CONTRA COSTA BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

Specialty Mental Health Assessment

Beneficiary: _____ MRN: _____ DOB: _____

Check one: ❑ Intake ❑ Annual

_____ _____
Provider Last Name, First Name (and Group name, if applicable) Location

PRIMARY REASON FOR REFERRAL	***Beneficiary-Identified Problems, History of Beneficiary-Identified Problem(s), Impact of Beneficiary-Identified Problem(s), Beneficiary-Identified Impairment(s):***

FUNCTIONAL IMPAIRMENTS (check all that apply):

☐ Family Relations	☐ Social/Peer Relations	☐ Episodes of decompensation & increase of symptoms, each of extended duration
☐ School Performance/Employment	☐ Physical Health	☐ Other:
☐ Self-Care	☐ Substance Use/Abuse	☐ Other:
☐ Food/Shelter	☐ Activities of Daily Living	☐ Other:
COMMENTS:		

MENTAL STATUS: (Check and/or describe if abnormal or impaired)

Appearance/Grooming:	☐ Unremarkable	☐ Remarkable for:			
Behavior/Relatedness:	☐ Unremarkable	☐ Motor Agitated	☐ Inattentive	☐ Avoidant	☐ Impulsive
	☐ Hostile	☐ Suspicious/Guarded	☐ Motor Retarded	☐ Other:	
Speech:	☐ Unremarkable	☐ Remarkable for:			
Mood/Affect:	☐ Unremarkable	☐ Depressed	☐ Elated/Expansive	☐ Anxious	☐ Labile
	☐ Irritable/Angry	☐ Other:			
Thought Processes:	☐ Unremarkable	☐ Concrete	☐ Distorted	☐ Disorganized	☐ Blocking
	☐ Odd/Idiosyncratic	☐ Paucity of Content	☐ Circumstantial	☐ Tangential	☐ Obsessive
	☐ Flight of Ideas	☐ Racing Thoughts	☐ Loosening of Assoc	☐ Other:	
Thought Content:	☐ Unremarkable	☐ Suicidal Ideation	☐ Homicidal Ideation	☐ Paranoid Ideation	
Perceptual Content:	☐ Unremarkable	☐ Hallucinations	☐ Delusions	☐ Flashbacks	☐ Dissociation
	☐ Depersonalization	☐ Derealization	☐ Ideas of Reference		
Fund of Knowledge:	☐ Unremarkable	☐ Remarkable for:			
Orientation:	☐ Unremarkable	☐ Remarkable for:			
Memory:	☐ Intact	☐ Impaired			
Intellect:	☐ Unremarkable	☐ Remarkable for:			
Insight/Judgment:	☐ Unremarkable	☐ Remarkable for:			
COMMENTS:					

TRAUMA HISTORY/EXPOSURE (Include any psychological, emotional response to an event that is deeply distressing or disturbing.):	☐ ***Experience w/Homelessness*** **Involvement with:** ☐ ***Juvenile Justice*** ☐ **Child Welfare System**

CONTRA COSTA BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

Specialty Mental Health Assessment

Beneficiary: _____ MRN: _____ DOB: _____

MENTAL HEALTH HISTORY (Including past diagnoses, suicide attempts, violence, hospitalizations, and other outpatient treatments & responses):

BIRTH AND DEVELOPMENTAL HISTORY: (Did Beneficiary meet developmental milestones? Were there environmental stressors? Include prenatal and perinatal events, including trauma during pregnancy.)

SUBSTANCE USE HISTORY **CURRENT SUBSTANCE USE**

Type	Prenatal Exposure	Past Use	Age at First Use	None/ Denies	Current Use	If Current Use			In Recovery	Client-perceived Problem?
						Mild	Mod	Sev		
Alcohol	☐	☐		☐	☐	☐	☐	☐	☐	Y ☐ N ☐
Amphetamines	☐	☐		☐	☐	☐	☐	☐	☐	Y ☐ N ☐
Cocaine/Crack	☐	☐		☐	☐	☐	☐	☐	☐	Y ☐ N ☐
Opiates	☐	☐		☐	☐	☐	☐	☐	☐	Y ☐ N ☐
Hallucinogens	☐	☐		☐	☐	☐	☐	☐	☐	Y ☐ N ☐
Sleeping Pills, Pain Killers, Valium, or Similar	☐	☐		☐	☐	☐	☐	☐	☐	Y ☐ N ☐
PCP (phencyclidine) / designer drugs (ghb)	☐	☐		☐	☐	☐	☐	☐	☐	Y ☐ N ☐
Inhalants (paint, gas, glue, aerosols)	☐	☐		☐	☐	☐	☐	☐	☐	Y ☐ N ☐
Marijuana / hashish	☐	☐		☐	☐	☐	☐	☐	☐	Y ☐ N ☐
Tobacco / nicotine	☐	☐		☐	☐	☐	☐	☐	☐	Y ☐ N ☐
Caffeine (energy drinks, sodas, coffee, etc.)	☐	☐		☐	☐	☐	☐	☐	☐	Y ☐ N ☐
Over the counter/other substance:	☐	☐		☐	☐	☐	☐	☐	☐	Y ☐ N ☐

Previous community-based treatment / Inpatient psychiatric admissions / Intoxication/detox/withdrawal management-based admissions and response:

MEDICAL HISTORY:	Last Physical:		Primary Care Provider:	
☐ If client has no PCP, then referral information has been provided (CCCHS Clinic @1-800-495-8885 or Private PCP)				
Allergies **(MANDATORY):**			☐ No Known Allergies	
Include severity of symptoms for allergies:				
Relevant Health History (including surgeries or significant medical /developmental conditions, as reported by client):				
PSYCHIATRIC MEDICATION HISTORY (Include relevant responses, side effects and compliance):				

CURRENT PSYCHIATRIC & NON-PSYCHIATRIC PRESCRIPTION & O.T.C. MEDICATIONS (use page 4 if needed):

Name of Medication	Dosage/ Frequency	Prescribed by	Date Prescribed	Date Last Taken

RX Compliant: ☐ Yes ☐ No ☐ Unknown Explain:

CONTRA COSTA BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

Specialty Mental Health Assessment

Beneficiary: _____ MRN: _____ DOB: _____

RELEVANT FAMILY PSYCHOSOCIAL HISTORY including mental illness, substance abuse, abuse/neglect (physical, sexual, emotional, etc.), suicide (suicide attempt/ unexplained death), and any education/school history**:**	***Family Involvement:*** ☐ **Very** ☐ **Moderate** ☐ **Minimal** ☐ **Not at all**

PSYCHOSOCIAL FACTORS (Living situation, daily activities, social support, cultural and linguistic factors, Legal or justice-involved history, Family history & current family involvement, Military history, Tribal affiliation, LGBTQ, & BIPOC):

SAFETY RISK: ☐ None Identified ☐ Not Currently Acute ☐ Danger to Self ☐ Danger to Others ☐ Domestic Violence
☐ Inability to Care for Self ☐ Physical Abuse ☐ Sexual Abuse ☐ Neglect

FORM(S) COMPLETED: ☐ CPS ☐ APS ☐ Duty to Warn ☐ Safety Plan

Provide additional detail for any box checked above:

Beneficiary Strengths (include information on strengths in achieving goals, personal motivation, drive, interest, resilience, & coping skills):

Beneficiary Protective Factors: (include available resources, supports (including support persons), interpersonal relationships, systems, activities)

Clinical Summary/Medical Necessity (justification for medical necessity/impairments)**:**

Client meets Specialty Mental Health Medical Necessity: ☐ Yes ☐ No (if "no" identify transition plan on page 4)

	DSM-V CODE:	**DSM-V NAME:** ***Must write full diagnosis narrative, no abbreviations***	**ICD-10 CODE:**
(P)			
(S)			

Substance Use Issue: ☐ Yes ☐ No	DSM-V Code:	**ICD-10 Code:**

Service Recommendations:

Modality
☐ Individual Therapy ☐ Group Therapy
☐ Family Therapy ☐ (MD) Med Mgt

Frequency
☐ Weekly ☐ Other: _____
☐ 2x/Month

Duration
☐ 3 months ☐ 6 months
☐ 12 months

Provider: _____ _____ _____ _____
(Print) (Signature) (Licensure) (License/Regist. #) Date

Provider's Signature certifies that the above information is accurate, and all required documentation is on file.

CONTRA COSTA
BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

Specialty Mental Health Assessment

Beneficiary: _____ MRN: _____ DOB:_____

Space for Data Continuation ***(Specify which item you are continuing from)***