**CLINICAL INTERVIEW AND ASSESSMENT**

| **Client Name** (First, MI, Last) | **MaGIK No.**  |
| --- | --- |
|       |       |
| **Presenting Problem** | **Date of Assessment** |
|  |       |
| **Referring FCM and Reason for Referral** |
|       |
| **Client’s Description of Problem** |
|       |
| **Family/Guardian/Child Perceptions of Problem** |
|       |
| **Living Situation** |
| **Parent’s Home**  | **\*\*Residential Care/Treatment Facility** |
| [ ]  | Rent | [ ]  | Own | [ ]  | Hospital | [ ]  | Temporary Housing | [ ]  | Residential Care | [ ]  | Nursing Home |
| **\*\*Other**  |
| [ ]  | Friend’s Home | [ ]  | Relative’s/Guardian’s Home | [ ]  | Foster Care Home | [ ]  | Respite Care | [ ]  | Jail/Prison |
| [ ]  | Homeless Living with Friend | [ ]  | Homeless in Shelter/No Residence | [ ]  | Others: |       |
| **\*\*Identify Facility or Person’s Name** |
|       |
| **Primary Household** |
| Household Member Names | Relationship to Client | Age | Occupation/School | Level of Education | Quality of Relationship |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
| **Street Address** (if different from client’s address listed on Demographic Information form)  |
|       |
| **Secondary Household** |
|  Does client live in more than one household?  |
| [ ]  | No | If no, skip to “Additional Family Members” |
| [ ]  | Yes | If yes, complete the secondary household information below. |
| Household Member Names | Relationshipto Client | Age | Occupation/School | Level of Education | Quality of Relationship |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
| **Secondary Household** (continued) |
| **Secondary Household Street Address** (if different from client’s address listed on Demographic Information form) |
|       |
| **Family Members Who Live in Both Households**  |
| [ ]  | Only Client | [ ]  | Client and (list): |
|  |       |
| **Additional Family Members** (i.e., parents or siblings not living in primary or secondary households)  |
| **[ ]**  | No Parents or Siblings Other Than Those Listed in Primary or Secondary Households |
|  |       |
| **Child Custody and Parenting Plan (if applicable)** |
| **[ ]**  | Lives with Both Parents (biological or adoptive) in Same Household or with Widowed Parent |
| **[ ]**  | Other (describe):      |
| **Family Environment/Relationships** |
| **Parent-Child (Client) Relationship(s)**: | [ ]  | Not Applicable | P = Primary Household S = Secondary Household B = Both |
| **Comment on Parent-Child Relationships** (could include: parent-child conflict; parent supervision and monitoring of child; cooperation between parent(s) regarding child-rearing; parent positive activities with child; parent satisfaction with relationship; child satisfaction with relationship) |
|       |
| **Sibling-Child (Client) Relationship(s )** | [ ]  | Not Applicable | P = Primary Household S = Secondary Household B = Both |
| **Comment on Sibling-Child Relationships** (could include: child-sibling(s) conflict; sibling(s) positive activities with child; sibling(s) satisfaction with relationship; child satisfaction with relationship) |
|       |
| **Parent Marital or Couples Relationship(s)**  | [ ]  | Not Applicable in this Case |  P = Primary Household S = Secondary Household B = Both |
| **Comment on parent Marital or Couples Relationship(s)** (could include: marital or couples conflict; marital or couples satisfaction) |
|       |
| **Other Family Concerns** |
| Family Member Alcohol Abuse: | [ ]  | No | [ ]  | Yes | If yes, indicate: | [ ]  | Parent | [ ]  | Sibling | [ ]  | Other |
| Family Member Substance Abuse: | [ ]  | No | [ ]  | Yes | If yes, indicate: | [ ]  | Parent | [ ]  | Sibling | [ ]  | Other |
| Family Member Mental Health Problems: | [ ]  | No | [ ]  | Yes | If yes, indicate: | [ ]  | Parent | [ ]  | Sibling | [ ]  | Other |
| Family Member Health Problems: | [ ]  | No | [ ]  | Yes | If yes, indicate: | [ ]  | Parent | [ ]  | Sibling | [ ]  | Other |
| Family Member Disability: | [ ]  | No | [ ]  | Yes | If yes, indicate: | [ ]  | Parent | [ ]  | Sibling | [ ]  | Other |
| Family Member Legal Issues: | [ ]  | No | [ ]  | Yes | If yes, indicate: | [ ]  | Parent | [ ]  | Sibling | [ ]  | Other |
| Family Financial Concerns: | [ ]  | No | [ ]  | Yes | If yes, indicate: | [ ]  | Parent | [ ]  | Sibling | [ ]  | Other |
|  |  |  |  |  |  |  |  |  |  |  |  |
| Other (describe) |
|       |
| Comment on Other Family Concerns and Information Relating to Financial Status (specify problems that impact client’s needs) |
|       |
| **Social Information** |
| **Pertinent Family History** (to include family MH and AoD history) |
|       |
| **Strengths/Capabilities** (Include CANS-Identified Strengths) |
|       |
| **Limitations of Activities of Daily Living** |
|       |
| **Friendship/Social Peer Support/Relationships** |
|       |
| **Meaningful Activities** (community involvements, volunteer activities, leisure/recreation, other interests) |
|       |
| **Community Supports/Self Help Groups** (AA, NA, NAMI, etc.) |
|       |
| **Religion/Spirituality** |
|       |
| **Cultural/Ethnic Issues/Information/Concerns**  |
|       |
| **Pertinent Developmental Issues** |
| **Mother’s Pregnancy History** (include prenatal exposure to alcohol, tobacco or other drugs) |
| [ ]  | No Problems Reported      |
| **Infancy (age 0-1)**  |
| **[ ]**  | No Problems Reported      |
| **Preschool (age 2-4)**  |
| **[ ]**  | No Problems Reported or Not Pertinent      |
| **Childhood (age 5-12)**  |
| **[ ]**  | No Problems Reported or Not Pertinent      |
| **Adolescent (age 13-17)**  |
| **[ ]**  | No Problems Reported or Not Pertinent      |
| **Sexual History to Include Pertinent Sexual Issues/Concerns**  |
|       |
| **School Functioning** |
| **Educational Classification**  |
| Name of School: |       | Current Grade: |       |
| Regular Education Classroom, No Special Services |
| [ ]  | Yes | [ ]  | No | If no, check all that apply.       |
| [ ]  | 01 Multiple disabilities (not deaf-blind) | [ ]  | 06 Orthopedic Impairment | [ ]  | 11 Autism |
| [ ]  | 02 Deaf-Blindness | [ ]  | 07 Emotional Disturbance (SED) | [ ]  | 12 Traumatic Brain Injury |
| [ ]  | 03 Deafness (hearing impairment) | [ ]  | 08 Mental Retardation  | [ ]  | 13 Other Health Impaired (major) |
| [ ]  | 04 Visual Impairment | [ ]  | 09 Specific Learning Disability | [ ]  | 14 Other Health Impaired (minor) |
| [ ]  | 05 Speech or Language Impairment | [ ]  | 10 Preschoolers with a Disability | [ ]  | 15 Current 504 Plan |
| [ ]  | Other:       |
| **Comments on Educational Classification/Placement** (please indicate if client is home schooled, in gifted program, etc.) |
|       |
| **Grades**  |
|       |
| **Test Results** (IQ, achievement, developmental) |
| [ ]  | No Test Results Reported      |
| **School Functioning** (continued) |
| **Attendance**  |
| **[ ]**  | Not a Problem      |
| **Previous Grade Retentions**  |
| **[ ]**  | None Reported      |
| **Suspensions/Expulsions**  |
| **[ ]**  | None Reported      |
| **Other Academic/School Concerns** (including performance/behavioral problems due to AoD use)  |
| **[ ]**  | None Reported      |
| **Barriers to Learning** |
| [ ]  | None Reported | [ ]  | Inability to Read and Write | [ ]  | Other:       |
| **Peer Relationships/Social Functioning**  |
|       |
| **Special Communication Needs**  |
| [ ]  | None Reported | [ ]  | TDD/TTY Device | [ ]  | Sign Language Interpreter | [ ]  | Assistive Listening Device(s) |
|  |  | [ ]  | Language Interpreter Services Needed/  |       |
|  |  |  | Other Spoken Language: |  |  |
|  |  |  |  |  |
| **Legal History** |
| **Current Legal Status** |
| [ ]  | None Reported | [ ]  | On Probation | [ ]  | Detention | [ ]  | On Parole | [ ]  | Awaiting Charge |
| [ ]  | AoD Related Legal Problems | [ ]  | Court Ordered to Treatment | [ ]  | Others:       |
| **History of Legal Charges**  |
| [ ]  | No | [ ]  | Yes | If yes, check and describe: | [ ]  | Status Offense (e.g., Unruly)       |
|  |  |  |  |  | [ ]  | Delinquency       |
| **Name of Probation/Parole Officer** (if applicable) |
|       |
| **Adjudications** |
| [ ]  | No | [ ]  | Yes |
| If yes, describe:       |
| **Detentions or Incarcerations** |
| [ ]  | No | [ ]  | Yes |
| If yes, describe:       |
| **Civil Proceedings** |
| [ ]  | No | [ ]  | Yes |
| If yes, describe:       |
| **Domestic Relations Court Involvement** |
| [ ]  | No | [ ]  | Yes |
| If yes, describe:        |
| **Juvenile Court Involvement** (related to child abuse, neglect, or dependency)  | **Probation Officer Name** (if applicable) |
| Current: | [ ]  | No | [ ]  | Yes | Comment: |       |       |
| Past: | [ ]  | No | [ ]  | Yes | Comment: |       |  |
|  |  |  |  |  |  |  |  |
| **Children’s Protective Services Involvement with Family**  |
| [ ]  | No | [ ]  | Yes |
| If yes, describe: |       |
| **Legal History** (continued) |
| **Name of CPS Caseworker(s) Assigned to Family** (if applicable)  |
| **[ ]**  | None Reported       |
| **Name of Guardian ad Litem (GAL) or Court Appointed Special Advocate (CASA) Assigned to Family**  |
| **[ ]**  | None Reported       |
| [ ]  | Not Pertinent - Skip this Section |  **Employment** |
| **Currently Employed?** If yes, name of employer: |  Job Title  |
| **[ ]**  | Yes | [ ]  | No |       |
| **Employment Interests/Skills/Concerns** |
|       |
| **Mental Health Treatment History** |
| **Outpatient Mental Health Treatment**  | [ ]  | None Reported |
| Agency | Check if Current | Past (Date) | Clinician Name |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
| **Psychiatric Hospitalizations/Residential Treatment Facilities**  | [ ]  | None Reported  |
| Facility | Date of Service | Reason (suicidal, depressed, etc.) |
|       |       |       |
|       |       |       |
|       |       |       |
| **Previous or Current Diagnoses** (if known)  |
| **[ ]**  | Not Known by Client      |
| **Other Comments Regarding Mental Health Treatment History**  |
| **[ ]**  | No Comment      |
| [ ]  | None Reported |  **Current Medication** (prescription/OTC/herbal) |
| Medication | Rationale | Dosage/Route/Frequency | Compliance  |
|  |  |  | Yes | No | Partial | Unk |
|       |       |       | [ ]  | [ ]  | [ ]  | [ ]  |
|       |       |       | [ ]  | [ ]  | [ ]  | [ ]  |
|       |       |       | [ ]  | [ ]  | [ ]  | [ ]  |
|       |       |       | [ ]  | [ ]  | [ ]  | [ ]  |
|       |       |       | [ ]  | [ ]  | [ ]  | [ ]  |
|       |       |       | [ ]  | [ ]  | [ ]  | [ ]  |
|       |       |       | [ ]  | [ ]  | [ ]  | [ ]  |
| **Primary Care Physician** (name, phone no., and address) |  **Date of Last Physical Exam**  |
|       |       |
| **Other Prescribing Physician(s)** (name, phone no., and address) |
|       |
| [ ]  | None Reported  |  **Past Psychotropic Medications** |
| Psychotropic Medications | Reason for Discontinuation |
|       |       |
|       |       |
|       |       |
|       |       |
| **Alcohol/Drug History** |
| Illegal drug use/abuse past 12 months? | [ ]  | No | [ ]  | Yes | Non-prescription drug abuse past 12 months? | [ ]  | No | [ ]  | Yes |
| Prescription drug abuse past 12 months? | [ ]  | No | [ ]  | Yes | Alcohol use/abuse past 12 months? | [ ]  | No | [ ]  | Yes |
| **Toxicology screen completed?** |
| [ ]  | No | [ ]  | Yes If yes, results:      |
| **Presenting with detox issues?**  |
| [ ]  | No | [ ]  | Yes If yes, symptoms:      |
| **Check All That apply**  |
| **[ ]**  | IV Drug User | [ ]  | Pregnant | [ ]  | Other Addictive Behaviors:       |
| Drug/Substance/Alcohol/Tobacco/OTC | Age of First Use | Date of Last Use | Frequency of Use | Amount | Method |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
| **Alcohol/Drug Treatment History** |
| **AoD Treatment**  |
| [ ]  | None Reported |
| Current: | [ ]  | OP | [ ]  | IOP | [ ]  | Residential | [ ]  | Other:       |
| Past: | [ ]  | OP | [ ]  | IOP | [ ]  | Residential | [ ]  | Hospital | [ ]  | Detox | [ ]  | Other:       |
| If current or past complete the following: |
| Name of Provider Agency | Type of Service | Date of Service |
|       |       |       |
|       |       |       |
|       |       |       |
| **Other Comments Regarding Substance Abuse/Use and Other Addictive Behaviors** (include AoD use/abuse by other family members/significant others, AoD related legal problems, SAMI stage of treatment for providers using dual disorders integrated treatment approach)  |
|       |
| **Abuse History** (describe in comments section each element checked) |
| [ ]  | No Self reported History of Abuse/Violence | [ ]  | Physical Abuse | [ ]  | Domestic Violence/Abuse | [ ]  | Community Violence |
| [ ]  | Physical Neglect | [ ]  | Emotional Abuse | [ ]  | Sexual Abuse/Molestation |  |  |
| [ ]  | Other:       |
| **Comments** (identify if client was/is a victim of abuse or a perpetrator or both)  |
|       |
| **Problem Checklist Including Functional Domains**(Check applicable age appropriate needs/preferences for the identified child/adolescent client and comment.) |
| Check | Check All Current Problem Areas As Evidenced By  |
| [ ]  | **Nutritional/Eating Pattern Changes/Disorders**  |
|  |       |
| [ ]  | **Pain Management** |
|  |       |
| [ ]  | **Depressed Mood/Sad** |
|  |       |
| [ ]  | **Bereavement Issues** |
|  |       |
| [ ]  | **Anxiety** |
|  |       |
| [ ]  | **Traumatic Stress**  |
|  |       |
| [ ]  | **Anger/Aggression** |
|  |       |
| [ ]  | **Oppositional Behaviors** |
|  |       |
| [ ]  | **Inattention** |
|  |       |
| [ ]  | **Impulsivity** |
|  |       |
| [ ]  | **Disturbed Reality Contact (psychosis)** |
|  |       |
| [ ]  | **Mood Swings/Hyperactivity**  |
|  |       |
| [ ]  | **Substance Use/Addiction**  |
|  |       |
| [ ]  | **Other Addictive Behaviors** |
|  |       |
| [ ]  | **Sleep Problems** |
|  |       |
| [ ]  | **Enuresis/Encopresis** |
|  |       |
| [ ]  | **Psychosocial Stressors** |
|  |       |
| **Problem Checklist Including Functional Domains** (continued) |
| Check  | Check All Current Problem Areas As Evidenced By  |
| [ ]  | **Pertinent Health Issues/Medical History** (include any allergies and food/drug reactions) |
|  |       |
| [ ]  | **Client’s Family Needs Education to Be Able to** (Describe areas of family education needs. Family education must be directed to the exclusive well being of the client.) |
|  |       |
| [ ]  | **Client Needs Other Environmental Supports** (Describe areas where environmental supports are needed to support the client in community living and possible sources of that support.) |
|  |       |
| [ ]  | **Other**  |
|  |       |
|  | **Skills Deficits/Skills Training/Community Support Needs** (Check all applicable age appropriate skills deficits, skills training, and/or community support needs identified.) |
|  | [ ]  | Client needs symptom and disability management skills. |
|  | [ ]  | Client needs restoration or development of social/personal skills. |
|  | [ ]  | Client needs residential supports to develop skills necessary for community living. |
|  | [ ]  | Client needs education related services to develop skills necessary to enhance academic success. |
|  | [ ]  | Client needs restoration or development of social support skills and networks including recreational activities. |
|  | **As Evidenced By** (Describe the specific age appropriate skill deficits or areas where improvement is needed.) |
|  |       |
|  |
| **Mental Status Summary** |
| [ ]  | Not Clinically Indicated | [ ]  | Unremarkable | [ ]  | Remarkable |
| If remarkable, describe under the following Mental Status Examination OR | [ ]  | Refer to attached Mental status Exam form. |
| **Mental Status Summary** (continued) |
| **Mental Status Examination** (Complete the Mental Status Examination form or provide a thorough written narrative below. If AoD client, include ODADAS MSE elements: appearance, attitude, motor activity, affect, mood, speech, and thought content.) |
|       |
| **Past attempts to Harm Self or Others** | [ ]  | None Reported | [ ]  | Self | [ ]  | Others       |
| Comment:      |
| **Current Risk of Harm to Self**  | [ ]  | None Noted | [ ]  | Low | [ ]  | Moderate | [ ]  | High |
| Comment:      |
| **Current Risk of Harm to Others** | [ ]  | None Noted | [ ]  | Low | [ ]  | Moderate | [ ]  | High |
| Comment:      |
| **Summary of Rating Scales or Measures Administered**  |
|       |
| **Client/Family/Guardian Expression of Service Preferences**(Describe Applicable Age Appropriate Needs/Preferences for the Client and Comment as Relevant) |
| Clinician, client, and parent/care taker/guardian should have a meaningful dialogue to engage and allow the client and family to express their desired treatment preferences and priorities. Identify the indicated needs/preferences of client/family/guardian for the full range of behavioral health clinical and community-based rehabilitative services, and environmental support services available to them.  |
| **1. Behavioral Health Clinical and Rehabilitative Service Preferences** |
|       |
| **2. Environmental Support Preferences**  |
|       |
| **Clinical/Interpretative Summary** |
| **This Clinical/Interpretative Summary is Based Upon Information Provided By** (check all that apply)  |
| [ ]  | Client | [ ]  | Parent(s) | [ ]  | Guardian(s) | [ ]  | Family/Friend | [ ]  | Physician | [ ]  | Records |
| [ ]  | Law Enforcement | [ ]  | Service Provider | [ ]  | School Personnel | [ ]  | Other:       |
| **Narrative -**Include etiology of presenting problem and maintenance of the problem; mental health history; AoD history; severity of problem; where problem occurs (functioning at home, at work, in community); onset of problem (acute vs. chronic); previous treatment history; current motivation for treatment, strengths, etc.  |
|       |
| **CANS Summary and Level of Care Recommendation** |
|       |
|  **Diagnosis:**  | [ ]  | DSM-IV Codes  | [ ]  | ICD-9 CM Codes  |
| **Check Primary** | **Axis** | **Code** | **Narrative Description** |
| [ ]  | **Axis I** |       |       |
| [ ]  |  |       |       |
| [ ]  |  |       |       |
| [ ]  | **Axis II** |       |       |
| [ ]  |  |       |       |
|  | **Axis III** |       |
|  | **Axis IV** | **Describe, if yes:** |
|  |  | Problems with primary support group: | [ ]  | Yes | [ ]  | No |
|  |  |       |
|  |  | Problems related to the social environment: | [ ]  | Yes | [ ]  | No |
|  |  |       |  |  |  |  |
|  |  | Educational problems: | [ ]  | Yes | [ ]  | No |
|  |  |       |  |  |  |  |
|  |  | Occupational problems: | [ ]  | Yes | [ ]  | No |
|  |  |       |  |  |  |  |
|  |  | Housing problems: | [ ]  | Yes | [ ]  | No |
|  |  |       |  |  |  |  |
|  |  | Economic problems: | [ ]  | Yes | [ ]  | No |
|  |  |       |  |  |  |  |
|  |  | Problems with access to health care services: | [ ]  | Yes | [ ]  | No |
|  |  |       |  |  |  |  |
|  |  | Problems with interaction with the legal system/crime:  | [ ]  | Yes | [ ]  | No |
|  |  |       |  |  |  |  |
|  |  | Other psychosocial and environmental problems: | [ ]  | Yes | [ ]  | No |
|  |  |       |  |  |  |  |
|  | **Axis V** |  **Current GAF:**       |  **Highest GAF in Past Year** (if known)**:**        |
| **Treatment Recommendations/Assessed Needs** |
|  1. | [ ]  | Deferred | [ ]  | Immediate Need |
|       |
| 2.  | [ ]  | Deferred | [ ]  | Immediate Need |
|       |
| 3.  | [ ]  | Deferred | [ ]  | Immediate Need |
|       |
| 4.  | [ ]  | Deferred | [ ]  | Immediate Need |
|       |
| 5.  | [ ]  | Deferred | [ ]  | Immediate Need |
|       |
| 6.  | [ ]  | Deferred | [ ]  | Immediate Need |
|       |
| 7.  | [ ]  | Deferred | [ ]  | Immediate Need |
|       |
| **Client/Guardian/Family Participation in Assessment and Response to Recommendations** |
|       |
| **Further Assessments Needed** (check all that apply)  |
| [ ]  | None Indicated | [ ]  | Psychiatric/Med | [ ]  | Psychological | [ ]  | Neuropsych | [ ]  | Trauma | [ ]  | Bonding/Attachment |
| [ ]  | Parenting/Family | [ ]  | Psychosexual | [ ]  | Comprehensive | [ ]  | Nutritional | [ ]  | Other:  |
| **Signatures** |
| **Clinician Signature/Credentials** |  **Date** |
|       |       |
| **Supervisor Signature/Credentials (if applicable)** |  **Date** |
|       |       |
| **Parent/Guardian Signature (if assessment results have been reviewed)** |  **Date** |
|       |       |
| **Parent/Guardian Signature (if assessment results have been reviewed)**  | **Date** |
|       |       |