|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Youth:** Name | **CRN:** 123456 | **DOB:** m/d/yy | **Age:** #y #m | **Gender Identity:** select |
| **School:** XYZ Intermediate | | **Grade:** # | **Education Status:** select | |
| **Guardian(s):** Name | | **Collateral Contact(s):** Name | | |
| **Evaluator:** Name | | **Date(s) of Assessment:** m/d/yy | | |
|  | | | | |

1. **Referral Source**

select

1. **Reason for Referral / Chief Complaint**

describe…

1. **History of Current Problem**

describe…

1. **Current Problems in Functioning**

*Interview Participants:* Names

* 1. Child and Adolescent Functional Assessment Scale (CAFAS)

***CAFAS scores must be entered into the FAS Outcomes system (***[**https://app.fasoutcomes.com/**](https://app.fasoutcomes.com/)***)***

*Describe current issues in each domain, then use this information to complete the CAFAS – rate most severe level for the past 90 days using CAFAS Manual.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | *School* | | | |
|  | describe current issues… | | | |
|  | *Level of Impairment & Behavior Description(s)* | | | *Could not score (0)* |
|  | Severe (30) | Moderate (20) | Mild (10) | Minimal / None (0) |
|  | Item number(s) | Item number(s) | Item number(s) | Item number(s) |
|  | *Home* | | | |
|  | describe current issues… | | | |
|  | *Level of Impairment & Behavior Description(s)* | | | *Could not score (0)* |
|  | Severe (30) | Moderate (20) | Mild (10) | Minimal / None (0) |
|  | Item number(s) | Item number(s) | Item number(s) | Item number(s) |
|  | *Community* | | | |
|  | describe current issues… | | | |
|  | *Level of Impairment & Behavior Description(s)* | | | *Could not score (0)* |
|  | Severe (30) | Moderate (20) | Mild (10) | Minimal / None (0) |
|  | Item number(s) | Item number(s) | Item number(s) | Item number(s) |
|  | *Behavior to Others* | | | |
|  | describe current issues… | | | |
|  | *Level of Impairment & Behavior Description(s)* | | | *Could not score (0)* |
|  | Severe (30) | Moderate (20) | Mild (10) | Minimal / None (0) |
|  | Item number(s) | Item number(s) | Item number(s) | Item number(s) |
|  | *Moods / Emotions* | | | |
|  | describe current issues… | | | |
|  | *Level of Impairment & Behavior Description(s)* | | | *Could not score (0)* |
|  | Severe (30) | Moderate (20) | Mild (10) | Minimal / None (0) |
|  | Item number(s) | Item number(s) | Item number(s) | Item number(s) |
|  | *Self-Harm* | | | |
|  | describe current issues… | | | |
|  | *Level of Impairment & Behavior Description(s)* | | | *Could not score (0)* |
|  | Severe (30) | Moderate (20) | Mild (10) | Minimal / None (0) |
|  | Item number(s) | Item number(s) | Item number(s) | Item number(s) |
|  | *Substance Abuse* | | | |
|  | describe current issues… | | | |
|  | *Level of Impairment & Behavior Description(s)* | | | *Could not score (0)* |
|  | Severe (30) | Moderate (20) | Mild (10) | Minimal / None (0) |
|  | Item number(s) | Item number(s) | Item number(s) | Item number(s) |
|  | *Thinking* | | | |
|  | describe current issues… | | | |
|  | *Level of Impairment & Behavior Description(s)* | | | *Could not score (0)* |
|  | Severe (30) | Moderate (20) | Mild (10) | Minimal / None (0) |
|  | Item number(s) | Item number(s) | Item number(s) | Item number(s) |
|  | *Other Noteworthy Problems / Concerns* | | | |
|  | describe… | | | |
|  | ***Total CAFAS Score:*** # | | | |

* 1. Developmental History
     1. *Pregnancy & Birth:* select and describe
     2. *Prenatal Exposure to Substance:* select and describe
     3. *Other Abnormalities in Development:* select and describe
     4. *Pubertal Development:* select *For Girls – Age at Menarche:* enter age here or select N/A
     5. *Issues Related to Sexuality:* select
     6. *Other Developmental Challenges (e.g. Intellectual Impairment):* select
  2. Medical History
     1. *Primary Care Physician:* enter name here or select Was not assessed
     2. *Date of Last Physical:* enter text here or select Was not assessed
     3. *Hospitalizations or Surgeries:* select
     4. *Head Injuries / Loss of Consciousness:* select
     5. *Significant Medical Past / Present:* select
     6. *Allergies / Drug Allergies:* select
     7. *Current Problems with…*

*Eating / Appetite:* select

*Sleeping:* select

*Bowel / Bladder Control:* select

* + 1. *Current Medications:* select
    2. *Other Medical Concerns:* select
  1. Psychosocial History
     1. *Youth Lives with:* select

*Custody / Visitation Issues:* describe here or select Was not assessed

* + 1. *Birth Parents’ Names:* enter names here or select Was not assessed
    2. *Everyone Living in the Current Home:* enter names here or select Was not assessed
    3. *Culture / Ethnicity of Youth:* check all that apply or select Was not assessed

African American Caucasian Chinese Filipino Japanese Korean

Micronesian Native American Native Hawaiian Pacific Islander other

* + 1. *Caregiver Employment:* describe here or select Was not assessed
    2. *Additional Sources of Income:* describe here or select Was not assessed
    3. *Access to Transportation:* describe here or select Was not assessed
  1. ACES Scale & Other Factors That Have Contributed to Youth’s Difficulties

*Check all that apply and describe.*

* + 1. *Emotional Abuse:* describe or select
    2. *Physical Abuse:* describe or select
    3. *Sexual Abuse:* describe or select
    4. *Physical Neglect:* describe or select
    5. *Lack of Feeling Loved & Supported:* describe or select
    6. *Breakdown of Family (Parents Separated / Divorced):* describe or select
    7. *Violence Between Intimate Partners in the Home:* describe or select
    8. *Incarceration of Parent Figure:* describe or select
    9. *Current or Previous Substance Abuse by Parent Figure:* describe or select
    10. *Current or Previous Mental Health Problem in Parent Figure:* describe or select

***ACES Score (of items 1-10, number checked):*** #

* + 1. *Family Poverty / Financial Problems:* describe or select
    2. *Out-of-Home Placements:* describe or select
    3. *Multiple Moves, Multiple Schools:* describe or select
    4. *Other Difficult Events / Experiences:* describe or select
    5. *Current Instability of Parent Figures & Family Setting:* describe or select
    6. *Current or Previous Involvement with Child Welfare Services:* describe or select
  1. Youth Psychiatric, Substance Abuse & Treatment History
     1. *Psychiatric & Substance Abuse History:* select
     2. *Previous Mental Health Treatment, Other Community Services & Response to Treatment:* select
  2. Family Psychiatric, Substance Abuse & Treatment History
     1. *Mother:* select
     2. *Father:* select
     3. *Other Important Family Member(s):* select
  3. Family Strengths / Informal Supports

describe here or select Was not assessed

* 1. Youth’s Interests & Strengths

describe here or select Was not assessed

* 1. Family / Drug Court Involvement & Charges / Reason

describe here or select Was not assessed

*Probation Officer:* enter name here or select N/A

1. **Review of Systems (For Psychiatrists)**  *Not completed*

* *Psychiatric:* describe here or select Was not assessed
* *Constitutional:* describe here or select Was not assessed
* *Neurologic:* describe here or select Was not assessed
* *Musculoskeletal:* describe here or select Was not assessed
* *Other Organ Systems Reviewed:* describe here or select Was not assessed

1. **Behavioral Observations During the Assessment**

describe…

1. **Mental Status Checklist**

* *Appearance:* select
* ***Attitude****:* select
* ***Behavior****:* select
* ***Speech****:* select
* ***Affect****:* select
* ***Mood****:* select
* ***Thought Processes****:* select
* ***Thought Content****:* select
  + ***Suicidal Ideation****:* select *If Active… Plan*: select *Intent:* select *Means:* select
  + ***Homicidal Ideation****:* select *If Active… Plan*: select *Intent:* select *Means:* select
* ***Perception****:* select
* ***Orientation****:* select
* ***Memory / Concentration****:* select
* ***Insight / Judgement****:* select

1. **Additional Individuals Interviewed**  *No additional individuals interviewed*

|  |  |
| --- | --- |
|  | enter name, manner of interview and date of interview |

1. **Additional Assessment Data**  *No additional assessments completed*

|  |  |
| --- | --- |
|  | enter name of assessment tool, person completed by and date |
|  | *Results:*  describe… |

1. **Barriers to Treatment and Plans to Address Barriers**

describe…

* 1. Family and/or Youth Expectations of Mental Health Treatment

describe…

1. **Clinical Formulation**

describe…

1. **Diagnostic Impression including DSM-5 / ICD10 Codes**

describe…

* 1. Symptoms Noted That Support the Diagnosis / Diagnoses

describe…

1. **Clinical Recommendation for CAMHD Eligibility**

select

1. **Clinical Recommendations for Treatment**
   1. Treatment Focus Areas & Treatment Targets

|  |  |  |  |
| --- | --- | --- | --- |
|  | *Treatment Focus Area 1* | | |
|  | describe… | | |
|  | *Treatment Target 1a (select 1)* | *Treatment Target 1b (select 1)* | *Treatment Target 1c (select 1)* |
|  | Externalizing Behaviors  Internalizing Behaviors  Positive Behaviors  Other Targets  Other | Externalizing Behaviors  Internalizing Behaviors  Positive Behaviors  Other Targets  Other | Externalizing Behaviors  Internalizing Behaviors  Positive Behaviors  Other Targets  Other |
|  | *Treatment Focus Area 2* | | |
|  | describe… | | |
|  | *Treatment Target 2a (select 1)* | *Treatment Target 2b (select 1)* | *Treatment Target 2c (select 1)* |
|  | Externalizing Behaviors  Internalizing Behaviors  Positive Behaviors  Other Targets  Other | Externalizing Behaviors  Internalizing Behaviors  Positive Behaviors  Other Targets  Other | Externalizing Behaviors  Internalizing Behaviors  Positive Behaviors  Other Targets  Other |
|  | *Treatment Focus Area 3* | | |
|  | describe… | | |
|  | *Treatment Target 3a (select 1)* | *Treatment Target 3b (select 1)* | *Treatment Target 3c (select 1)* |
|  | Externalizing Behaviors  Internalizing Behaviors  Positive Behaviors  Other Targets  Other | Externalizing Behaviors  Internalizing Behaviors  Positive Behaviors  Other Targets  Other | Externalizing Behaviors  Internalizing Behaviors  Positive Behaviors  Other Targets  Other |

* 1. Additional Recommendations for Other Assessments
     1. *Mental Health Assessment:* describe here or select None needed
     2. *Other Assessment or Medical Consult:* describe here or select None needed
  2. Other Recommendations

describe…

1. **Evaluator Comments**

comments…

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *This assessment formulation is based on information provided at the time of this report. Any new or additional information may alter the diagnostic impression. Please contact the Evaluator with any questions or comments.* | | | | | | |
| Evaluator: Name | | Phone: (808) 555-1212 | | Email: email@agency.org | | |
| Supervisor: Name (if applicable) | | Phone: (808) 555-1212 | | Email: email@agency.org | | |
| Agency: Name | | | | | | |
| Respectfully submitted, | | | | | | |
|  |  | |  | |  |  |
|  | Signature of Evaluator | |  | | Date |  |
|  |  | |  | |  |  |
|  | Signature of Supervisor (if applicable) | |  | | Date |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Youth:** Name | | | | **Date:** select | |
| *PROBLEM BEHAVIORS – These are behaviors I sometimes show, especially when I’m stressed:* | | | | | |
| Losing control | Assaulting people | Feeling suicidal | Running away | | Using other drugs |
| Injuring myself | Attempting suicide | Threatening others | Using alcohol | | Feeling unsafe |
| Other | Other | Other | Other | | Other |
| *TRIGGERS – When these things happen, I am more likely to feel unsafe and upset:* | | | | | |
| Not being listened to | Feeling pressured | Being touched | Lack of privacy | | People yelling |
| Loud noises | Feeling lonely | Arguments | Not having control | | Being isolated |
| Darkness | Being stared at | Being teased | Contact with family | | Time of day: Specify |
| Time of year: Specify | Particular person: Name | | Other | | Other |
| *WARNING SIGNS – These are things other people may notice me doing if I begin to lose control:* | | | | | |
| Sweating | Breathing hard | Racing heart | Clenching teeth | | Clenching fists |
| Red faced | Wringing hands | Loud voice | Sleeping a lot | | Sleeping less |
| Acting hyper | Swearing | Bouncing legs | Rocking | | Can’t sit still |
| Being Rude | Pacing | Crying | Squatting | | Hurting things |
| Eating more | Eating less | Not taking care of myself | Isolating / avoiding people | | Laughing loudly / giddy |
| Singing inappropriately | Other | Other | Other | | Other |
| *INTERVENTIONS – These are things that might help me calm down and keep myself safe when I’m feeling upset:*  *Check off what you know works; star things you might like to try in the future* | | | | | |
| Time out in my room | Listening to music | Reading a book | Sitting with staff | | Pacing |
| Talking with friends | Talking with an adult | Coloring | Molding clay | | Humor |
| Exercising | A cold cloth on face | Writing in a journal | Punching a pillow | | Hugging a stuffed animal |
| Taking a hot shower | Taking a cold shower | Playing cards | Video Games | | Lying down |
| Ripping paper | Screaming into pillow | Holding ice in my hand | Getting a hug | | Using the gym |
| Bouncing a ball | Male staff support | Female staff support | Deep breathing | | Speaking w/ my therapist |
| Drawing | Being read a story | Making a collage | Crying | | Snapping bubble wrap |
| Being around others | Doing chores / jobs | Cold water on hands | Drinking hot herb tea | | Using a rocking chair |
| Calling a family member: Name | | Other | Other | | Other |
| *THINGS THAT MAKE IT WORSE – These are things that do NOT help me calm down or stay safe:* | | | | | |
| Being alone | Being around people | Humor | Not being listened to | | Peers teasing |
| Being disrespected | Loud tone of voice | Being ignored | Having staff support | | Talking to an adult |
| Being reminded of rules | Being touched | Other | Other | | Other |

|  |  |  |  |
| --- | --- | --- | --- |
| *Crisis Prevention Plan* | | | |
| 1. *I will try to notice the following warning signs and triggers:*   Describe… | | | |
| 1. *I’d like staff / my family to notice the following warning signs:*   Describe… | | | |
| 1. *When I notice these triggers or warning signs, I will take action to prevent a crisis from developing by doing the following:*   Describe… | | | |
| 1. *When staff / my family notice that I’m getting upset, I’d like them to help me prevent a crisis by doing the following:*   Describe… | | | |
| *Crisis Intervention Plan (if the prevention supports above are not effective)* | | | |
| *SIGNS THAT I MAY NOT BE ABLE TO STAY SAFE – Thoughts, feelings, and/or actions that indicate loss of control:* | | | |
|  |  | |  |
| *SUPPORT PEOPLE – People I can call or have someone call when I have these thoughts, feelings, or actions:* | | | |
| 1. Name | Relationship to youth | | Phone |
| *\* If you cannot reach the first person, go down the list until you reach someone.* | | | |
| *HELP STATEMENT – This is my clear and specific statement to let my support person know what I need:* | | | |
| I feel out of control… | | | |
| *CRISIS SUPPORT – If all of my coping strategies have not worked and I cannot reach a support person, contact crisis support:* | | | |
| * Crisis Line: 832-3100 (Oahu) / 1-800-753-6879 (Neighbor Islands) * Crisis Text Line: 741741 (Text: ALOHA) * Suicide Prevention Line: 1-800-273-TALK (8255) * Dial 911 or go to the Emergency Room | | TELL THE CRISIS WORKER:   1. If you plan to harm yourself / someone else or already have - BE SPECIFIC 2. How long you will be able to remain safe 3. Where you are and with whom (if anyone) | |