



Fairfax County System of Care Office Short Term Behavioral Health Service for Youth

Clinical Assessment

CLIENT NAME:	Click here to enter text.	DOB:	Click here to enter text.
ASSESSMENT DATE:	Click here to enter a date.		
PRESENTING CONCERN:	Click here to enter text.		

MENTAL STATUS EXAMINATION

Appearance/Behavior:	<input type="checkbox"/> oriented	<input type="checkbox"/> person	<input type="checkbox"/> place	<input type="checkbox"/> time
Mood/Predominant Emotion Status:	<input type="checkbox"/> elation	<input type="checkbox"/> fearful	<input type="checkbox"/> sad	<input type="checkbox"/> angry <input type="checkbox"/> anxious <input type="checkbox"/> shame
	<input type="checkbox"/> curious	<input type="checkbox"/> euthymic		
Thought Process:	<input type="checkbox"/> WNL	<input type="checkbox"/> linear	<input type="checkbox"/> circumstantial	<input type="checkbox"/> tangential <input type="checkbox"/> loose <input type="checkbox"/> slowed
Perception:	<input type="checkbox"/> unremarkable	<input type="checkbox"/> hallucinations	<input type="checkbox"/> flashbacks	<input type="checkbox"/> disassociation
Insight/Self Awareness:	<input type="checkbox"/> unremarkable	<input type="checkbox"/> fair	<input type="checkbox"/> poor	<input type="checkbox"/> developmentally appropriate <input type="checkbox"/> other
Psychomotor:	<input type="checkbox"/> unremarkable	<input type="checkbox"/> hyperactivity	<input type="checkbox"/> agitated	<input type="checkbox"/> hypoactive <input type="checkbox"/> tics <input type="checkbox"/> tremor
	<input type="checkbox"/> abnormal movements	<input type="checkbox"/> repetitive behavior	<input type="checkbox"/> stereotyped behavior	<input type="checkbox"/> gross motor
	<input type="checkbox"/> impaired coordination	<input type="checkbox"/> fine motor		
Affect:	<input type="checkbox"/> WNL	<input type="checkbox"/> dysphoric	<input type="checkbox"/> labile	<input type="checkbox"/> intense <input type="checkbox"/> flat <input type="checkbox"/> restricted
	<input type="checkbox"/> situationally inappropriate			
Thought Content:	<input type="checkbox"/> unable to assess	<input type="checkbox"/> developmentally appropriate	<input type="checkbox"/> fears	<input type="checkbox"/> guilty <input type="checkbox"/> dreams/nightmares
	<input type="checkbox"/> inadequate	<input type="checkbox"/> hopeless	<input type="checkbox"/> worthless	<input type="checkbox"/> delusions <input type="checkbox"/> obsessions
Judgment/Reason:	<input type="checkbox"/> unremarkable	<input type="checkbox"/> fair	<input type="checkbox"/> poor	<input type="checkbox"/> developmentally appropriate
Speech/Language:	<input type="checkbox"/> unremarkable	<input type="checkbox"/> pressured	<input type="checkbox"/> limited expression	<input type="checkbox"/> loud <input type="checkbox"/> soft <input type="checkbox"/> mute
	<input type="checkbox"/> hypo talkative	<input type="checkbox"/> hyper talkative	<input type="checkbox"/> limited comprehension	<input type="checkbox"/> incoherent
	<input type="checkbox"/> nonverbal	<input type="checkbox"/> articulate		
Emotion Regulation:	<input type="checkbox"/> WNL	<input type="checkbox"/> over controlled		<input type="checkbox"/> under controlled
Attention:	<input type="checkbox"/> WNL	<input type="checkbox"/> easily distracted	<input type="checkbox"/> poor focus	<input type="checkbox"/> poor sustained attention
	<input type="checkbox"/> hyper-vigilance			
Suicidal Ideation:	<input type="checkbox"/> none	<input type="checkbox"/> passive thoughts	<input type="checkbox"/> active thoughts	<input type="checkbox"/> plan <input type="checkbox"/> intent
	<input type="checkbox"/> means	<input type="checkbox"/> attempt		
Homicidal Ideation:	<input type="checkbox"/> none	<input type="checkbox"/> passive thoughts	<input type="checkbox"/> active thoughts	<input type="checkbox"/> plan <input type="checkbox"/> intent
	<input type="checkbox"/> means	<input type="checkbox"/> attempt		

RISK AND SAFETY ASSESSMENT

BEHAVIORS	No Hx	Active	Past Hx	DESCRIBE
Suicidal ideation/gestures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Click here to enter text.
Homicidal ideation/gestures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Click here to enter text.
Self-injurious behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Click here to enter text.
Assaultive (identify targets)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Click here to enter text.
Sexualized behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Click here to enter text.
Elopement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Click here to enter text.
Fire Setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Click here to enter text.
Substance use/abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Substances, amount, last use, consequences, etc.</i>
Click here to enter text.				
Other risk behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Click here to enter text.



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SOMATIC FUNCTIONING

Form section for Somatic Functioning including Sleep, Weight, Appetite, and Energy Libido with checkboxes for various symptoms.

TRAUMA/ABUSE/TREATMENT HISTORY

Form section for Trauma/Abuse/Treatment History with checkboxes for Sexual abuse, Physical abuse, Neglect, Domestic violence, Dating/Relationship Violence, and Trauma Associated Symptoms.

PREVIOUS TREATMENT HISTORY: Click here to enter text.

Form section for Family History of Substance Use and Mental Illness with checkboxes for Yes/No.

MEDICAL/SOCIAL

Form section for Medical/Social history including Last Visit to MD, Current Medical Conditions, Current Medications, Environmental/Home/School/Social/Peer Supports, and Relevant Social History.

SCHOOL INFORMATION

Form section for School Information including School, Grade, School Status, Special Education, IEP, Academic Status, and Decline in Academic Performance with reasons.



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CLIENT STRENGTHS/LIMITATIONS

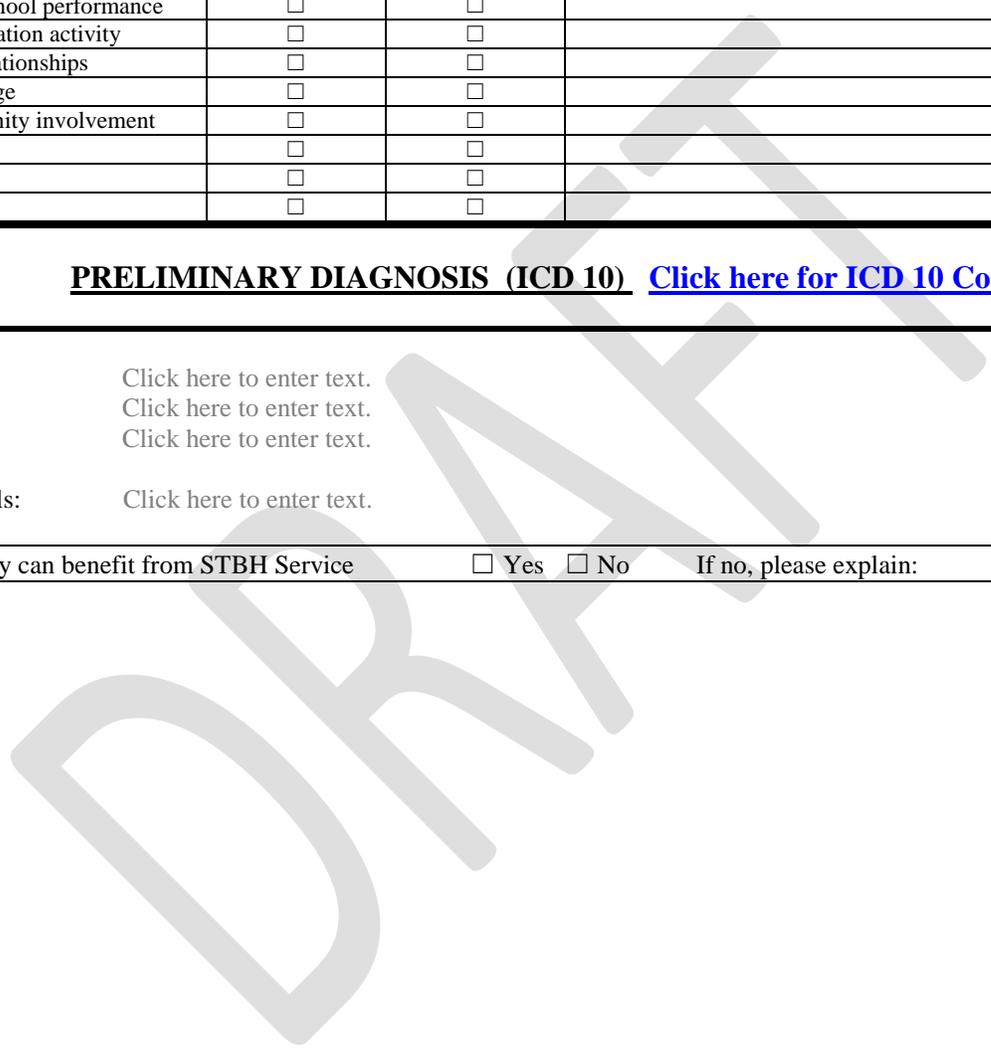
	Present	Absent	Notes:
Bright, learns quickly	<input type="checkbox"/>	<input type="checkbox"/>	
Insightful/self-aware	<input type="checkbox"/>	<input type="checkbox"/>	
Relates well to others	<input type="checkbox"/>	<input type="checkbox"/>	
Good social support system	<input type="checkbox"/>	<input type="checkbox"/>	
Satisfied with school	<input type="checkbox"/>	<input type="checkbox"/>	
Satisfied with school performance	<input type="checkbox"/>	<input type="checkbox"/>	
Hobbies or recreation activity	<input type="checkbox"/>	<input type="checkbox"/>	
Positive peer relationships	<input type="checkbox"/>	<input type="checkbox"/>	
Motivated to change	<input type="checkbox"/>	<input type="checkbox"/>	
Cultural/community involvement	<input type="checkbox"/>	<input type="checkbox"/>	
Spiritual focus	<input type="checkbox"/>	<input type="checkbox"/>	
Special Needs	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

PRELIMINARY DIAGNOSIS (ICD 10) [Click here for ICD 10 Codes](#)

1st Problem: Click here to enter text.
 2nd Problem: Click here to enter text.
 3rd Problem: Click here to enter text.

 Treatment Goals: Click here to enter text.

Youth & Family can benefit from STBH Service Yes No If no, please explain:





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Statement of Understanding

You have chosen to receive Short-Term Behavioral Health (STBH) Services for Youth funded through the Fairfax County System of Care Office and provided by their approved providers. STBH services may include assessment and referral or brief counseling. The STBH provider will work with you to clarify the problem, identify choices, and develop an action plan. You may receive up to eight sessions total, to include an assessment, counseling sessions, and wrap-up closing session. System of Care staff are available to answer any questions you may have about the program and STBH providers are available to respond to your calls and will advise you of their after-hours contact policy.

Fees

These services are provided at no direct cost to you or your family. The System of Care Office pays for these services. However, if you need longer-term counseling or a specialized service, your STBH provider will assist in locating a resource or service in the community. **It is your responsibility to pay for services provided by any resources outside the STBH program.** (If you have health insurance, your insurance benefit plan may cover some of the cost. **Check with your benefits representative before services are provided by outside resources.**)

Confidentiality

The STBH Services program will maintain confidential records of your contact.

No one will reveal information concerning your use of this service to anyone outside the program except as follows: 1) you consent in writing; 2) life or safety is seriously threatened; 3) disclosure is required by law; or 4) your STBH provider refers you to benefits-covered treatment and the claims payer requires information. In addition, your STBH provider will disclose information and records to the System of Care Office as needed for coordination of STBH services, quality assurance, or payment.

I, (print parent name) _____, understand this form, including the confidentiality of the STBH Service and the limitations to confidentiality, and accept it as the terms of my participation in the program. As an STBH Service for Youth consumer, I also understand that I may request written information describing the System of Care Office's confidentiality policy and the STBH Service provider's confidentiality policy.

I understand that there may be a no-show fee charged by the STBH Service provider.

Parent/Guardian Signature _____ **Date** _____

Youth Signature _____ **Date** _____

STBH Provider Signature _____ **Date** _____



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Discharge Summary

Youth's Name:

Case #:

STATUS OF PROGRESS:

Target Problem(s)

- Deteriorated
- No change
- Minimal improvement
- Moderate improvement
- Significant improvement
- Not addressed/Plan changed
- Unknown: _____

REASON CASE CLOSED:

- Goals met/Client satisfied
- Client dropped out against advice
- Client referred
- Client utilized all available sessions
- Other: _____

REFERRALS: (check all that apply)

Client referred to:

- Substance use treatment
- Mental health treatment
- Provider within insurance plan
- Community Services Board
- Private non-profit behavioral health provider
- Other private provider
- Other: _____
- No referral

Level of care:

- Community resources
- Outpatient
- Intensive inpatient
- Partial hospitalization
- Inpatient
- Other: _____

Provider/Facility/Resource Information referred to:

- Name:**
- Address:**
- Phone:**

FOLLOW-UP:

Did client receive services for which they were referred? Yes No

Number of sessions attended by youth:

Summary/Comments: