CONFIDENTIAL To be completed by Network Providers: Placer County Systems of Care **BIOPSYCHOSOCIAL ASSESSMENT** Authorization Number: New Staff Member: **Update** Division/Office: Name of individual being assessed: ______ Date of assessment: _____ Who was present during assessment? Location of assessment: ______ If minor, attach "Authorization to Treat Minor." 1. **Presenting Problem(s) and Requested Service(s):** What is the client's presenting problem / why are they here? (in client's own words when possible) B. Describe precipitating events: What service(s) is the client asking for? C. 2. Lifespan / Developmental History: A. Health at birth: B. Developmental milestones: Within normal limits (use this box for adults only, complete section if child)

D. Other lifespan / developmental issues: (include mid-life, senior/elder, other issues)

Special services received during lifetime:

C.

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Clie	nt Name	·		Case Number:	
3.	Educ	ation and Occupation:			
	A.	School currently atte	nding, if applicable:		Grade:
	В.	Education history: (in	nclude learning problems, school issu	es). Highest grade completed:	
	C.	Occupation and emp	loyment history: (present and pas	st, include # of years worked, and reaso	ns for periods of unemployment)
	D.	Occupational skills /	training:		
4.	Fami	lly of Origin History:			
	A.	Family's current and	l past psychiatric history:		
	В.	Family's and client's	s physical / sexual / emotional a	buse history:	
	C.	Family's substance u	use / abuse history:		
5.		nt's Current and Signifi tual Supports/Affiliatio		mily Supports, Significant Rela	tionships, Religious and
6.		-		ceiving Services From, i.e., Dep t person–ATTACH RELEASES)	
7.	Clier	nt's Legal History: (AT	TACH RELEASES)		
		Informal Probation	☐ Formal Probation	Parole	Child Welfare Services
		Conservatorship	D.U.I.	Restraining order	☐ None reported
	(des	cribe and, if currently invol	ved, give name of probation officer	, parole office, or case manager and	estimated start and end dates)

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nt Name	t Name:				Case Number:				
Clien A.	nt's Substance Use:	(alcohol and oti	her drugs, check al	l that apply)	☐ No substand	ce use reported			
C T C P	Caffeine Cobacco Over-the-counter me Prescription medicat Other; please identify	ation Marijuana		Stimulants Sedatives Tranquilizers Cocaine		☐ Barbiturates☐ Methamphetamines☐ Opiates☐ Methadone			
	Substance	Age of Amount/ 1st Use Frequency		Duration of Use	Date of Last Use	Period of Heaviest Use	Amount Used in Last 24 hrs.		
, ,	Substance	1st Use	Frequency	of Use	Last Use	neaviest Use	Last 24 III's.		
В.	Does client have	e a history of w	ithdrawal, DTs, b	olackouts (loss	of time), seizures,	etc.? Yes	No		
C.	Ask the client "	What happens v	vhen you stop usi	ing?" What is	the response?				
D.	What is the long	gest period of so	briety?	Wh	en?				
E.					Yes No (A)		SES)		
Clien	nt's Mental Health	Services Histor	ry: (ATTACH I	RELEASES)					
A.	Current and pas	t psychiatric his	tory:	Clie	nt reports no psych	niatric history			
В.	Current service	provider(s):							
C.	Past service pro	vider(s): (includ	le in-patient, out-p	atient; provider	names, dates, therap	eutic interventions	and outcomes)		

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Name:			Case N	(ullibel		
Client reports no Client reports no	outstanding med	ical problems	dical conditions, including allergies) (ATTACH RELEASES)			
Primary Care Physicia	n's name and pho	one #:				
Date of last physical e	xamination:					
List alternative treatme	ents/therapies: (i.e					
If Lab Tests Were D			cable			
Medication History: A. Current psychiatri			reported by client			
Drug Name	Dose/ Frequency	Benefit/ Side Effects	Prescribed By: (Dr.'s Name)	When Prescribed?	When is Next	
Drug Hume	Trequency	Side Effects	(DI: 5 Italie)	Trescribeu.	Rem Required	
B. Past psychiatric m			reported by client			
	Dose/	Benefit/	Prescribed By:	When Prescribed?		
B. Past psychiatric m				When Prescribed?		
	Dose/	Benefit/	Prescribed By:			
	Dose/	Benefit/	Prescribed By:			
	Dose/	Benefit/	Prescribed By:			
	Dose/	Benefit/	Prescribed By:			
Drug Name C. Other medications	Dose/ Frequency	Benefit/ Side Effects None 1	Prescribed By:	Prescribed?		
Drug Name C. Other medications	Dose/ Frequency	Benefit/ Side Effects None 1	Prescribed By: (Dr.'s Name)	Prescribed?	Refill Required	
Drug Name C. Other medications	Dose/ Frequency S: atric prescriptions of	Benefit/ Side Effects None in the indicate and alternative medicate	Prescribed By: (Dr.'s Name) reported by client ions, i.e., homeopathic, herba	Prescribed?	Refill Required	
Drug Name C. Other medications (include non-psychia	S: atric prescriptions of Dose/	Benefit/ Side Effects None in alternative medicate Benefit/	Prescribed By: (Dr.'s Name) reported by client ions, i.e., homeopathic, herba	Prescribed? al remedies) When	Refill Require	
Drug Name C. Other medications (include non-psychia	S: atric prescriptions of Dose/	Benefit/ Side Effects None in alternative medicate Benefit/	Prescribed By: (Dr.'s Name) reported by client ions, i.e., homeopathic, herba	Prescribed? al remedies) When	Refill Require	
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Key:	Severity Ration Rat	_	Mild Less Than 1 Month	2 = Moderate 2 = 1 - 6 Months	3 = Severe 3 = 7 - 11 Months	4 = More T	Than 1
		Sev	verity Durat			Severity	Dui
1. Ans	•			15. Bizarre			
	ic Attacks	-		16. Bizarre			
3. Pho		-		17. Paranoio			
	essive Compulsiv	ve		18. Gender			
	natization			19. Eating D			
-	ression			20. Poor Jud			
	aired Memory				Support System		
	r Self Care Skills				erpersonal Skills		
	s of Interest			23. Conduct 24. School I			
	s of Energy	-		24. School I 25. Family I			
	ual Dysfunction p Disturbance				iving Problems		
	etite Disturbance				Body Movements		
	ight Change						
Mental		escribe client's	s physical appearance		contact, mood, affect, sp , judgment, and orientat		hought
Mental processes	Status: (please descriptions, thought content, descriptions)	escribe client's audio / visual /	s physical appearance / tactile hallucination.		contact, mood, affect, sp		hought
Mental processes Assessm A. Curr	Status: (please do s, thought content, o nent of Risk: ent risk factors: (escribe client's audio / visual /	s physical appearance tactile hallucination. apply)	s, intelligence, insight	contact, mood, affect, sp , judgment, and orientat	ion)	
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17. Summary of Findings / Formulation: (identify problem areas and underlying dynamics. Include info differential diagnosis.)	rmation used to make
18. Recommended Services: (check all that apply.)	
Community referrals made, no further services needed. Medication assessment □ By Primary Care Physician □ By ASOC or CSOC Psychiatrist Individual therapy, frequency recommended is times per month . □ Brief therapy □ Long-ter Family therapy Collateral, describe reason: □ Group, specify type: □ Testing, specify type: (i.e., Conner's, Beck, etc.) □ Day rehab / treatment □ Other, specify:	
19. Services Provided:	
A. If community referrals were made, please describe: None B. If client was placed on a 5150, please give details: (i.e., which hospital, how transported, etc.)	:.)
20. Are the Following Documents Attached? Releases as needed Authorization to Treat a Minor (mandatory for all minors under 12, minors 12 and older may consent for tre Client Services Information Coversheet, CARE-015a (mandatory) Outcome Screen, CARE-011 or 012 (mandatory) Periodic Information Sheet, CARE-024 (mandatory) Test results or other related/relevant documents	atment if certain conditions apply)
Assessment completed by:	
Counselor/Clinician/Practitioner Signature: (include licensure, degree, or job title):	Date:
Print Name: Work Unit/ Organization: Phone	#
Placer County Use Only Supervisor's Signature:	
	No services needed, Close

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Placer County Systems of Care ICD-9-CM Diagnosis Form

Client Name:				_ Case	Number:		
Type of Diagnosis:	Admission D	ischarge 🗌 U	lpdate				
Axis I: Clinical Disorder	rs; Other Conditions	Γhat May Be a F	ocus of Cl	inical Atte	ntion (ICD-9-CM)		
	_					a.	
	-					b.	
						C.	
	_					d.	
Substance Abuse/Depend	lency:						
Does a substance abu	ise/dependency issue		buse diag	□Y∈ nosis?	es	own/Not Reported □c □d	
Axis II: Personality Disc	orders; Mental Retard	lation (ICD-9-C	M)				
						e.	
						f	
	-						
Which Axis I or Axis II I		di-Cal covered IC	'D-0 Diagr	nosis?	a	e ∏f	
						С <u>П</u>	
General Medical Condition Allergies	n: Summary by Client ☐ Carpal Tunnel	Epilepsy/Seizure		□ Migraine		☐ Physical Disability	
☐ Anergies ☐ Anemia	☐ Chronic Pain	☐ Heart Disease	5 5	☐ Multiple		Psoriasis	
☐ Arterial Sclerotic Disease	Cirrhosis	☐ Hepatitis			r Dystrophy	STDs	
☐ Arthritis	Cystic Fibrosis	☐ Hypercholestora	lemia		eral Medical Condition	Stroke	
☐ Asthma	☐ Deaf/Hearing Impaired	☐ Hyperlipidemia		☐ Obesity		☐ Tinnitus	
☐ Birth Defects	□ Diabetes	☐ Hypertension		☐ Osteopo	orosis	□ Ulcers	
☐ Blind/Visually Impaired	☐ Digestive Disorders	☐ Hyperthyroid		☐ Other		☐ Unknown/	
☐ Cancer	☐ Ear Infections	☐ Infertility		☐ Parkinso	on's Disease	Not Reported	
Axis IV: Psychosocial a	nd Environmental Pr	oblems (DSM-IV	TR). Che	eck yes or	no for each proble	em.	
Primary Support Group	☐ Yes ☐ No	Occupational	Yes I		Access to Health Ca		
Social Environment Educational	☐ Yes ☐ No ☐ Yes ☐ No	Housing Economic	☐ Yes ☐ 1		Legal System/Crime Other Problems	☐ Yes ☐ No ☐ Yes ☐ No	
Trauma:		Locrionic		10	- Other Fredering		
Has the client witnessed	violence, lived through	a natural disaster,	been a co	mbatant or	civilian in a war zon	e, 🗌 Yes	
witnessed or been a victi						□ No □ Unknown	
Axis V: Global Assessn	nent of Functioning S	cale (GAF – DSI	M-IV TR)				
Current:	Highest in last 12	months:		Lowest	in last 12 months:		
Transcribed by:					Date		
Transcribed by.					Date	•	
Print Name of Diagnosing Practitioner: Date:							
(Must be Master's level of	or above)			·			
Signature of Licensed	Practitioner:				Date		
(Must include licensure a						·	