

Protocol for Completing the Biopsychosocial Assessment

The Biopsychosocial Assessment is an important document that sets up the rationale for all the work to follow in the clinical setting. All areas of this document need to be addressed in full. There are to be no blanks left on this document, as blank space suggests the writer did not address the information in that section. Full completion of the assessment is also an expectation from reviewers. One will need to enter "none reported" in any area where no check box is available – this indicates that there is no issue or need to be addressed.

Some sections have “non contributory” box to mark – this means the information is not relevant to the presenting problem.

Some sections have “none reported” indicates that either the client did not answer the questions or that the section was not addressed because the client did not complete the Biopsychosocial – you must explain the reasons none were reported in the summary.

DEMOGRAPHIC DATA

Open/Open Close: Mark either of the two boxes. Open refers to any client that is intending to continue receiving services. Open/Close is used only if the client has made it clear they are not intending to continue services beyond the initial assessment.

Label: The label requires demographic data that includes the client’s name, agency identification number, the date of birth, and the client’s RIN number. You must either complete the area identified or place an agency approved sticker within the box.

Client Name: Please list full name including middle name and Sr., Jr. or the II, III etc.

ID#: Enter the identification number assigned to the client by your agency.

DOB: Give full date of birth. (mm/dd/yyyy)

RIN#: Enter the client’s RIN number (Recipient Identification Number). This is assigned by the state to your client – all clients who have Medicaid and who have state of Illinois funding have a RIN – this is based on the agency program in which the client is being served. If there are questions regarding a particular client ask your supervisor.

Date: The date the client presented for services-must be completed by the primary clinician at the time of service.

Start Time: The exact time the assessment session begins. Ex. the client arrives in your office at 10:15AM the start time would be 10:15 ☒ AM ☐ PM

Duration: The length of the session from beginning to completion of the initial assessment session. Ex. Starting at 10:15AM and ending at 11:00AM would be a duration of 45 minutes.

Age: Enter the number.

First Face to Face Appointment: You must enter the date of your first face to face engagement with the client that signifies the client has engaged in services. This will determine the length of time available in which to complete the MHA – you have 30 days from the first face to face appointment. This date is determined by the clinician and should signify the beginning of treatment. Most often the date will correspond to the date of the first service.

Phone (Home/Cell/Work): A phone number needs to be entered on each of these lines. Please let the client understand if there is an emergency or need to reschedule an appointment so they would not have to make a trip to the office, we would want to be able to get a hold of them. If there are no numbers available, please enter “none.”

Address: Full address written out including: street or avenue, zip code, apartment number etc. If the client is homeless complete this section as required by your agency policy.

Gender: Check the appropriate box.

Primary Method of Communication: What is their primary language? (English, Spanish, French, American Sign Language, etc.)

Referral Name: Referral source needs to be listed by agency if applicable, the name of the person referring. You should complete this information by following your agency guidelines.

Funding Source: Check the appropriate box to indicate what payer source the client is using to pay for services.

Completed Assessment With: Check the appropriate box to indicate who was present for the assessment. Also since you must go over consents and rights with the client and/or guardian you must check the box indicating you did so.

CLIENT PREFERENCES AND BARRIERS TO ACHIEVING CLIENT PREFERENCES

This section and the next need to be clear in the nature, extent and severity of the problems. It also needs to identify the client's personal/treatment goals and the strengths the client identifies as keys to achieving their goals.

Client Preferences: You need to ask the client the stated question: "If you were to wake up tomorrow morning and your life was exactly the way you wanted it to be, what would it look like and what goals would you have achieved? Which strengths would you use to achieve your goals?" You will write down the client's response and document their personal and treatment goals and strengths.

Barriers to Achieving Client Preferences: List the problems that led the client to seek treatment as identified by the client and/or guardian. These are the reasons why the client has not already met their goals. Be specific

Duration: This relates to how long the problem has been present.

Additional Info: This area is to address issues such as: "aggression only in the home," school only," "lacks social skills in groups does well 1-on-1," "mitigating circumstances," "daily functioning," "psychosocial stressors impacting presenting problem," etc. Further define what and where the problem may be. Be as descriptive as possible so the reader understands the nature of the problem. "Aggressive" by itself does not let the reader know if the aggression is physical, verbal or uses weapons etc.

CURRENT SYMPTOM CHECKLIST

This section needs to directly correlate to the list of presenting problems. All issues reported in the presenting problem section needs to be addressed plus further identifiers. Ensure this list is complete as it is the set-up for your treatment plan development.

Check all boxes that apply to your client and assess the symptoms in terms of severity and documentation of a history of symptoms. You only need to check the sections that apply. You must address the sections related to the client's presenting problem. Note that there is space in which to make comments related to the check boxes or add additional information below each symptom checklist section.

Sections that must be addressed in the assessment:

Cognitive Functions: Be sure to indicate current symptoms and their level as well as the history of symptoms. Often the history of past symptoms is forgotten and is very important in showing the progression of an illness/symptoms and/or the changing in how the symptoms are manifested.

Dangerous Behaviors & Immediate Threat to Personal Safety: This section has lines added to address details as these are very serious issues that need to be conveyed precisely. Be sure to indicate history of when necessary. If history is marked write in how long ago, address current safety issues of client or others etc.

Indicators of Personality Disorder: Many of our clients are 18 and under, therefore, personality disorders are not commonly identified. In the written section, one can address concerns of possible developing personality disorders by including symptoms of such that could lead to mention of “traits” on Axis II.

EMOTIONAL/PSYCHIATRIC HISTORY

This section looks at what treatment services have been in place and if they were effective or not. Medications previously tried and the history of psychological problems within the family that may be genetically inherited or learned. If yes is indicated, it is necessary to obtain a release of information to obtain the diagnosis, date of psychiatric and treatment information.

Prior Outpatient TX: Mark the appropriate box to indicate yes or no and specify if the client has seen a mental health professional, substance abuse professional, psychiatrist, psychologist, and their names or place of business in case information may need to be elicited from them in the future etc. The client should know what their diagnosis was, how long they were in treatment, and if they thought it was effective. If they do not know or refuse to explain their history write unknown or client refused. Best practice is to complete a release of information where the service(s) were completed and request appropriate medical, mental health, or other documentation.

Prior Inpatient TX: Mark the appropriate box to indicate yes or no. This is inpatient for a psychiatric or substance abuse hospitalization only. Usually lasting 10 days or less, but in a few cases the length of stay can be longer. The client should know where they were treated, what their diagnosis was, how long they were in treatment and if they thought it was effective and if not. If they do not know or refuse to explain their history write unknown or client refused. Best practice is to complete a release of information where the service(s) were completed and request appropriate medical, mental health, or other documentation.

Prior Residential Treatment: Mark the appropriate box to indicate yes or no. This is for the longest term of treatment available. For example it could be in C&A residential facility, long term-inpatient substance abuse facilities, skilled nursing facilities, adult residential facilities, long-term psychiatric hospitalizations, etc. The client should know the name of the treating facility, what their diagnosis was, how long they were in treatment and if they thought it was effective and if not. If they do not know or refuse to explain their history write unknown or client refused. Best practice is to complete a release of information where the service(s) were completed and request appropriate medical, mental health, or other documentation.

***Date of most recent psychiatric assessment: This is mandated information that needs to be included in your assessment. Best practice is to complete a release of information where the service(s) were completed and request appropriate medical, mental health, or other documentation.

Current Psychotropic Medication: Indicate yes or no. If yes, indicate if they are compliant with medication, which means *taking the prescribed dose everyday*. List *each* medication; its dosage in mgs. How many times a day, when did they start the current dose (since this is current meds there should be no end date unless the client has indicated non-compliance) and who prescribed the medication and they believe it is effective.

Prior Psychotropic Medication: Indicate yes or no. If yes, indicate if they were compliant with medication, which means *taking the prescribed dose everyday*. List *each* medication, its dosage, how many times a day the medication was taken, when the prescription was started and date they stopped taking it, who prescribed the medication and did the client believe it was effective.

Family Members Treatment History

List family members by relationship only and not by name (ex. Sibling, parent, grandparent, cousin, etc.) If the client does not know or refuses to answer write unknown or client refused in each section.

Has any family member had outpatient treatment?: This section relates to family history of mental illness, substance abuse, primary diagnoses, history of treatment intensity, etc. This may include

outpatient counseling, groups for all types of problems, groups or special sessions with school-based counselors etc. This information is good background for helping diagnose the client. It may also help assess services the client and/or family have already engaged in. This may include the family's ability to parent and/or follow through with treatment as well as identifying learned behaviors/skills from previous interventions etc. You MUST keep names out to abide by confidentiality law.

Has any family member had inpatient treatment?: Under this section include residential placements as well as inpatient hospital for mental health reasons and substance abuse treatment. You MUST keep names out to abide by confidentiality law.

Has any family member used psychotropic medications?: Enter what psychotropic medications a family member was prescribed including length of use and purpose of use. You MUST keep names out to abide by confidentiality law.

FAMILY HISTORY

This section is valuable in identifying how our client has been raised and any significant issues that affected the client during childhood that would have a psychological effect on them currently.

Family of Origin

Present during childhood: Check appropriate boxes. "Other" would be used for grandparents, other relatives or family friends that are/were living in the home. If there are boxes marked that suggest any impact on the client's past or current functioning you must give an explanation in section titled "special circumstances in childhood."

Parents' current marital status: Mark the correct status of each parent. Complete all lines needed for more than a check mark. If there are boxes marked that suggest any impact on the client's past or current functioning you must give an explanation in section titled "special circumstances in childhood."

Describe childhood family experience: Indicate the box that most closely describes your client's home life. If chaotic or abusive situations are indicated, please expand on the lines below, otherwise enter "none." If there are boxes marked that suggest any impact on the client's past or current functioning you must give an explanation in section titled "special circumstances in childhood."

Emancipation from home: If the client has not been emancipated, mark non-contributory. If they have, indicate the age of emancipation and how this came about. If there are boxes marked that suggest any impact on the client's past or current functioning you must give an explanation in section titled "special circumstances in childhood."

Special Circumstances in Childhood: Document in narrative form any information regarding family of origin that impacts client's past and/or current functioning. If there are no special circumstances enter "none" in the space.

Current Family

Marital Status: Indicate client's current marital status.

Intimate Relationship: Indicate client's report of their current relationship status.

Relationship Satisfaction: Indicate client's report of satisfaction with current relationship.

List all persons currently living in client's household: List all people related or living in the home by relationship only, i.e. brother, step-father, half-sister etc. Complete all information on age and their gender. You may refer back to registration page 2 in the chart if it was properly completed.

List all children not living in client's household including frequency of visitation: List all full, half or step sibling of significance to the client. Include any children removed from the home due to

allegations of abuse and/or neglect. Again, due to confidentiality law, list by relationship and not name. Must include how often they are able to see each other.

Describe any past or current significant issues in intimate or immediate family relationships: This section refers to relationships within the family, boy/girlfriends, significant other etc. Significant conflicts leading to relationship dysfunction. Include issues that impact client's current presenting problem, symptoms, and/or functioning.

Client Abuse History

If there is a history of abuse, it is very important to clearly and accurately describe the issues and how they have been addressed. Have the issues been identified publicly, legally, and in any previous treatment settings. It is also important to maintain confidentiality standards by not identifying names of abuse perpetrators. Remember we are also mandated reports and must ensure the client is currently in a safe setting.

- If after speaking with your client and collaterals there is no evidence abuse, check the first box under the title of this section.
- Otherwise, check all categories of "victim and/or accused of." Complete at what age, to the best recollection of the client, did these events take place. Specify what treatment type and where it was provided and if none, indicate "none."

Description of Abuse etc.: Expand on what type of abuse that is indicated above, who perpetrated the abuse (relationship ONLY) and any other pertinent details that need to be addressed.

Concerns/Needs/Issues/Services accessed/Linkages needed: Document any services, linkages, issues, etc that need to be addressed in relationship to this section of the assessment. Ex. The client was sexually assaulted: what did you do to address the issue, what services were offered, referrals provided.

MEDICAL HISTORY

It is important to remember that medical issues can directly affect one's mental health. It is also important for a Psychiatrist if a client is referred, to know who are the doctor(s) involved with the client, current non-psychotropic medications etc. before prescribing psychotropic medications and what drug interactions that may come about.

- Check all that indicates present medical concerns. Describe other medical not listed on the lines below the boxes.
- Enter the name of the client's current primary care physician. Get address phone, number, etc if possible. Best practice is to complete a release of information where the service(s) were completed and request appropriate medical, mental health, or other documentation.
- Indicate the client's current health status by their own report and below enter the date of the last physical exam and comments/concerns from that exam.

Significant Medical History: List any surgeries, head injuries, any type of accidents or trips to the emergency room, broken legs, stitches etc. Many physical issues can be related to emotional reactions or uncover physical abuse not yet identified.

List All Non-psychotropic Medication Currently Taken: Enter all over the counter medications and non-psychotropic medication prescriptions are being taken. That may include medication for asthma, menses, joint/muscle problems, chronic headaches etc. List vitamins and minerals as clients may be treated by homeopathic measure. Again, there may be medication interaction issues a psychiatrist needs to consider prior to prescribing psychotropic medications. It also may give good insight into your client.

Nutritional Development: Check all boxes that apply to the client. Eating disorders are being assessed for here including possible malnutrition. If there are no concerns indicate “normal” and on the Concerns line below enter, “none.” Again address any referrals, services, medical care needed.

Concerns/Needs/Issues/Services Accessed/Linkages Needed: Either mark the box for none or describe the concerns, needs, issues, services accessed, or linkages needed for this section of the form.

SUBSTANCE USE HISTORY

It is important to learn if substance abuse is interfering with functioning. Is your client attempting to self-medicate or is a family member(s) substance abuse a factor in treating your client.

- Check first box ONLY if you are a substance abuse clinician intending to complete a network approved substance abuse addendum or a substance abuse addendum was completed by another network approved substance abuse treatment provider – the completed substance abuse addendum must then be attached to the back of the biopsychosocial to indicate the level of abuse.
- Check second box if *after interviewing client* and there is no substance use reported by them.
- If you identify any substance use you must mark the appropriate box and provide all information.
- You must identify any consequences of substance use/abuse by marking the appropriate box(es).

Family Substance Abuse History

- Check all appropriate boxes related to family history of substance abuse.
- Explain how this may or may not involve/affect the client’s emotional stability and any issues that will need to be addressed in treatment. Again address any referrals, services, medical care needed.

Concerns/Needs/Issues/Services Accessed/Linkages Needed: Either mark the box for none or describe the concerns, needs, issues, services accessed, or linkages needed for this section of the form.

DEVELOPMENTAL HISTORY

This section is assessing any biological issues from birth that could be interfering with current functioning.

Physical Development:

Each category of development must have a box checked.

Chronological Age: List both years and months.

Prenatal History: The history of a client while they were in utero related to health and exposure to drugs, illness, or injury.

Birth: The status of the client during labor/delivery to identify any issues that may have impacted physical or cognitive functioning.

Delayed Developmental Milestones: Identify per client report any delayed development in regards to cognitive or physical functioning – only check boxes if the milestone was delayed - note that in parentheses the norm is identified as a guide. *Motor refers to basic motor skills such as walking, moving arms, etc.*

Sensorimotor Functioning & Motor Development: Identify if there were any sensorimotor or motor development problems in childhood – if there were no delayed milestones there are unlikely to be sensorimotor or motor development problems. *Sensorimotor refers to fine motor skills such as using a pencil or painting, etc*

Concerns/Needs/Issues/Services Accessed/Linkages Needed: Either mark the box for none or describe the concerns, needs, issues, services accessed, or linkages needed for this section of the form.

Educational Development (If you are unsure of what a term means ask your supervisor):

Last/Current Grade Completed and School Attended: Indicate the client's last grade completed and last school attended – if the client is still in school identify their current grade and school.

Elementary, Middle/High and College/Vocational Training Schools: This needs to be completed for all clients including current and/or past school attendance and performance. For schools not yet attended, indicate non-contributory. If they did not finish high school but received a GED, please indicate so in the last grade completed section above.

Any Hx of the Following: Check applicable boxes - if none check the non-contributory box.

If Received Special Education Services: Check what are/were the special education services received.

Concerns/Needs/Issues/Services Accessed/Linkages Needed: Either mark the box for none or describe the concerns, needs, issues, services accessed, or linkages needed for this section of the form.

Developmental History (child and adolescent client)

This next section must be completed for all clients that are people under the age of 18. It is optional for adult clients - you may complete it or leave it blank. Mark the assessed not history box only if the client is under age 18 and does not have any developmental issues in ANY category.

Emotional Development:

Mood: Check *all* applicable mood indicators to client's history and current state.

Emotional/Behavior Problems: Check *all* indicators that describe your client's behavior. If a behavioral concern is not listed, use the "other" box and explain on the line specify line that follows.

Concerns/Needs/Issues/Services Accessed/Linkages Needed: Either mark the box for none or describe the concerns, needs, issues, services accessed, or linkages needed for this section of the form.

Cognitive Development:

Check all appropriate boxes to indicate any past or current issues in cognitive development or functioning. Use "other" for issues that need to be mentioned and not listed in the available boxes.

Concerns/Needs/Issues/Services Accessed/Linkages Needed: Either mark the box for none or describe the concerns, needs, issues, services accessed, or linkages needed for this section of the form.

Social Development:

Check boxes to identify issues related to social functioning that impedes development of healthy peer or adult/child relationships.

Concerns/Needs/Issues/Services Accessed/Linkages Needed: Either mark the box for none or describe the concerns, needs, issues, services accessed, or linkages needed for this section of the form.

****This ends the section that relates to child and adolescent clients only
– all further sections must be completed for all clients.****

SOCIO-ECONOMIC HISTORY

This section identifies the client's current economic status, ability to care for self, social supports, sexuality, military involvement, employment status, financial situation, involvement with the criminal justice system, cultural/spiritual/recreational activities/support, and guardianship status. If you are unsure of what a term means ask your supervisor.

Living Situation:

Check ALL boxes that apply to your clients living situation - more than one box may apply.

Daily Living Skills:

Check ALL boxes that apply to your client's capacity to care for him/herself.

Social Support System:

Check all boxes that apply to your client's social network.

Sexual History:

Check appropriate boxes that describe your client's sexual orientation and activity. If the client is too young to identify their sexual preference, indicate non-contributory.

Military History:

Check appropriate box. Use non-contributory only if the client is unable to or unwilling to provide the information. Most clients under 18 will be identified as never in military. Otherwise indicate the client's military history per client report.

Conditional Discharge: discharge from the military due to non-physical issues, such as mental illness, that made him/her "unfit for duty."

Dishonorable discharge: discharge from the military due to a crime, broken rule, or other form of inappropriate conduct while enlisted.

Employment:

Check boxes that indicate your client's status of work. Use non-contributory only if the client is unable to or unwilling to provide the information. Clients under age 16 and without a work permit would be identified as not in labor force. For clients 16 and up mark the box(es) that best describes their work life.

Financial Situation:

Check boxes to identify the client and/or the client's household in relationship to their current financial status. Use non-contributory only if the client is unable to or unwilling to provide the information.

Concerns/Needs/Issues/Services Accessed/Linkages Needed: Either mark the box for none or describe the concerns, needs, issues, services accessed, or linkages needed for this section of the form.

Legal History/Status:

Check first box ONLY if you are a substance abuse clinician intending to complete a network approved substance abuse addendum or a substance abuse addendum was completed by another network approved substance abuse treatment provider – the completed substance abuse addendum must then be attached to the back of the biopsychosocial to indicate the level of abuse.

Check the non-contributory box if *after interviewing client* and there is no history of legal problems and/or criminal behavior. Do not include traffic violations unless they are also considered criminal such as DUI or vehicular homicide.

History of Arrests: Take detailed history of arrests. This information is important to know as it identifies the progression and level of their criminal activity as well as current criminal activity. It also determines eligibility for some programs such as HUD or section 8.

Probation Officer/Parole Agents Info: List name, phone number, address, and jurisdiction (i.e. county/state/federal). YOU MUST get a release of information for the probation officer or parole agent to coordinate services and identify barriers to treatment. Probation/parole can also be allies in keeping the client committed to treatment.

Conditions of Probation/Parole etc: Explain the parameters of the court expectations and identify any barriers to treatment including home detention, computer use, etc. A copy of the current court order and/or release papers should be included in the file and can be obtained from probation or parole agent.

Concerns/Needs/Issues/Services Accessed/Linkages Needed: Either mark the box for none or describe the concerns, needs, issues, services accessed, or linkages needed for this section of the form.

Cultural/spiritual/recreational status:

Check first box **ONLY** if you are a substance abuse clinician intending to complete a network approved substance abuse addendum or a substance abuse addendum was completed by another network approved substance abuse treatment provider – the completed substance abuse addendum must then be attached to the back of the biopsychosocial to indicate the level of abuse.

Check the none reported box if the client refuses to provide the requested information or for some reason the questions were not asked. If the questions were not asked the reason must be documented in the summary section of the Biopsychosocial Assessment.

Spiritual/Religious Affiliation: Mark the box yes or no to identify if the client does or does not have a particular spiritual or religious affiliation.

If yes - - -

- Check the *box* yes or no to identify if the client is currently engaging in spiritual activities listed above. Ex. Goes to church weekly, involved in youth group, volunteers for his/her church.
- On the next line inquire if their spiritual/religious affiliation adds to the current problem the client is seeking treatment for and document the client's response. If your client does not see any interference, enter "none reported."
- The *line* following is to describe how your client reports their spiritual practices help them or not in coping with life stresses. If the client does not see any identifiable help, enter this information. Write the answer from the client's perspective per his/her report.

Cultural/Ethnicity Affiliation: Mark the box yes or no to identify if the client does or does not have a particular cultural or ethnic affiliation.

If yes - - -

- Check the *box* yes or no to identify if the client is currently engaging in cultural/ethnic activities listed above. Ex. Goes to cultural organizations, cultural society groups, engages in traditional activities and events, specific travel/food activities, cultural holidays and celebrations.
- On the next line inquire if their cultural affiliation adds to the current problem the client is seeking treatment for and document the client's response. If your client does not see any interference, enter "none reported."
- The *box* following the cultural identification information asks if the client currently is involved activities surrounding their culture and whether it helps them or not in coping with life stresses. If the client does not see any identifiable help, enter this information. Write the answer from the client's perspective per his/her report.

Community Involvement/Recreational Status: Indicate in the next *set of 3 boxes* appropriate responses. Mark the corresponding yes no response to indicate if the client has community involvement (past or present) and engage in hobbies. Otherwise leave the sections blank. You should be identifying some form of hobby, interest, or activity with most every client.

- List client's interests, sports involvement, community programs or groups. Do they enjoy writing, reading, games, drawing, woodworking etc.
- The last line asks what does you client do when not in school or work. How do they use their free time.
- The *box* following the community/recreational/hobbies information asks if the client currently is involved in activities and/or has particular interests that help them or not in coping with life stresses. If the client does not see any identifiable help, enter this information. Write the answer from the client's perspective per his/her report.

Guardianship Status:

Mark the box next to the term that identifies the client's guardianship status. Below is the list of terms and their respective meanings. Note if the guardianship status is other than own guardian or minor child you must get documentation to corroborate the status.

OWN GUARDIAN: the client is over age 18 (or under 18 and legally emancipated) and has full control over all life decisions.

MINOR CHILD – PARENT/GUARDIAN HAS GUARDIANSHIP: the client is under age 18 and is not legally emancipated and the parent(s) or guardian(s) have the ability to make decisions on the minor's behalf.

DCFS GUARDIANSHIP: the client is under 21 and is a ward of the state – the state (DCFS) makes all the decisions on behalf of the client. Must get all consents and documentation from DCFS or a licensed foster care agency.

TRUST BENEFICIARY: a third party controls financial resources until a specified period of time and/or the client meets some other pre-determined criteria for release of the funds. Ex. A child with wealthy parents loses them in a car accident. The court usually sets up a trust and identifies a trust beneficiary to oversee the money until the client is capable to manage it on their own.

PENDING COURT DECISION: the guardianship status is not yet resolved and the case is still being heard in court. Most of the time the court takes temporary guardianship until the case is resolved. A guardian ad litem is appointed to make decisions on the client's behalf.

REPRESENTATIVE PAYEE: the client is an adult and unable to manage their own finances. An organization or person is identified to manage the client's money, pay bills, pay rent, provide the client with an allowance for food, etc. The client should be aware of who their representative payee is. Make sure to document name, address, phone number, etc. and secure a release of information for the representative payee.

LIMITED GUARDIANSHIP TYPE

PLENARY GUARDIANSHIP: this refers to guardianship of estate and person. Meaning, the client is over the age of 18 and unable to make decisions not only about money, property, and etc. but they are also unable to make decisions about medical care, dental care, mental health care etc. The client has impaired decision-making ability and all decisions are made on behalf of the client by the plenary guardian. Much like a parent making decisions on behalf of a minor child.

GUARDIANSHIP OF ESTATE: this refers to guardianship of estate. Meaning, the client is over the age of 18 and unable to make decisions about money, property, etc. They are, however, able to make decisions about medical care, dental care, mental health care etc.

GUARDIANSHIP OF PERSON: this refers to guardianship of person. Meaning, the client is over the age of 18 is unable to make day to day decisions medical care, dental care, mental health care etc. The client is able to make decisions about finances.

You must identify the guardian and get his/her name, address, and telephone number. If the client has a guardian of person or plenary guardian, that guardian must sign all consents for treatment.

Mark the box to note you got documentation to corroborate the status if needed.

MENTAL STATUS EXAMINATION

This section is very important. What has been written about the presenting problems and issues reported throughout this report should be reflected in the various cognitive areas listed. The checks in the boxes should also coordinate with your diagnosis in the upcoming pages.

Check all appropriate boxes that match what you have observed in your sessions, feedback from school personnel, probation etc.

Appearance:

- Cleanliness
- Clothing and accessories
 - Typical or bizarre
 - Related to a certain group
- Posture – erect or slumped
- Physical abnormalities or body art: limp, scars, missing limbs, tattoos are illegal under age 18 (meaning, symbolizes what, reason for getting them,) piercings, etc.
- Untidy: **poor hygiene**, not orderly or neat, messy, unkempt
- Disheveled: disorderly, tousled – especially hair and clothing
- Bizarre: strikingly unconventional in style or appearance, odd
- Note build: obese, slender, extremely thin, “wasted,” stocky, muscular

Manner: Showing frequent and or intense non-goal directed motor movements

- Agitated: moving with sudden force as in shaking, staggering, twinges, spasms, stumbling, convulsing, jumpiness, repetitive motion, restlessness, little focus or concentration
- Awkward: lacking grace or dexterity – clumsy or ungainly
- Tics: a spasmodic muscular contraction usually of the face or extremities
- Restless: not able to rest, relax, or be still
- Compulsive: performing actions repeatedly in a way that is neither useful nor appropriate – patient is usually aware of the behavior
- Bizarre: odd
- Tearful: crying, tears

Attitude:

- Cooperative: is eager to please, charming
- Uncooperative: hostile, defensive
- Guarded: not willing to answer questions or generally not open about self or issues

Consciousness:

- Alert: awareness of environment and ability to respond
- Lethargic: sluggish, apathetic
- Confused: unclear, lacking logic or order, chaotic, jumbled
- Stuporous: only partly conscious; arousable only by repeated noise, sound, or noxious smell, reduced sensibility
- Comatose: unconscious

Affect: How the person appears to be feeling

- Anxious: uneasy or apprehensive
- Labile: abnormally quick and minimally cued (unprovoked) changes in type of affect, quick/wide mood swings
- Blunted: a dulled or diminished intensity of emotional expressiveness
- Flat: absence of emotional expression, compressed range of mood
- Hostile: anger directed at someone

Prevailing Mood: How the person claims to be feeling (optimistic, pessimistic, hopeless, guilty)

- Elated: client has high energy and reports feelings of happiness or euphoria

- Depressed: client reports feelings of depression
- Anxious: client is uneasy and shows signs of anxiety and/or panic symptoms

Thought Processes:

Rate: rate of speech

- Retarded: slow speech pattern
- Over-talkative: speaks freely without response to a question, unable to ask questions of client
- Difficulty in speech: has a difficult time expressing self and speaking clearly
- Flight of ideas: not able to string thoughts together so they make sense, moves from one topic to another without any connection between ideas

Content:

- Delusional: a fixed, false belief that cannot be explained by education and/or culture
- Somatic: a fixed, false belief that involves illness and/or bodily functions
- Persecutory: paranoid delusions
- Ideas of reference: ascribing a personal meaning to events which are neutral
- Obsessions: domination of the mind by one idea or set of ideas – unable to think of other things
- Hypochondriasis: believing that you have specific medical issues with no physical symptoms usually for attention or secondary gain
- Suicidal: thoughts about suicide
- Homicidal: thoughts about homicide

Associations:

- Logical: rational and reasonable
- Relevant: providing information related to a topic (i.e. reason for attending session)
- Goal directed: content of conversation is focused entirely on a single goal
- Circumstantial: providing irrelevant, digressive, detailed information before getting to the point of an idea
- Blocking: a sudden halt in thought and speech, client is unable to remember their line of thought
- Nonsensical: the ideas make no sense and there is no frame of reference for them
- Perseveration: talking about the same thing over and over
- Inadequate: not able to fully understand connections between ideas
- Loose: nonsensical or unclear connections between ideas

Speech:

- Spontaneous: client talks on own not just in response to questions
- Pressured: rapid often loud speech
- Excessive: client does not stop talking even when there is no particular topic
- Delayed: delay of responses, pauses between speech
- Incoherent: speech that is not understood
- Soft: speaking in a soft voice
- Perseveration: talking about the same thing over and over
- Loud: talking in a loud voice
- Slurred: words are slurred or jumbled when client speaks

Faculty orientation:

- Time: person does not know time of day
- Person: person does not know who they are
- Place: person does not know where they are

Attention span/concentration:

- Short: person can only repeat a small amount of information for a period of time
- Preoccupied: engrossed in thought instead of the task at hand
- Distractible: easily taken off task by other internal or external stimuli

Perception:

- Hallucinations
 - Olfactory: smells things that aren't there
 - Visual: sees things that aren't there
 - Auditory: hears things that aren't there

Intellectual Functions:

- Intelligence: the level at which one is understood
- Fund of information: awareness of basic facts
- Calculation: questions that require attention, concentration, or memory (this will usually be not applicable as you are not asking client to complete tests for memory and digit span)
- Abstraction and Symbolization: ability to grasp the nature of questions

Memory Deficits:

- Note any observed problems with the clients memory

Judgment: ability to make reasonable and realistic life decisions

Insight:

- Partial: unable to make use of correct insight, understands self at a limited capacity
- Denial: client is aware of issues but acts like they are not a problem
- Absent: client has no insight into issues

Additional Comments: Review what you observed with the client during your interviewing process. All boxes checked in the above sections that were not normal need to be addressed as to what took place to indicate an answer other than normal. You should comment on your own observations that were not reported by others or not specifically designated in the mental status exam.

CLIENT STRENGTHS AND BARRIERS TO RECOVERY

It is important to acknowledge the client's strengths and use them as platforms to build coping/problem solving skills and develop a more positive self-concept. Also identifying barriers to recovery provides keys to treatment goals/objectives and measurable outcomes. Strength based focused treatment is crucial when addressing difficult issues.

- Check all boxes that relate to your client in both categories.
- You must identify strengths as required by various funders, regulations, and accrediting bodies.

SUMMARY OF PRESENTING PROBLEMS, SYMPTOMS, LEVEL OF FUNCTIONING, ANALYSIS, CONCLUSIONS AND RECOMMENDATIONS FOR SPECIFIC SERVICES

- Check first box ONLY if you are a substance abuse clinician intending to complete a network approved substance abuse addendum or a substance abuse addendum was completed by another network approved substance abuse treatment provider – the completed substance abuse addendum must then be attached to the back of the biopsychosocial to indicate the summary was completed.

This is the pivotal point of your assessment. You have located all the possible data and now you are ready to synthesize all this information using your professional opinion of what is happening with your client. Again, this is not a repeating of what has already been presented in this report, but how all of what has been presented effects the client today. In this discussion, you will need to lay ground to support your following diagnosis and recommendations you include. Throughout the report one has listed sections of information and here one pulls it all together in a manner to explain and support a diagnosis.

You must identify and explain the following sections in your summary in a narrative format:

- 1) Summary of presenting problem
 - Nature of the problem: what are the symptoms identified by the client and your observation that indicate the client's behavioral health status and diagnosis.
 - Extent of the problem: how long has the client been struggling with each of the symptoms noted and how they affect current functioning.
 - Severity of the problem: how intense are the symptoms and how severe are they in regards to the daily impact on the client's functioning.
- 2) Current and past level of functioning
 - What is the client's current functioning including ability to care for self, maintain employment/school, manage finances, cope with life stressors, engage in social contact, manage emotions and behavior, etc. Include their highest level of functioning in the past year if the current symptoms are new or recent problems.
- 3) Analysis
 - What is your clinical analysis and clinical opinion about the symptoms, all gathered data, the client's prognosis. The analysis should support your diagnosis. For example - you must synthesize all the data and explain why the information all suggests Major Depressive Disorder – Recurrent/Moderate.
- 4) Conclusions and Recommendations
 - What conclusions have you made about the client's need for treatment, level of care needed, services that need to be provided, barriers to services, and any other relevant information that relates to the next phase of treatment. You must include specific recommended services also explain how you would remove the barriers to service. For example – your client with Major Depressive Disorder – Recurrent/Moderate may need
 - Therapy/Counseling
 - Psychiatric Diagnostic
 - Medication Management
 - Case Management
 - Client Centered Consultation

The following is an excellent sample of a summary:

Clt is a 31yo white male who described presenting problems as depression and anxiety; clt noted severe insomnia and social isolation; clt reported moderate depressed mood, fatigue, emotionality, agitation/irritability, hopelessness/worthlessness, anxiety – nervousness, feeling scared, "I'm just anxious a lot", and poor concentration; clt reported mild grooming issues on weekends and infrequent and fairly mild anger outbursts (verbal only); clt has Hx of depression w 1 episode of suicidal ideation – was hospitalized at 18yo; clt denies any current suicidal ideation, intent, or plan; clt has taken medication in the past for depression; some family Hx of depression; clt noted verbal and physical abuse by parents during childhood; clt noted chronic back pain but has not accessed medical Tx; clt uses alcohol 3 times per week and drinks to excess – also smokes marijuana 1 joint per week per his self-report; clt stated he had 1 DUI; clt has a poor support system; clt noted depression is impacting productivity at work – at risk of losing his job; clt is struggling w recurrent depression and recent anxiety symptoms; anxiety is likely secondary to depression and may reflect the increase in psychosocial stressors; clt needs T/C, T/C Group, ITP, CM, CCC, DX, Medication monitoring, A/D evaluation, and medical services referral to stabilize mood, reduce symptoms, resolve psychosocial stressors, and evaluate substance use and provide A/D Tx if needed

- Check the appropriate box for your client's ability and willingness to participate in the treatment process.
 - Ability: the client's physical, emotional, or financial ability to receive and benefit from services.

- Willingness: the extent to which the client accepts services voluntarily or is compelled by parents, court order, spouse, etc. Also, the degree to which the client actually wants to improve functioning and/or quality of life.

Justification for issues not addressed in treatment:

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- Mark the second box if all mental health issues identified in the assessment will be addressed in treatment.
- If there are issues that require treatment that you do not intend to address - describe the issue(s) you will not address in treatment and explain why.
 - Then check the box indicating why you will not be addressing these issues.

SUMMARY OF TREATMENT RECOMMENDATIONS

- Check first box ONLY if you are a substance abuse clinician intending to complete a network approved substance abuse addendum or a substance abuse addendum was completed by another network approved substance abuse treatment provider – the completed substance abuse addendum must then be attached to the back of the biopsychosocial to indicate the summary was completed.
- DSM IV-TR or ICD-9 Diagnosis
 - All five Axis' must have complete diagnoses with correct code number and specified identifiers to each diagnosis
 - Axis I: identify the client's primary and secondary diagnoses as identified in the ICD-9-CM or DSM-IV TR
 - Axis II: identify any personality disorder or organic disorder such as mental retardation or a personality disorder
 - Axis III: any medical condition the client has – if there is no ICD-9 code for the medical problem write the problem in the line without a 5-digit code
 - Axis IV: check the appropriate sub-categories to identify life stressors that may exacerbate the client's mental illness and/or impact functioning. Specify the particular problem in your client's life. These are key areas to document because they identify the medical necessity for any and all case management services provided
- Specify all appropriate scales used with your client
- Enter the client's report of their highest level of functioning over this past year

Responsible Staff:

Enter who is primary clinician with the client – it is usually going to be you. If there is a second person treating your client their name needs to be added; lastly, if the client is seeing a psychiatrist, enter their name (if known.)

Program Assignment:

Check the program your client has been primarily assigned to

Preliminary Treatment Plan and Recommended Services:

Check all services that will be needed in treating your client. If a service is not listed, you can add services under the last heading of "other." You should always mark the following services: ITP, CM, and CCC

Signatures:

Sign your name on the line next to your classification. If you are not an LPHA you MUST have an LPHA sign off on your assessment.