELF-CARE DAILY LIVING SKILLS

Specify IQ: ☐ Unknown **Means of assessment:**

Specify Developmental Diagnoses:

Does the child require any special assistive devices? ☐ Yes ☐ No

If YES, please specify:

Does the child require any special accommodations for home or school? ☐ Yes ☐ No

If YES, please specify:

Comments:

CANS: Health Module

Child's Current Health Status: ☐ Excellent ☐ Good ☐ Fair ☐ Poor **Are child's immunizations up to date?** ☐ Yes ☐ No

Are child's immunization records available? ☐ Yes ☐ No **Date of last TB test:**

Past Medical Conditions:

Current Medical Conditions:

☐ Allergies ☐ Asthma ☐ Diabetes ☐ Heart Disease ☐ Other Current Medical Conditions:
☐ Physical Injury ☐ Seizure Disorder ☐ Thyroid Disorder ☐ Traumatic Brain Injury

Specify physical injury:

Current Medical Treatment:

Medications:

Is the child reporting any pain? ☐ Yes ☐ No **How is the child's dental health?** ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Any activity limitations/restrictions due to health? ☐ Yes ☐ No

If YES, please specify:

CANS: Sexuality Module

Please describe any sexual development issues that have been identified in the past year:

PROMISCUITY *(past year)*

REACTIVE SEXUAL BEHAVIOR *(using time frames provided in the anchors)*

MASTURBATION *(past 30 days)*

CHOICE OF RELATIONSHIPS *(past 30 days)*

KNOWLEDGE OF SEX *(past 30 days)*

SEXUAL IDENTITY *(past year)*

Are there any sexually deviant behaviors that are not captured in the above ratings? ☐ Yes ☐ No

If YES, specify:

What interventions have been tried that were not successful?

What interventions have been tried that were at least partially successful?

CANS: Trauma Module

CHARACTERISTICS OF THE TRAUMATIC EXPERIENCE(S): *(Please rate within the lifetime)*

SEXUAL ABUSE

NATURAL DISASTER

WITNESS FAMILY VIOLENCE

PHYSICAL ABUSE

WITNESS TO COMMUNITY VIOLENCE

EMOTIONAL ABUSE

WITNESS/VICTIM TO CRIMINAL ACTIVITY

MEDICAL TRAUMA

Other Traumatic Experience(s) (e.g. natural disasters):

IF SEXUAL ABUSE > 1, COMPLETE THE FOLLOWING:

EMOTIONAL CLOSENESS TO PERPETRATOR

FORCE

FREQUENCY OF ABUSE

REACTION TO DISCLOSURE

DURATION

ADJUSTMENT: *(past 30 days)*

AFFECT REGULATION

ATTACHMENT

INTRUSIONS

DISSOCIATION

What Trauma Treatment/Services have been tried in the past and have been helpful?

What Trauma Treatment/Services have been tried in the past and not been helpful?

Recommendations for Treatment Approach:

CANS: Substance Abuse Disorder (SUD) Module

SEVERITY OF USE

DURATION OF USE

STAGE OF RECOVERY

PEER INFLUENCES

PARENTAL INFLUENCES

ENVIRONMENTAL INFLUENCES

Specify Substance-related diagnoses

During the past six months, about how many times did the youth use these substances without a doctor's order?	**Never**	**A Few Times Ever**	**Once a Month**	**Once a Week**	**A Few Times a Week**	**Once or More a Day**
An alcoholic drink.	☐	☐	☐	☐	☐	☐
Marijuana (pot, weed, grass, hash, bud)	☐	☐	☐	☐	☐	☐
Inhalants (things you sniff, huff, or breathe to get high)	☐	☐	☐	☐	☐	☐
Cocaine (coke, crack, rock, base, snort)	☐	☐	☐	☐	☐	☐
LSD or other psychedelics (acid, mescaline, peyote, mushrooms)	☐	☐	☐	☐	☐	☐
Ecstasy (E, X, EXTC, MDMA)	☐	☐	☐	☐	☐	☐
Any other drug or pill (illegal or prescribed) to get high	☐	☐	☐	☐	☐	☐
Two or more drugs at the same time (for examples, alcohol with marijuana, cocaine with PCP, ecstasy with mushrooms)	☐	☐	☐	☐	☐	☐

How many times has the youth tried to quit or stop using:	**N/A Never Used**	**0 Times**	**1 Time**	**2 - 3 Times**	**4 or More Times**
Alcohol?	☐	☐	☐	☐	☐
Marijuana?	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

What Substance Abuse Treatment/Services have been tried in the past and have been helpful?

What Substance Abuse Treatment/Services have been tried in the past and have not been helpful?

Comments:

CANS: Violence Module

HISTORICAL RISK FACTORS *(Please rate within the lifetime)*

HISTORY OF PHYSICAL ABUSE

HISTORY OF VIOLENCE

WITNESS TO DOMESTIC VIOLENCE

WITNESS TO ENVIRONMENTAL VIOLENCE

Please describe important Historical Risk Factors:

EMOTIONAL/BEHAVIORAL RISKS *(Past 30 days)*

BULLYING

FRUSTRATION MANAGEMENT

HOSTILITY

PARANOID THINKING

SECONDARY GAINS FROM ANGER

VIOLENT THINKING

Please describe important Behavioral/Emotional Risks:

RESILIENCY FACTORS *(Past 30 days)*

AWARENESS OF VIOLENCE POTENTIAL

RESPONSE TO CONSEQUENCES

COMMITMENT TO SELF CONTROL

TREATMENT INVOLVEMENT

Please describe important resiliency factors that help reduce the risk of future violence:

CANS: Sexually Aggressive Behavior (SAB) Module

Date of most recent sexually aggressive behavior:

Note: Sexually abusive behavior is defined as non-consenting sexual activity initiated by the abuser in which one of the following conditions apply: use or threat of physical force, age differential, power differential. A child or youth is only assessed on this dimension if they were an active abuser in this form of sexual abuse of another person.

Describe the most recent behavior (include activity, circumstances, reasons and results):

Was sexual act against a family member? ☐ Yes ☐ No **Identify:**

Please rate the highest level from the most recent episode of sexual behavior:

RELATIONSHIP *(most recent episode)*

PHYSICAL FORCE/THREAT *(most recent episode)*

PLANNING *(most recent episode)*

AGE DIFFERENTIAL *(most recent episode)*

TYPE OF SEX ACT *(most recent episode)*

RESPONSE TO ACCUSATION *(past 30 days)*

TEMPORAL CONSISTENCY

HISTORY OF SEXUALLY AGGRESSIVE BEHAVIOR TOWARD OTHERS

SEVERITY OF SEXUAL ABUSE

PRIOR TREATMENT

Is the youth currently subject to the provisions of Megan's Law? ☐ Yes ☐ No **Tier:** ☐ 1 ☐ 2 ☐ 3

What Specialty Sexual Aggression Treatment/Services have been tried in the past and have been helpful?

What Specialty Sexual Aggression Treatment/Services have been tried in the past and not been helpful?

Recommendations for Treatment Approach

CANS: Runaway Module

FREQUENCY OF RUNNING

CONSISTENCY OF DESTINATION

SAFETY OF DESTINATION

INVOLVEMENT IN ILLEGAL ACTIVITIES

LIKELIHOOD OF RETURN ON OWN

INVOLVEMENT WITH OTHERS

REALISTIC EXPECTATIONS

PLANNING

To what locations has the child run in the past:

What reasons has the youth given for running in the past:

In the past, what does the youth do while on the run?

Has any approach been successful in the past in helping youth control his/her running?

CANS: Juvenile Justice (JJ) Module

Date most recent delinquent behavior:

SERIOUSNESS *(past 30 days)*

PEER INFLUENCES *(past 30 days)*

HISTORY *(using time frames provided in anchors)*

PARENTAL CRIMINAL BEHAVIOR *(past 30 days)*

PLANNING *(past 30 days)*

ENVIRONMENTAL INFLUENCES *(the environment around the youth's living situation)*

COMMUNITY SAFETY *(past 30 days)*

During the past year has the youth committed acts of delinquency against property? ☐ Yes ☐ No

If YES, specify:

During the past year has the youth committed acts of delinquency against people? ☐ Yes ☐ No

If YES, specify:

Has the youth used a weapon in the commission of an act of delinquency? ☐ Yes ☐ No

If YES, specify:

Has the youth committed any acts of delinquency involving illegal substances? ☐ Yes ☐ No

If YES, specify:

Describe any current court orders:

Juvenile Justice Commission contact person: **Telephone:**

Probation Officer: **Telephone:**

Current Living Situation of youth:

Comments:

CANS: Fire Setting Module

Date of most recent fire-setting behavior:

Describe the incident including circumstances, reasons, frequency and results/damage:

Was the child alone at the time of the incident or where other children involved? ☐ Alone ☐ With Others

Rate the child on the following dimensions based on their most recent fire-setting behavior and any prior history of similar behaviors:

SERIOUSNESS *(most recent incident)*

COMMUNITY SAFETY *(past 30 days)*

HISTORY *(using time frames provided in the anchors)*

RESPONSE TO ACCUSATION *(past 30 days)*

PLANNING *(most recent incident)*

REMORSE *(past 30 days)*

USE OF ACCELERANTS *(most recent incident)*

LIKELIHOOD OF FUTURE FIRE SETTING *(past 30 days)*

INTENTION TO HARM *(most recent incident)*

Explain your assessment of the child's likelihood of future fire setting:

Section III: STAT

Prior Visit to AC: ☐ Yes ☐ No ☐ Unknown | Date(s):

Comment:

SIBLINGS OR OTHER FAMILY MEMBERS ADMITTED TO AC

Name	Age	Relation to Client

REASON FOR ADMISSION TO AC

☐ New Entry: (child was removed from home/caregiver; child was not a dependent at time of admission to AC)
☐ Physical Abuse ☐ Sexual Abuse ☐ Neglect ☐ No P/G ☐ Other:

☐ COP: (child was dependent at time of admission to AC; last official living situation was CFS placement (FH, GH, or NREFM) or child was receiving FM services and living with parent/legal guardian)
☐ AWOL ☐ Other behavior of child ☐ No fault of child ☐ Other:

☐ Courtesy hold
☐ Other:

Consultation with Emergency Response Unit: ☐ Yes ☐ No

MEDICAL HISTORY

Child was transported to hospital for medical clearance: ☐ Yes ☐ No
Please describe reason for medical clearance and outcome:

Child was examined by Public Health Nurse: ☐ Yes ☐ No
If yes: ☐ PHN found no heath concerns ☐ PHN found following concerns:

SERVICES PROVIDED/TO BE PROVIDED

☐ Screening Only ☐ Screening & Transition ☐ Screening, Transition, & Extension beyond 30 days

DISCHARGE SUMMARY FOR CASES CLOSED WITHIN 30 DAYS

(a). Progress and Status Summary: (Describe services provided and progress made)

DISCHARGE SUMMARY FOR CASES CLOSED WITHIN 30 DAYS *(continued)*

(b). Rationale for Discharge (Describe reason case is being closed):

(c). Recommendations/Plans for Future Care

(Describe recommendations made to CWW and any referrals that are in place):

(d). Primary Living Situation at Time of Termination:

☐ With parent(s) ☐ With extended family ☐ Foster home ☐ Group home ☐ NREFM ☐ Other:

(e). Initial Transition Goals (**Transition Cases Only)**

1.) Assess mental health needs of child.

2.) Make recommendations to client's social worker (and other involved professionals, as appropriate) regarding ongoing mental health services or other services that would be positive support to client's mental health.

3.) Assist client in transition to and stabilization in placement by intervening to reduce client's presenting symptoms and/or improve client's level of functioning

(f). Additional Comments:

Section III: Discharge

Tentative Discharge Plan/After Care Plan:

Additional Persons Involved in Client's Care: (name/role/phone)

Clinician Signature: _____ Date: _____

Supervisor Approval: _____ Date: _____