

CONFIDENTIAL

To be completed by Network Provider:

Authorization Number: _____
Staff Member: _____
Division/Office: _____

Placer County Systems of Care
BIOPSYCHOSOCIAL ASSESSMENT

New
 Update

Name of individual being assessed: _____ Date assessment began: _____

Who was present during assessment? _____

Location of assessment: _____ ***If minor, attach "Authorization to Treat Minor."***

1. Presenting Problem(s) and Requested Service(s):

A. What is the client's presenting problem / why are they here? (in client's own words when possible)

B. Describe precipitating events:

C. What service(s) is the client asking for?

2. Lifespan / Developmental History:

A. Health at birth:

B. Developmental milestones: Within normal limits (*use this box for adults only, complete section if child*)

C. Special services received during lifetime:

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

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Client Name: _____ **Case Number:** _____

3. Education and Occupation:

A. School currently attending, if applicable: _____ Grade: _____

B. Education history: *(include learning problems, school issues)*. Highest grade completed: _____

C. Occupation and employment history: *(present and past, include # of years worked, and reasons for periods of unemployment)*

D. Occupational skills / training:

4. Family of Origin History:

A. Family's current and past psychiatric history:

B. Family's and client's physical / sexual / emotional abuse history:

C. Family's substance use / abuse history:

5. Client's Current and Significant Past Social Supports, Family Supports, Significant Relationships, Religious and Spiritual Supports/Affiliations:

6. Other Agencies / Systems Client is Involved With or is Receiving Services From, i.e., Dept of Rehab., CalWORKs, ASOC, etc.: *(include the name of the agency and primary contact person—ATTACH RELEASES)*

7. Client's Legal History: (ATTACH RELEASES)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Informal Probation | <input type="checkbox"/> Formal Probation | <input type="checkbox"/> Parole | <input type="checkbox"/> Child Welfare Services |
| <input type="checkbox"/> Conservatorship | <input type="checkbox"/> D.U.I. | <input type="checkbox"/> Restraining order | <input type="checkbox"/> None reported |

(describe and, if currently involved, give name of probation officer, parole office, or case manager and estimated start and end dates)

Client Name: _____

Case Number: _____

8. Client's Substance Use: (alcohol and other drugs, check all that apply) No substance use reported

A.

- Caffeine Alcohol Stimulants Barbiturates
- Tobacco Inhalants Sedatives Methamphetamines
- Over-the-counter medication Hallucinogens Tranquilizers Opiates
- Prescription medication Marijuana Cocaine Methadone
- Other; please identify:

Substance	Age of 1st Use	Amount/Frequency	Duration of Use	Date of Last Use	Period of Heaviest Use	Amount Used in Last 24 hrs.

B. Does client have a history of withdrawal, DTs, blackouts (loss of time), seizures, etc.? Yes No

C. Ask the client "What happens when you stop using?" What is the response?

D. What is the longest period of sobriety? _____ When? _____

E. Has the client received treatment for drug or alcohol issues? Yes No **(ATTACH RELEASES)**
(if yes, list in-patient providers, out-patient, providers, services received, dates of service; and outcomes)

9. Client's Mental Health Services History: (ATTACH RELEASES)

A. Current and past psychiatric history: Client reports no psychiatric history

B. Current service provider(s):

C. Past service provider(s): (include in-patient, out-patient; provider names, dates, therapeutic interventions and outcomes)

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Client Name: _____ **Case Number:** _____

10. Medical History: (document significant past and present medical conditions, including allergies) **(ATTACH RELEASES)**

- Client reports no outstanding medical problems
- Client reports no known allergies
- Client reports the following medical conditions: _____

Primary Care Physician's name and phone #: _____

Date of last physical examination: _____

List alternative treatments/therapies: (i.e., biofeedback, acupuncture, hypnosis, etc.) _____

11. If Lab Tests Were Done, Describe Results: Not applicable

12. Medication History: (ATTACH RELEASES)

A. Current psychiatric medications: None reported by client

Drug Name	Dose/ Frequency	Benefit/ Side Effects	Prescribed By: (Dr.'s Name)	When Prescribed?	When is Next Refill Required?

B. Past psychiatric medications: None reported by client

Drug Name	Dose/ Frequency	Benefit/ Side Effects	Prescribed By: (Dr.'s Name)	When Prescribed?	When is Next Refill Required?

C. Other medications: None reported by client
(include non-psychiatric prescriptions and alternative medications, i.e., homeopathic, herbal remedies)

Drug Name	Dose/ Frequency	Benefit/ Side Effects	Prescribed By: (Dr.'s Name)	When Prescribed?	When is Next Refill Required?

D. Medication allergies or adverse reactions: None known—per client report

Drug Name	Reaction

E. Does client follow medication regime? Yes No Explain: _____

Client Name: _____

Case Number: _____

13. Current Symptoms/Problems: (rate severity and duration for each)

Severity Rating:	1 = Mild	2 = Moderate	3 = Severe
Key: Duration Rating:	1 = Less Than 1 Month	2 = 1 - 6 Months	3 = 7 - 11 Months
			4 = More Than 1 Year

	Severity	Duration		Severity	Duration
1. Anxiety	_____	_____	15. Bizarre Ideation	_____	_____
2. Panic Attacks	_____	_____	16. Bizarre Behavior	_____	_____
3. Phobia	_____	_____	17. Paranoid Ideation	_____	_____
4. Obsessive Compulsive	_____	_____	18. Gender Issues	_____	_____
5. Somatization	_____	_____	19. Eating Disorders	_____	_____
6. Depression	_____	_____	20. Poor Judgement	_____	_____
7. Impaired Memory	_____	_____	21. Lack of Support System	_____	_____
8. Poor Self Care Skills	_____	_____	22. Poor Interpersonal Skills	_____	_____
9. Loss of Interest	_____	_____	23. Conduct Problems	_____	_____
10. Loss of Energy	_____	_____	24. School Problems	_____	_____
11. Sexual Dysfunction	_____	_____	25. Family Problems	_____	_____
12. Sleep Disturbance	_____	_____	26. Indep. Living Problems	_____	_____
13. Appetite Disturbance	_____	_____	27. Unusual Body Movements	_____	_____
14. Weight Change	_____	_____	28. Other: _____	_____	_____

Please describe symptoms / problems above in detail:

14. Mental Status: (please describe client's physical appearance, motor behavior, eye contact, mood, affect, speech pattern, thought processes, thought content, audio / visual / tactile hallucinations, intelligence, insight, judgment, and orientation)

15. Assessment of Risk:

A. Current risk factors: (check all that apply)

- Suicidality: None Ideation Plan Intent w/o means Intent with means
- Homicidality: None Ideation Plan Intent w/o means Intent with means
- If risk exists, client is able to contract not to harm: Self Others
- Impulse control: Sufficient Moderate Minimal Inconsistent Explosive
- Substance abuse: None Abuse Dependence Unstable remission
- Medical risks: No Yes If "Yes", explain: _____

B. Risk history: (explain any significant history of suicidal, homicidal, impulse control, medical or substance abuse behavior that may affect client's current level of risk or impairment to functioning. Include description of plan / ideation / intent checked above)

16. Describe Client Strengths in Achieving Case Plan / Treatment Goals:

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Client Name: _____ **Case Number:** _____

17. Summary of Findings / Formulation: *(identify problem areas and underlying dynamics. Include information used to make differential diagnosis.)*

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-term therapy
- 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.)* Not applicable

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 treatment if certain conditions apply)*
- 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

Assessment must be completed by LPHA/LPHA waived staff:

LPHA/LPHA waived Practitioner Signature: _____ **Date of assessment:** _____
(include licensure, degree, or job title):

Print Name: _____ **Work Unit/ Organization:** _____ **Phone #:** _____

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Supervisor's Signature: _____ **Date:** _____

- Less Intensive - Managed Care Unit needed, Close
- More Intensive - ASOC
- More Intensive - CSOC
- No services

Client Name: _____ Case Number: _____

Diagnosis

Clinical Disorders; Other Conditions That May Be a Focus of Clinical Attention	
_____ . _____	a.
_____ . _____	b.
_____ . _____	c.
_____ . _____	d.

Substance Abuse/Dependency:

Does a substance abuse/dependency issue exist? Yes No Unknown/Not Reported

If yes, which substance disorder is the primary substance abuse diagnosis? a b c d

General Medical Condition: Summary by Client Report or Medical Record Documentation				
<input type="checkbox"/> Allergies	<input type="checkbox"/> Carpal Tunnel	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Migraines	<input type="checkbox"/> Physical Disability
<input type="checkbox"/> Anemia	<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Arterial Sclerotic Disease	<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> STDs
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Hypercholesterolemia	<input type="checkbox"/> No General Medical Condition	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Deaf/Hearing Impaired	<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Obesity	<input type="checkbox"/> Tinnitus
<input type="checkbox"/> Birth Defects	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Blind/Visually Impaired	<input type="checkbox"/> Digestive Disorders	<input type="checkbox"/> Hyperthyroid	<input type="checkbox"/> Other	<input type="checkbox"/> Unknown/
<input type="checkbox"/> Cancer	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Infertility	<input type="checkbox"/> Parkinson's Disease	Not Reported

Trauma:

Has the client witnessed violence, lived through a natural disaster, been a combatant or civilian in a war zone, witnessed or been a victim of a severe accident, or been the victim of physical, emotional, or sexual abuse? Yes No Unknown

Print Name of Diagnosing Practitioner: _____ Date: _____
(Must be LPHA/LPHA waived)

Signature of LPHA/LPHA waived Practitioner: _____ Date: _____
(Must include licensure after signature)

Please Note: The signature date of the diagnosis must match the signature date of the assessment on page 6 of this assessment.