



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

## Clinical Assessment

|                            |                             |             |                           |
|----------------------------|-----------------------------|-------------|---------------------------|
| <b>CLIENT NAME:</b>        | Click here to enter text.   | <b>DOB:</b> | Click here to enter text. |
| <b>ASSESSMENT DATE:</b>    | Click here to enter a date. |             |                           |
| <b>PRESENTING CONCERN:</b> | 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.                               |



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

**Clinical Assessment**

**SOMATIC FUNCTIONING**

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| Sleep   | <input type="checkbox"/> unremarkable                | <input type="checkbox"/> hypersomnia    | <input type="checkbox"/> insomnia      | <input type="checkbox"/> initial        | <input type="checkbox"/> middle        |
|   | <input type="checkbox"/> early awakening             | <input type="checkbox"/> other          |  |   |  |
| Weight  | <input type="checkbox"/> unremarkable                | <input type="checkbox"/> loss 1-10 lbs. | <input type="checkbox"/> loss 10+ lbs. | <input type="checkbox"/> gain 1-10 lbs. | <input type="checkbox"/> gain 10+ lbs. |
|   | <input type="checkbox"/> other                       |   |  |   |  |
| Appetite  | <input type="checkbox"/> developmentally appropriate | <input type="checkbox"/> increased      | <input type="checkbox"/> decreased     | <input type="checkbox"/> other          |  |
| Energy Libido                                       | <input type="checkbox"/> developmentally appropriate | <input type="checkbox"/> increased      | <input type="checkbox"/> decreased     | <input type="checkbox"/> other          |  |
| Comments: <a href="#">Click here to enter text.</a> |  |   |  |   |  |

**TRAUMA/ABUSE/TREATMENT HISTORY**

|                                     |   |                                     |   |                                    |   |
|-------------------------------------|---|-------------------------------------|---|------------------------------------|---|
| None                                | <input type="checkbox"/>                  |                                     |   |                                    |   |
| Type                                | No  | Yes                                 | Time Frame/Duration                         |                                    |   |
| Sexual abuse                        | <input type="checkbox"/>                  | <input type="checkbox"/>            | <a href="#">Click here to enter text.</a>   | to                                 | <a href="#">Click here to enter text.</a> |
| Description:                        | <a href="#">Click here to enter text.</a> |                                     |   |                                    |   |
| Physical abuse                      | <input type="checkbox"/>                  | <input type="checkbox"/>            | <a href="#">Click here to enter text.</a>   | to                                 | <a href="#">Click here to enter text.</a> |
| Description:                        | <a href="#">Click here to enter text.</a> |                                     |   |                                    |   |
| Neglect                             | <input type="checkbox"/>                  | <input type="checkbox"/>            | <a href="#">Click here to enter text.</a>   | to                                 | <a href="#">Click here to enter text.</a> |
| Description:                        | <a href="#">Click here to enter text.</a> |                                     |   |                                    |   |
| Domestic violence                   | <input type="checkbox"/>                  | <input type="checkbox"/>            | <a href="#">Click here to enter text.</a>   | to                                 | <a href="#">Click here to enter text.</a> |
| Dating/Relationship Violence        | <input type="checkbox"/>                  | <input type="checkbox"/>            | <a href="#">Click here to enter text.</a>   | to                                 | <a href="#">Click here to enter text.</a> |
| Trauma Associated Symptoms Present: | <input type="checkbox"/> none             | <input type="checkbox"/> nightmares | <input type="checkbox"/> intrusive thoughts | <input type="checkbox"/> avoidance |   |
|                                     | <input type="checkbox"/> numbness         | <input type="checkbox"/> detachment | <input type="checkbox"/> hyper-vigilance    | <input type="checkbox"/> starting  | <input type="checkbox"/> other            |

PREVIOUS TREATMENT HISTORY: [Click here to enter text.](#)

Family History of Substance Use  Yes  No    Mental Illness  Yes  No  
[Click here to enter text.](#)

**MEDICAL/SOCIAL**

Last Visit to MD: [Click here to enter a date.](#)                      Physicians Name: [Click here to enter text.](#)

Current Medical Conditions:  None [Click here to enter text.](#)

Current Medications: [Click here to enter text.](#)

Environmental, Home, School, Social and Peer Supports: [Click here to enter text.](#)

Relevant Social History:  None [Click here to enter text.](#)

**SCHOOL INFORMATION**

School: [Click here to enter text.](#)                      Grade: Choose an item.                      School Status: Choose an item.

Special Education:  Yes  No                      IEP:  Yes  No                      Academic Status: Choose an item.

Decline in Academic Performance:  Yes  No

Reason:  school attendance     conflict with peers     accidents/safety violations     bullying  
 recipient of threat(s)     discipline problems at school     conflict with authority figures



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

Attachment A

**Clinical Assessment**

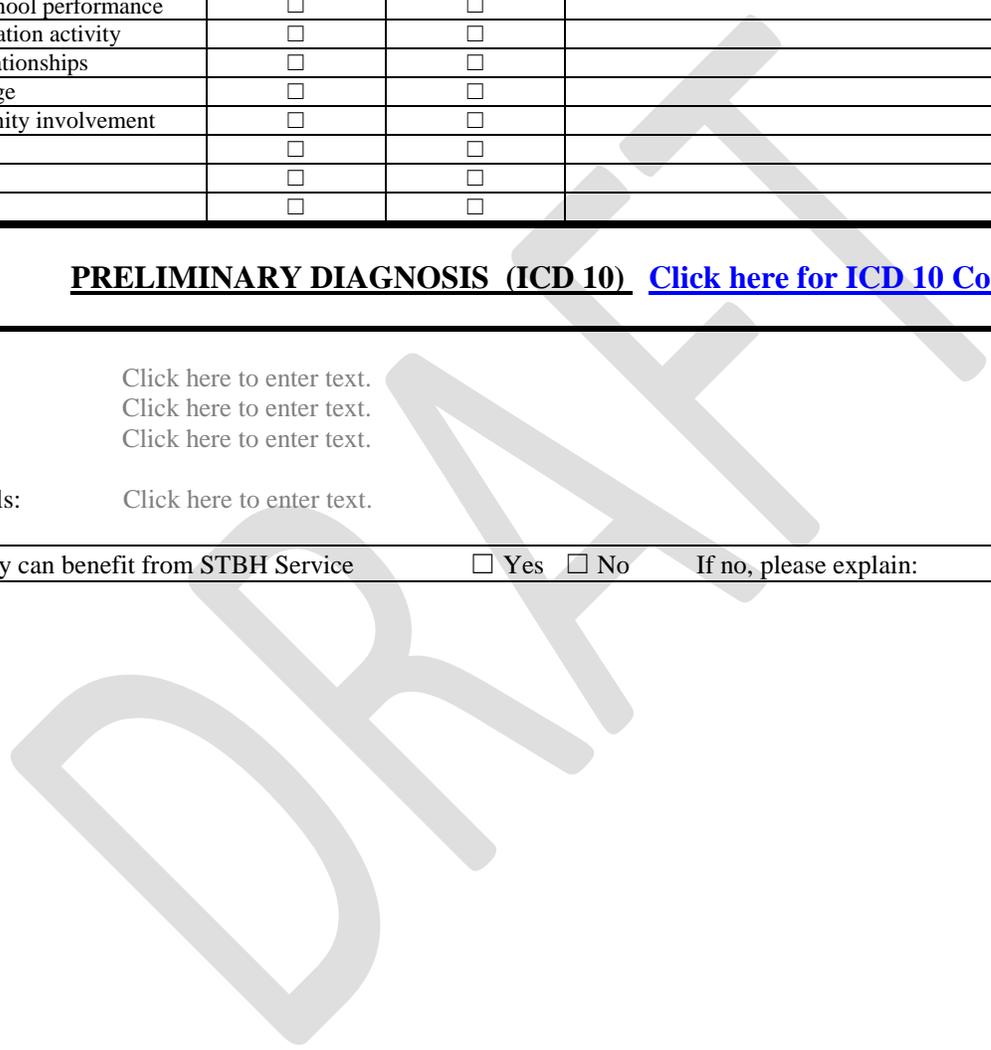
**CLIENT STRENGTHS/LIMITATIONS**

|                                   | 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](#)

1<sup>st</sup> Problem:           Click here to enter text.  
 2<sup>nd</sup> Problem:         Click here to enter text.  
 3<sup>rd</sup> 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:





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

### 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** \_\_\_\_\_



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

Attachment C

DISCHARGE SUMMARY

|   |  |
|---|--|
| <b>Client Name:</b> <a href="#">Click here to enter text.</a> | <b>Final Diagnosis (ICD 10 Code):</b><br><a href="#">Click here to enter text.</a> |
|---|--|

**STBH Start Date:** [Click here to enter a date.](#)

**STBH End Date:** [Click here to enter a date.](#)

**STATUS OF PROGRESS:**

**Targeted Problems:**

- Deteriorated
- No Change
- Minimal Improvement
- Moderate Improvement
- Significant Improvement
- Not Addressed/Plan Changed
- Unknown: [Click here to enter text.](#)

**REASON CASE CLOSED:**

- Goals met/Client satisfied
- Client dropped out against advice
- Client referred
- Client utilized all available sessions
- Other: [Click here to enter text.](#)

**CONTINUED SERVICES RECOMMENDED: (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
- No referral
- Other:

**REFERRED LEVEL OF CARE**

- Community resources
- Outpatient
- Intensive inpatient
- Inpatient
- Other: [Click here to enter text.](#)

[Click here to enter text.](#)

**Provider/Facility/Resource information referred to:**

|                 |   |
|-----------------|---|
| <b>Name:</b>    | <a href="#">Click here to enter text.</a> |
| <b>Address:</b> | <a href="#">Click here to enter text.</a> |
| <b>Phone:</b>   | <a href="#">Click here to enter text.</a> |

**FOLLOW UP:**

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

Number of session attended by youth: [Choose an item.](#)

Clinical Summary/Comments:

[Click here to enter text.](#)

|                      |                                |
|----------------------|--------------------------------|
| <b>Provider Name</b> | <b>Provider Signature/Date</b> |
| <br>                 | <br>                           |

## **Sample of On Line Risk Assessment Related Trainings from Cross Country Education**

### **Completing the Mental Status Exam: Practical, Hands-On Lessons from the Field**

By [Tim Webb](#)

Improve clinical care and liability protection by performing and documenting the MSE correctly. Learn keys to differentially diagnosing, quickly assessing suicide/homicide/medical risk, evaluating psychotic symptoms, and more!

### **Emergency Mental Health: Assessment and Treatment**

By [Tim Webb](#)

Learn how to quickly assess and triage mental health emergencies. Information will be provided on performing suicide and homicide risk assessments, mental status examinations, and evaluation of the need for detoxification.

### **On Call: Triageing Mental Health Emergencies by Phone**

By [Tim Webb](#)

Assure your clients that help is only a phone call away. Discover triaging methods for determining crisis levels and appropriate interventions.

### **The Clinician's Survival Guide to Suicide & Homicide - from Transformation to Recovery**

By [Gary Massey](#)

How do you detect and defuse a client who is suicidal or homicidal? Stop tragedy before it strikes. Take the proper steps necessary to accurately assess, treat, and intervene with those who are at-risk to themselves and/or others.

### **Stopping Our Children From Hurting Themselves: Foundations of Assessment and Treatment of Non-Suicidal Self-Injury in Children and Adolescents**

By [David Kamen](#)

With increased attention in the DSM-5 to non-suicidal self-injury (NSSI), Dr. David Kamen takes an opportunity to shine a spotlight on this growing epidemic among children and adolescents.