Community Mental Health for Central Michigan

PSYCHOSOCIAL ASSESSMENT (CIGMMO)

☐ **Initial** ☐ **Annual**

DEMOGRAPHIC INFORMATION

Consumer Name: **Case Number:**

Date of Psychosocial Assessment:

Date of Birth: **Gender:** ☐ **Male** ☐ **Female**

Aliases and Other Identifying Information:

SS #: **Medicaid ID #:** **MI Child ID #:**

Home Address:

Primary Phone: **Alternate Phone:**

County of Residence: **Different COFR:**

Primary Spoken Language: **Communication Preference:**

Referral Source: **Religion:**

Time to Treatment: **Prior Treatment Episodes:**

Pregnant on Service Start Date:

Is this a Minor Referral (without parental consent): ☐ **Yes** ☐ **No**

OTHER DEMOGRAPHIC INFORMATION

Marital Status: **Maiden Name:**

Veteran Status:

Race/Ethnic Origin:	**Hispanic or Latino Ethnicity:**
☐ Alaskan native	☐ Puerto Rican
☐ American Indian	☐ Mexican
☐ Black or African American	☐ Cuban
☐ White	☐ Other specific Hispanic or Latino
☐ Asian	☐ Not of Hispanic or Latino origin
☐ Other race	☐ Hispanic or Latino – specific origin not specified
☐ Native Hawaiian or other Pacific	☐ Unknown
☐ Refused to Provide	

How can I help you today/reason for seeking services *(as described by consumer/family/other)*:

DEVELOPMENTAL DISABILITY

Relevant Symptoms of the Problem

☐ Cognitive Impairment ☐ Learning Problems ☐ Motor Skills Disorder ☐ Communication Disorder
☐ Pervasive Disorder ☐ Physical Impairment ☐ Closed Head Injury ☐ Other

Intensity of the Problem

☐ Borderline ☐ Mild ☐ Moderate ☐ Severe ☐ Profound

Age of Onset: _____

Consumer's Report of Problem's Severity:

ABUSE OF OTHERS

Relevant Symptoms of the Problem

☐ Physical ☐ Sexual ☐ Emotional ☐ Neglect ☐ Domestic Violence ☐ Other

Intensity of the Problem

☐ Mild ☐ Moderate ☐ Severe

Duration of the Problem

☐ First Episode ☐ Current and Ongoing ☐ Past history, no current abuse

Consumer's Report of Problem's Severity:

ADJUSTMENT ISSUES

Relevant Symptoms of the Problem

☐ Relationship Problems ☐ School ☐ Home ☐ Community
☐ Family ☐ Social/Peer ☐ Work ☐ Other

Intensity of the Problem

☐ Mild ☐ Moderate ☐ Severe

Duration of the Problem

☐ Acute, First Episode ☐ Acute, Chronic ☐ Acute, Duration Unknown ☐ Chronic

Consumer's Report of Problem's Severity:

ANGER

Relevant Symptoms of the Problem

☐ Irritability ☐ Physically Aggressive ☐ Verbally Aggressive ☐ Destruction of Property ☐ Legal Violations
☐ Other

Intensity of the Problem

☐ Mild ☐ Moderate ☐ Severe

Duration of the Problem

☐ Acute, First Episode ☐ Acute, Chronic ☐ Acute, Duration Unknown ☐ Chronic

Consumer's Report of Problem's Severity:

ANXIETY

Relevant Symptoms of the Problem

☐ Agitation ☐ Excessive Worry ☐ Fatigue ☐ Irritability
☐ Poor Concentration ☐ Restlessness ☐ Sleep Disturbance ☐ Tension ☐ Other

Intensity of the Problem

☐ Mild ☐ Moderate ☐ Severe

Duration of the Problem

☐ Acute, First Episode ☐ Acute, Chronic ☐ Acute, Duration Unknown ☐ Chronic

Consumer's Report of Problem's Severity:

DELUSIONS

Relevant Symptoms of the Problem
☐ Grandiosity ☐ Religiosity ☐ Paranoia ☐ Somatization ☐ Other

Intensity of the Problem
☐ Mild ☐ Moderate ☐ Severe

Duration of the Problem
☐ Acute, First Episode ☐ Acute, Chronic ☐ Acute, Duration Unknown ☐ Chronic

Consumer's Report of Problem's Severity:

DEPRESSION

Relevant Symptoms of the Problem
☐ Anhedonia ☐ Appetite Disturbance ☐ Excessive Guilt ☐ Suicidal Ideation ☐ Fatigue
☐ Agitation ☐ Diminished Self-Esteem ☐ Insomnia ☐ Hopelessness
☐ Hypersomnia ☐ Psychomotor Retardation ☐ Weight Gain ☐ Weight Loss ☐ Other

Intensity of the Problem
☐ Mild ☐ Moderate ☐ Severe

Duration of the Problem
☐ Acute, First Episode ☐ Acute, Chronic ☐ Acute, Duration Unknown ☐ Chronic

Consumer's Report of Problem's Severity:

EATING ISSUES

Relevant Symptoms of the Problem
☐ Intense Fear of Gaining Weight ☐ Distorted Body Image ☐ Amenorrhea ☐ Binge Eating
☐ Self-Induced Vomiting ☐ Laxative Abuse ☐ Diuretic Abuse ☐ Excessive Exercise
☐ Other

Intensity of the Problem
☐ Mild ☐ Moderate ☐ Severe

Duration of the Problem
☐ Acute, First Episode ☐ Acute, Chronic ☐ Acute, Duration Unknown ☐ Chronic

Consumer's Report of Problem's Severity:

HALLUCINATIONS

Relevant Symptoms of the Problem
☐ Auditory ☐ Olfactory ☐ Tactile ☐ Visual ☐ Other

Intensity of the Problem
☐ Mild ☐ Moderate ☐ Severe

Duration of the Problem
☐ Acute, First Episode ☐ Acute, Chronic ☐ Acute, Duration Unknown ☐ Chronic

Consumer's Report of Problem's Severity:

IMPULSE CONTROL

Relevant Symptoms of the Problem
☐ Assaultive Acts ☐ Destruction of Property ☐ Stealing ☐ Fire Setting
☐ Maladaptive Gambling ☐ Pulling Hair ☐ Self-Harm ☐ Other

Intensity of the Problem

☐ Mild ☐ Moderate ☐ Severe

Duration of the Problem
☐ Acute, First Episode ☐ Acute, Chronic ☐ Acute, Duration Unknown ☐ Chronic

Consumer's Report of Problem's Severity:

INATTENTION

Relevant Symptoms of the Problem
☐ Inability to Concentrate ☐ Difficulty with Focus ☐ Short Attention Span ☐ Difficulty Learning ☐ Other

Intensity of the Problem
☐ Mild ☐ Moderate ☐ Severe

Duration of the Problem
☐ Acute, First Episode ☐ Acute, Chronic ☐ Acute, Duration Unknown ☐ Chronic

Consumer's Report of Problem's Severity:

MANIA

Relevant Symptoms of the Problem
☐ Grandiosity ☐ Decreased Sleep ☐ Pressured Speech ☐ Racing Thoughts ☐ Other

Intensity of the Problem
☐ Mild ☐ Moderate ☐ Severe

Duration of the Problem
☐ Acute, First Episode ☐ Acute, Chronic ☐ Acute, Duration Unknown ☐ Chronic

Consumer's Report of Problem's Severity:

PANIC

Relevant Symptoms of the Problem
☐ Heart Palpitations ☐ Sweating ☐ Trembling ☐ Shortness of Breath ☐ Choking
☐ Chest Pain ☐ Nausea ☐ Dizziness ☐ Derealization ☐ Fear of Losing Control
☐ Fear of Dying ☐ Numbness ☐ Chills or Hot Flashes ☐ Other

Intensity of the Problem
☐ Mild ☐ Moderate ☐ Severe

Duration of the Problem
☐ Acute, First Episode ☐ Acute, Chronic ☐ Acute, Duration Unknown ☐ Chronic

Consumer's Report of Problem's Severity:

PHOBIA

Relevant Symptoms of the Problem
☐ Animals ☐ Natural Environment Events ☐ Particular Situations ☐ Other

Intensity of the Problem
☐ Mild ☐ Moderate ☐ Severe

Duration of the Problem
☐ Acute, First Episode ☐ Acute, Chronic ☐ Acute, Duration Unknown ☐ Chronic

Consumer's Report of Problem's Severity:

RELATIONSHIP ISSUES

Relevant Symptoms of the Problem
☐ Unstable/Intensive Relationships ☐ Fear of Abandonment ☐ Feelings of Emptiness ☐ Conflict ☐ Other

Intensity of the Problem

☐ Mild ☐ Moderate ☐ Severe

Duration of the Problem
☐ Acute, First Episode ☐ Acute, Chronic ☐ Acute, Duration Unknown ☐ Chronic

Consumer's Report of Problem's Severity:

SEXUAL ISSUES

Relevant Symptoms of the Problem
☐ Deficit Desire ☐ Aversion ☐ Inadequate Arousal ☐ Inadequate Erection
☐ Non-orgasmic ☐ Premature Ejaculation ☐ Dyspareunia ☐ Vaginismus
☐ Paraphilas ☐ Gender Concerns ☐ Other

Intensity of the Problem
☐ Mild ☐ Moderate ☐ Severe

Duration of the Problem
☐ Acute, First Episode ☐ Acute, Chronic ☐ Acute, Duration Unknown ☐ Chronic

Consumer's Report of Problem's Severity:

VICTIM OF ABUSE

Relevant Symptoms of the Problem
☐ Physical ☐ Sexual ☐ Emotional ☐ Neglect ☐ Domestic Violence ☐ Other

Intensity of the Problem
☐ Mild ☐ Moderate ☐ Severe

Duration of the Problem
☐ First Episode ☐ Current and Ongoing ☐ Past history, no current abuse

Consumer's Report of Problem's Severity:

OTHER

Specify Problem and Symptoms:

Intensity of the Problem
☐ Mild ☐ Moderate ☐ Severe

Duration of the Problem
☐ Acute, First Episode ☐ Acute, Chronic ☐ Acute, Duration Unknown ☐ Chronic

Consumer's Report of Problem's Severity:

Was a Suicide Risk Assessment Completed: ☐ **Yes** ☐ **No**

Have you had thoughts or plans of wanting to hurt or kill yourself? ☐ Yes ☐ No ☐ Unable to Assess
If No, skip to the History of "Risk to Self" section.

Crisis Plan: ☐ Accepted ☐ Declined

DELIBERATE SELF-HARM?

Explain:

DOES THE INDIVIDUAL HAVE SUICIDAL IDEATION?

☐ Denies Having Suicidal Thoughts
☐ Reports Infrequent Suicidal Thoughts
☐ Reports Suicidal Thoughts during the Past 24 hours

☐ Reports Frequent Suicidal Thoughts

DOES THE INDIVIDUAL REPORT HAVING A SUICIDE PLAN?

☐ Denies Having a Suicide Plan
☐ Has a Well Developed Suicide Plan
☐ Reports Having a Plan but it Does Not Appear Fully Developed

PRIMARY SUICIDE METHOD IN PLAN

☐ Overdose ☐ Shooting ☐ Hanging ☐ Cutting Self ☐ Jumping from a Height ☐ Other:_____

DOES THE INDIVIDUAL HAVE THE MEANS READILY AVAILABLE TO IMPLEMENT PLAN?

☐ Yes ☐ No ☐ Declines to Disclose if Suicidal Means is Readily Available
Comments:

Does the individual have someone that can restrict means?
☐ Yes ☐ No
Comments:

WHAT IS THE REPORTED LEVEL OF SUICIDAL INTENT?

☐ Denies Suicidal Intent for Clear Reasons
☐ Denies Suicidal Intent Though Reasons are Unclear
☐ Level of Suicidal Intent is Weak
☐ Strong Suicide Intent
Comments:

PRESENSE OF TERMINATION BEHAVIORS

☐ Note ☐ Will ☐ Giving Away Possessions ☐ Other: _____

SUICIDE RISK FACTORS

☐ Past Suicide Attempts
☐ Impulse Control Problems
☐ Rejection by Significant Other
☐ No Sense of Belonging
☐ Problems Related to Job/School
☐ History of Mental Illness
☐ High Risk Age Group
☐ Death of a Love One/Relative/Significant Other
☐ History of Substance Abuse
☐ Childhood Trauma
☐ Lack of Interest/Pleasure
☐ Suicide by Relatives/Significant Others
☐ Self-Hate
☐ Unable to See the Need for Treatment
☐ Lack of Support
☐ Financial Stressors
☐ Perceived Burdensomeness
☐ Chronic Pain/Illness/Disability
☐ Feelings of Hopelessness
☐ Access to Weapons/Methods

Additional Risk Factors for Children/Adolescents
☐ Issues around Sexual Identify ☐ Victim of Bullying ☐ Other: _____

Protective Factors
☐ Close to Natural Supports
☐ Identified Reason to Live
☐ Sense of Unfinished Business
☐ Emotion Regulation
☐ Sense of Belonging
☐ Relief about Not Completing Suicide
☐ Established Therapeutic Alliance
☐ Resilient Temperament
☐ Framework of Meaning – Cultural/Religious Beliefs
☐ People Relying on them for Ongoing Care
☐ Awareness of Other about Suicidal Thoughts
☐ Other: _____
Comments:

HISTORY OF RISK TO SELF

Has the individual ever attempted suicide? ☐ Has Attempted Suicide ☐ No Known Suicide Attempts
Comments:

SUICIDE ATTEMPTS

Recency:
☐ Within Past Week
☐ Within Past Month
☐ Within Past 90 Days
☐ Within Past Year

Consequence:
☐ Serious Injury Requiring Acute Medical Care
☐ Injury Requiring No or Minimal Medical Care
☐ No Injury

Lethality:
☐ Low Lethality
☐ Moderate Lethality
☐ High Lethality

☐ Over One Year Ago

LIKELIHOOD OF RESCUE

☐ Yes ☐ No
Comments:

SUICIDE ATTEMPTS

Recency:
☐ Within Past Week
☐ Within Past Month
☐ Within Past 90 Days
☐ Within Past Year
☐ Over One Year Ago

Consequence:
☐ Serious Injury Requiring Acute Medical Care
☐ Injury Requiring No or Minimal Medical Care
☐ No Injury

Lethality:
☐ Low Lethality
☐ Moderate Lethality
☐ High Lethality

LIKELIHOOD OF RESCUE

☐ Yes ☐ No
Comments:

REASONS, MEANING AND SOCIAL CONTEXT OF PAST ATTEMPT(S)

☐ Lack of Resources/Social Support
☐ Death of a Loved One
☐ Problems related to Job/School
☐ Feelings of Hopelessness
☐ Chronic Pain Illness/Disability
☐ Other: _____
☐ Rejection by Significant Other
☐ Suicide of Relative/Significant Other

Comments:

Have you had any thoughts of wanting to hurt or kill someone? ☐ Yes ☐ No ☐ Unable to Assess

Crisis Plan: ☐ Accepted ☐ Declined

Plan: ☐ Yes ☐ No **Intent:** ☐ Yes ☐ No

Means to carry out plan: ☐ Yes ☐ No **Lethality:** ☐ Yes ☐ No

Recent Threatening Behavior: ☐ Yes ☐ No

Potential Risk to Staff: ☐ Yes ☐ No *If yes, Risk to Staff Assessment (CMHCM-735) must be completed.*

ACCESS TO GUN/WEAPONS

If yes, explain:

PRIOR AGGRESSION

If yes, explain:

PPO

If yes, explain:

Can thought of harm be managed? ☐ Yes ☐ No (*If no, contact supervisor to discuss possible Duty to Warn and completed Consultation Note)*
Comments:

CAFFEINE USE

☐ None **Amount Currently Used:**

Comments:

TOBACCO USE

☐ None **Current Use:** ☐ Cigarettes ☐ Pipe ☐ Chewing Tobacco ☐ Cigars **Age First Used:**

Amount Currently Used:

Heaviest Amount Used: **When Heaviest Amount Used:**

Comments

OTHER SUBSTANCE USE

Does not have a history of Substance Use: ☐ Yes ☐ No ☐ Unable to Assess *(if yes, skip the rest of this section)*

OBSERVATION CHECKLIST

The following signs/symptoms may indicate a substance abuse problem in the individual being screened:

☐ None
☐ Needle track marks
☐ Skin abscesses, cigarette burns, or nicotine stains
☐ Tremors (shaking and twitching of hands and eyelids)
☐ Unclear speech; slurred, incoherent, or too rapid
☐ Unsteady gait; staggering or off balance
☐ Dilated (enlarged) or constricted (pinpoint) pupils
☐ Scratching
☐ Swollen hands or feet
☐ Smell of alcohol or marijuana on breath
☐ Drug paraphernalia such as pipes, papers, needles, or roach clips
☐ "Nodding out" dozing or falling asleep
☐ Agitation
☐ Inability to focus
☐ Burns on the inside of lips (from freebasing cocaine)

Comments:

SUBSTANCE USE CHART

Substance/Route	Substance Rank	Age at First/ Problem Use	Heaviest Amount Consumer & When/Current Consumption	Frequency of Use/Last Use (month/year)

WHO HAS/DOES THE CONSUMER USED WITH?

☐ Friends ☐ Parents ☐ Siblings ☐ Spouse/Significant Other
☐ Other family members ☐ Alone ☐ Anyone who happens to be around

Any relationship/legal/medical/employment difficulties related to substance use? ☐ Yes ☐ No

Describe Difficulties:

Other Substance Use Information:

SUBSTANCE USE TREATMENT

Has consumer ever received treatment for substance use disorder? ☐ Yes ☐ No

Treatment date(s) *(approximate)*:

Provider/Unit Name(s):

Treatment type: ☐ Inpatient ☐ Outpatient ☐ Intensive OP ☐ Day Tx ☐ Partial Hosp ☐ Resident Tx ☐ Detox ☐ Other:

Response to treatment(s):

Describe relapse history:

Treatment date(s) *(approximate)*:

Provider/Unit Name(s):

Treatment type: ☐ Inpatient ☐ Outpatient ☐ Intensive OP ☐ Day Tx ☐ Partial Hosp ☐ Resident Tx ☐ Detox ☐ Other:

Response to treatment(s):

Describe relapse history:

Treatment date(s) *(approximate)*:

Provider/Unit Name(s):

Treatment type: ☐ Inpatient ☐ Outpatient ☐ Intensive OP ☐ Day Tx ☐ Partial Hosp ☐ Resident Tx ☐ Detox ☐ Other:

Response to treatment(s):

Describe relapse history:

SUD TREATMENT EPISODES

Is Methadone/Suboxone planned: ☐ Used Currently ☐ Planned ☐ None Planned
Comments:

OTHER ADDICTIONS

Gambling	☐ Yes	☐ No	How Often? _____
Shopping	☐ Yes	☐ No	How Often? _____
Eating	☐ Yes	☐ No	How Often? _____
Sex	☐ Yes	☐ No	How Often? _____
Other: _____	☐ Yes	☐ No	How Often? _____

Medication-Assisted Opioid Therapy: ☐ Yes ☐ No ☐ Not Applicable

Attendance at Substance Use Self-Help Groups in Past 30 Days:

RESIDENTIAL LIVING ARRANGEMENT

☐ Homeless
☐ Specialized Residential Home – Adult Foster Care Facility certified to provide a specialized program
☐ Specialized Residential Home – Licensed Children's Therapeutic Group Home
☐ General Residential Home – Licensed foster care facility not certified to provide specialized program, any # of beds
☐ Private residence not owned by the PIHP, CMHSP or the contracted provider, alone, with spouse or non-relative(s)

☐ Foster Home/Foster Care
☐ Private residence owned by the PIHP, CMHSP or the contracted provider, alone, with spouse or non-relative(s)
☐ Crisis Residential
☐ Institutional Setting
☐ Jail/Correctional/Other Institutions under the justice system
☐ Private residence with relative(s) or individual(s) other than spouse upon whom the primary consumer is dependent

EDUCATION

☐ No schooling or less than one school grade
☐ Nursery school, pre-school or head start
☐ Kindergarten
☐ Self-contained Special Education Class
☐ Grade 1 ☐ Grade 2 ☐ Grade 3 ☐ Grade 4 ☐ Grade 5 ☐ Grade 6
☐ Grade 7 ☐ Grade 8 ☐ Grade 9 ☐ Grade 10 ☐ Grade 11 ☐ Grade 12 or GED
☐ 1 Year of College/University ☐ 2 Years of College/University or Associate Degree
☐ 3 Years of College/University ☐ 4 Years of College/University or Bachelor's Degree
☐ Graduate or professional school
☐ Vocational School
☐ Not collected at this co-located service
☐ Not collected for this crisis-only service

Education Level: _____ **Currently in Mainstream Special Education:** ☐ Yes ☐ No

School Attendance Status:

☐ Yes, client has attended school at any time in the past 3 months
☐ No, client has not attended school at any time in the past 3 months
☐ Not applicable (not school-age and not protected by MI Spec Ed Law)
☐ Not collected at this co-located service
☐ Not collected for this crisis-only service

SPOUSE OR SIGNIFICANT OTHER

Have you ever been married? ☐ Yes ☐ No **How many times?** _____

Are you currently involved in a significant relationship? ☐ Yes ☐ No

Length of current relationship:

CHILDREN

☐ **Consumer has no children**

Name	Date of Birth	Gender	Live With	Biological
		☐ Male ☐ Female		☐ Yes ☐ No
		☐ Male ☐ Female		☐ Yes ☐ No
		☐ Male ☐ Female		☐ Yes ☐ No
		☐ Male ☐ Female		☐ Yes ☐ No
		☐ Male ☐ Female		☐ Yes ☐ No
		☐ Male ☐ Female		☐ Yes ☐ No
		☐ Male ☐ Female		☐ Yes ☐ No

HOUSEHOLD MEMBERS

Name	Gender	Relationship
	☐ Male ☐ Female	
	☐ Male ☐ Female	
	☐ Male ☐ Female	
	☐ Male ☐ Female	
	☐ Male ☐ Female	
	☐ Male ☐ Female	

HOW WOULD YOU DESCRIBE YOUR (PAST/PRESENT) RELATIONSHIP WITH YOUR…

	Describe
Spouse/ Significant Other	

Children	
Father	
Mother	
Siblings	
Friends	
Other	

DO YOU HAVE DIFFICULTY CARRYING OUT BASIC AND COMPLEX INTERACTIONS WITH FRIENDS, RELATIVES, FAMILY MEMBERS, OR STRANGERS?

☐ Yes ☐ No ☐ Unable to Assess

Comments:

ARE YOUR CHILDREN AT RISK FOR REMOVAL FROM CHILD PROTECTIVE SERVICES?

☐ Yes ☐ No ☐ Not Applicable

Comments:

DOES FAITH OR RELIGION PLAY A PART IN YOUR LIFE?

☐ Yes ☐ No

Explain:

What cultural/ethnic beliefs/traditions play a part in your life?

OTHER AGENCIES/PROVIDERS INVOLVED

☐ Protective Services
☐ School/RESD
☐ MRS
☐ Support Group
☐ Health Care Provider
☐ Other DHHS Services
☐ Staffing Agency
☐ Activity Program
☐ Court System
☐ Other: _____
☐ SSA
☐ Employer
☐ Church
☐ Wraparound

NATURAL SUPPORTS

Name	Assistance/Support Provided

If no natural supports, explain:

HAS THE CONSUMER EXPERIENCED ANY SIGNIFICANT LOSSES OR DEATHS?

Has the consumer experienced any significant losses or deaths? ☐ Yes ☐ No

Describe:

Has the consumer ever experienced a traumatic event? ☐ Yes ☐ No ☐ Unable to Assess

What was the nature of the trauma?

How did the traumatic event change them or the way others view them?

Other significant information about the consumer's history? ☐ Yes ☐ No

If yes, describe:

EARLY CHILDHOOD DEVELOPMENT (for children or Infant Mental Health cases)

Were there any complications at the consumer's birth or with the pregnancy? ☐ Yes ☐ No ☐ Unknown
Comments:

Did the consumer have any health issues as a newborn or child? ☐ Yes ☐ No
If yes, describe:

Was there any prenatal exposure to alcohol, tobacco, or other drugs/toxins? ☐ Yes ☐ No
If yes, describe:

Were/are there any parent-child attachment issues? ☐ Yes ☐ No
If yes, describe:

Were/are there any parent-child interaction issues? ☐ Yes ☐ No
If yes, describe:

Developmental Milestones: ☐ Normal ☐ Delayed
If delayed, describe:

Are there any motor and/or sensory motor issues? ☐ Yes ☐ No
If yes, describe:

Does the consumer have any temperament/emotional regulation issues? ☐ Yes ☐ No
If yes, describe:

Does the consumer have any eating or sleeping issues? ☐ Yes ☐ No
If yes, describe:

Does the consumer have any communication issues? ☐ Yes ☐ No
If yes, describe:

Does the consumer have any cognition issues? ☐ Yes ☐ No
If yes, describe:

Did the consumer ever live outside their parents' home for an extended period of time? ☐ Yes ☐ No ☐ Unknown
Comments:

Other significant information about the consumer's childhood/history: ☐ Yes ☐ No
If yes, describe:

LEGAL/FINANCIAL

Legal Guardian: ☐ No guardianship in place ☐ Parent(s) of Minor Child ☐ Court Appointed Guardian

PARENT(S) OF MINOR CHILD AUTHORIZED TO CONSENT TO TREATMENT

Mother : ☐ Biological Mother ☐ Adoptive Mother

First Name: **Last Name:**

□ Check if address is same as consumer- provide address if not the same
Mailing Address:

City: **State:** **Zip:**

Phone Number #1: **Phone Number #2:**

Father: ☐ Biological Father ☐ Adoptive Father

First Name: **Last Name:**

□ Check if address is same as consumer- provide address if not the same
Mailing Address:

City: **State:** **Zip:**

Phone Number #1: **Phone Number #2:**

Divorce Information: If parents are divorced, indicate Child Custody Status

Legal Custody:	☐ Sole-Mother	☐ Sole-Father	☐ Joint	☐ Unknown
Physical Custody:	☐ Sole-Mother	☐ Sole-Father	☐ Joint	☐ Unknown

Copy of Divorce Papers Scanned into CIGMMO? ☐ Yes ☐ No ☐ See Hybrid (Paper) Record

Additional Information Related to Parent Consent:

COURT APPOINTED GUARDIAN

First Name: **Last Name:**

□ Check if address is same as consumer- provide address if not the same
Mailing Address:

City: **State:** **Zip:**

Phone Number #1: **Phone Number #2:**

Type of Guardianship:

☐ Plenary of Person ☐ Plenary of Estate ☐ Plenary of Person & Estate ☐ Guardian Ad Litem
☐ DHS Ward – Permanent ☐ DHS Ward – Temporary ☐ Partial (*describe powers*): _____

Guardian's Relationship to Consumer:

☐ Mother ☐ Father ☐ Child ☐ Spouse ☐ Sibling ☐ Public Guardian
☐ Unrelated ☐ Other (*describe*): _____

Date of Court Order: **Expiration Date:**

Copy of Guardianship Papers Scanned into CIGMMO? ☐ Yes ☐ No ☐ See Hybrid (Paper) Record

CO/STANDBY GUARDIAN INFORMATION

☐ **Co-Guardian** ☐ **Standby Guardian**

First Name: **Last Name:**

□ **Check if address is same as consumer- provide address if not the same**

Mailing Address:

City: **State:** **Zip:**

Phone Number #1: **Phone Number #2:**

Type of Guardianship:

☐ Plenary of Person ☐ Plenary of Estate ☐ Plenary of Person & Estate ☐ Guardian Ad Litem
☐ DHS Ward – Permanent ☐ DHS Ward – Temporary ☐ Partial (*describe powers*): _____

Guardian's Relationship to Consumer:

☐ Mother ☐ Father ☐ Child ☐ Spouse ☐ Sibling ☐ Public Guardian
☐ Unrelated ☐ Other (*describe*): _____

Date of Court Order: **Expiration Date:**

Copy of Guardianship Papers Scanned into CIGMMO? ☐ Yes ☐ No ☐ See Hybrid (Paper) Record

ADVANCE DIRECTIVES

Advance Directive Acknowledgement —***DO NOT*** *complete if consumer has a guardian or is a minor*

☐ Completed and scanned into CIGMMO ☐ Has Guardian

Does the Consumer have an Advance Directive and/or Durable Power of Attorney: ☐ Yes ☐ No

If yes, what type of Advance Director/Durable Power of Attorney: ☐ Medical ☐ Financial ☐ Mental Health

Location where Directives are kept:

Active DPOA: ☐ Yes ☐ No

Additional Guardianship Information:

PERSON TO NOTIFY IN CASE OF DEATH

Name: **Phone Number:**

PAYEESHIP

☐ **No Payee in place** ☐ **Minor Child** ☐ **Has Payee**

REF PAYEE

First Name: **Last Name:**

Primary Phone: **Alternate Phone:**

Address:

City: **State:** **ZIP:**

Relationship:

☐ Mother ☐ Father ☐ Child ☐ Spouse ☐ Sibling
☐ Unrelated ☐ Other (*describe*): _____

□ **Check if address is same as consumer**

□ **Do Not Contact**

SOURCES OF INCOME

☐ Employment ☐ Unemployment Compensation ☐ Worker's Compensation ☐ Social Security Benefits
☐ Tribal Income ☐ Veteran's Benefits ☐ Retirement Pension ☐ Alimony
☐ Child Support ☐ Adoption Subsidy ☐ Other: _____ ☐ Other: _____

EMPLOYMENT/FINANCIAL

Employment Status:

☐ Full-time competitive, integrated employee
☐ Part-time competitive, integrated employee
☐ Not in competitive, integrated labor force
☐ Unemployed
☐ N/A – Individual is under 16 years of age

Detailed "Not in competitive, integrated labor force:"

☐ Homemaker
☐ Student
☐ Retired
☐ Individual's current disability symptoms prevents him/her from competitively or non-competitively working/seeking employment
☐ Receiving services from institutional facility
☐ Participates in sheltered workshop
☐ Discouraged worker
☐ Unpaid volunteering, community service, etc.
☐ Micro-enterprise
☐ In enclaves/mobile crews/agency-funded transitional employment
☐ Participates in facility-based activity program where an array of specialty supports and services are provided
☐ Not applicable
☐ N/A – individual is under 16 years of age

Total Annual Income: $_____
☐ Not collected at this co-located service
☐ Not collected for this crisis-only service

Number of Dependents: _____
☐ Not collected at this co-located service
☐ Not collected for this crisis-only service

Enrolled in SDA, SSI or SSDI: ☐ Yes ☐ No

Work/Task Hours (total in the past 2 weeks): _____
☐ Not collected for this crisis-only service

Earnings Per Hour (in the past 2 weeks): _____
☐ Not collected for this crisis-only service

Employer:

Employment History: ☐ Regularly Employed ☐ Sporadic Employment ☐ Infrequent Employment ☐ Never Employed

Do you require support to pursue employment goals? ☐ Yes ☐ No

(Competitive employment options must be explored first before other types of work options [referrals to open jobs, education/training, MI Works, MRS, Individualized Placement Supports, Supported Employment, Skills Building, etc.].)

Comments:

Additional Employment Information:

CORRECTIONS/LEGAL STATUS

Corrections Related Status:

☐ In prison
☐ In jail
☐ Paroled from a state or federal correctional facility
☐ Probation
☐ Tether
☐ Juvenile detention center
☐ Pre-trial (Adult) or Preliminary Hearing (Youth)
☐ Pre-sentencing (Adult) or Pre-disposition (Youth)
☐ Post-booking diversion

☐ Booking diversion
☐ No under jurisdiction of corrections of law enforcement program
☐ Not collected at this co-located services
☐ Not collected for this crisis-only service

Arrests in Past 30 Days:

Notes on Relevant Legal History (e.g., history of arrests):

Voter Registration Information:

☐ Not eligible to register/vote
☐ Not registered; does not want to register
☐ Not registered; would like assistance in registering
☐ Registered to vote

TRANSPORTATION

☐ Walking ☐ Bicycle ☐ Public Transportation ☐ Transported by Others ☐ Drives Vehicle

Recreation:

CLOTHING NEEDS

☐ Yes ☐ None

Comments:

SAFETY

(For more information, refer to the "Consumer Health and Safety/Risk Areas" list on the intranet Community Resources.)

COMMUNITY SAFETY

☐ **Has no risks/issues in this area**
☐ **Risks/issues:**

HEALTH/MEDICAL SAFETY

☐ **Has no risks/issues in this area**
☐ **Risks/issues:**

SEXUALITY/RELATIONSHIPS SAFETY

☐ **Has no risks/issues in this area**
☐ **Risks/issues:**

ABUSE ISSUES

☐ **Has no risks/issues in this area**
☐ **Risks/issues:**

FINANCIAL EXPLOITATION

☐ **Has no risks/issues in this area**
☐ **Risks/issues:**

BEHAVIORAL SAFETY

☐ **Has no risks/issues in this area**
☐ **Risks/issues:**

HOME ENVIRONMENT AND FIRE SAFETY

☐ **Has no risks/issues in this area**
☐ **Risks/issues:**

POLICE INVOLVEMENT

☐ **Has no risks/issues in this area**
☐ **Risks/issues:**

OTHER SAFETY AREAS

☐ **Has no risks/issues in this area**
☐ **Risks/issues:**

RESPITE SERVICES

☐ **Explained and Offered (Medicaid Only)** ☐ **Not Appropriate**
Comments:

LIFE ACTIVITIES

Are you able to manage a household which includes scheduling activities, managing financial affairs, housekeeping tasks, arranging transportation, and preparing meals? ☐ Yes ☐ No ☐ Infant/Toddler (n/a) ☐ Unable to Assess

DAILY LIVING SKILLS
(Identify The Support Needed In The Following Areas As They Relate To Your Current Living Situation)
1=Independent, 2=Needs Verbal Prompting, 3=Needs Physical Assistance, 4=Not Age Appropriate

	1	2	3	4	
Eating/Feeding	☐	☐	☐	☐	
Toileting	☐	☐	☐	☐	
Bathing	☐	☐	☐	☐	
Dressing	☐	☐	☐	☐	
Grooming	☐	☐	☐	☐	
Transferring	☐	☐	☐	☐	
Ambulation/Mobility	☐	☐	☐	☐	
Medication Administration	☐	☐	☐	☐	
Laundry	☐	☐	☐	☐	
Cooking	☐	☐	☐	☐	
Daily Living Transportation	☐	☐	☐	☐	
Housecleaning	☐	☐	☐	☐	
Paying Bills	☐	☐	☐	☐	
Leisure/Recreation	☐	☐	☐	☐	
Community Access	☐	☐	☐	☐	

PRIMARY CARE PHYSICIAN

PHCP Name:

Practice Name:

Address:

City: **State:** **Zip:**

Phone Number #1: **Phone Number #2:**

Date last seen by a health care provider:

If a consumer does not have a Primary Health Care Provider (PHCP), specify why:

☐ Consumer cannot find a doctor
☐ Consumer does not know PHCP's name

☐ Consumer does not wish to discuss
☐ Consumer prefers to use ER
☐ Consumer prefers to use Urgent Care/Ready Care facility

VITAL SIGNS READING INFORMATION						
Data Collected						
BP Sitting						
BP Standing						
Pulse						
Respiration						
Temperature						
Height						
Weight						
BMI						
Waist Circumference						
Smoking						
Pregnant						
BAC (Blood Alcohol Content)						

COLLECTION INFORMATION

Collection Date: **Collection Time:** **Collected By:**

GENERAL INFORMATION

Height: _____ft _____in ☐ Declined ☐ No Information Collected

Weight: _____lbs _____oz ☐ Declined ☐ No Information Collected

Waist Circumference: _____in ☐ Declined ☐ No Information Collected

BMI: _____

Pregnant: ☐ Yes ☐ No ☐ N/A

TOBACCO USE

☐ **Declined** ☐ **No Information Collected**

Smoking Status:

☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker
☐ Heavy smoker ☐ Light smoker ☐ Never smoker
☐ Smoker, current status unknown ☐ Unknown if ever smoked ☐

Effective:

Other Tobacco Use:

☐ User, current status unknown ☐ Current every day ☐ Former other tobacco user
☐ Never tobacco user ☐ Current some day ☐ Unknown if ever used tobacco

Provided consumer with advice to quit smoking or tobacco use, or recommended or discussed smoking or tobacco use cessation, medications, methods, or strategies: ☐ Yes ☐ No

TEMPERATURE

☐ **Declined** ☐ **No Information Collected**

Value: _____ F

PULSE

☐ **Declined** ☐ **No Information Collected**

Value: _____ bpm

RESPIRATION

☐ **Declined** ☐ **No Information Collected**

Value: _____ breaths per minutes

BLOOD PRESSURE

☐ **Declined** ☐ **No Information Collected**

Sitting Systolic: _____ mmHg/Diastolic: _____mmHg

Standing Systolic: _____ mmHg/Diastolic: _____mmHg

BLOOD GLUCOSE RESULTS

☐ **Declined** ☐ **No Information Collected**

Comments:

Reaction: ☐ Cooperative ☐ Declined ☐ Resisted (Uncooperative)

Comments:

Date Reviewed:

HEARING

Ability to hear (with hearing appliance normally used)

☐ Adequate; no difficulty in normal conversation, social interaction, listening to TV
☐ Minimal Difficulty; difficulty in some environments (e.g., when person speaks softly or is more than 6 feet away)
☐ Moderate Difficulty; problem hearing normal conversation, requires quiet setting to hear well
☐ Severe Difficulty; difficultly in all situations (e.g., speaker has to talk loudly or speak very slowly, or persons reports that all speech is mumbled)
☐ No hearing

Hearing Aid Used: ☐ Yes ☐ No

VISION

Ability to see in adequate light (with glasses or with other visual appliance normally used)

☐ Adequate; sees fine detail, including regular print in newspapers/books or small items in pictures
☐ Minimal Difficulty; sees large print but not regular print in newspapers/books or cannot identify large objects in pictures
☐ Moderate Difficulty; limited vision, not able to see newspaper headlines or small items in pictures but can identify objects in his/her environment
☐ Severe Difficulty; object identification in question but the person's eyes appear to follow objects, or the person sees only light, colors, shapes
☐ No Vision; eyes to not appear to follow objects; absence of sight

Visual Appliance: ☐ Yes ☐ No

HEALTH CONDITIONS

Indicate whether or not the individual had the presence of each of the following health conditions, as reported by the individual, a health care professional or family member, in the past 12 months.

Pneumonia (2 or more times) – including Aspiration Pneumonia

☐ Never present
☐ History of condition but not treated for the condition within the past 12 months
☐ Treated for the condition within the past 12 months
☐ Information unavailable

Asthma

☐ Never present
☐ History of condition but not treated for the condition within the past 12 months
☐ Treated for the condition within the past 12 months
☐ Information unavailable

Upper Respiratory Infections (3 or more times within past 12 months)

☐ Never present
☐ History of condition but not treated for the condition within the past 12 months
☐ Treated for the condition within the past 12 months
☐ Information unavailable

Gastroesophageal Reflux or GERD

☐ Never present
☐ History of condition but not treated for the condition within the past 12 months
☐ Treated for the condition within the past 12 months
☐ Information unavailable

Chronic Bowel Impactions
☐ Never present
☐ History of condition but not treated for the condition within the past 12 months
☐ Treated for the condition within the past 12 months
☐ Information unavailable

Seizure Disorder or Epilepsy
☐ Never present
☐ History of condition but not treated for the condition within the past 12 months
☐ Treated for the condition within the past 12 months and seizure free
☐ Treatment for the condition within the past 12 months but still experience occasional seizures (less than one per month)
☐ Treated for the condition within the past 12 months but still experience frequent seizures
☐ Information unavailable

Progressive Neurological Disease, include Alzheimer's and Parkinson's Disease
☐ Not present
☐ Treated for the condition within the past 12 months
☐ Information unavailable

Diabetes
☐ Never present
☐ History of condition but not treated for the condition within the past 12 months
☐ Treated for the condition within the past 12 months
☐ Information unavailable

Hypertension
☐ Never present
☐ History of condition but not treated for the condition within the past 12 months
☐ Treated for condition within the past 12 months and blood pressure is stable
☐ Treated for condition within the past 12months but blood pressure remains high or unstable
☐ Information unavailable

Obesity
☐ Not present
☐ Medical diagnosis of obesity present or Body Mass Index (BMI) >30

HEALTH CONCERNS

Do you have any current health concerns such as (but not limited to) obesity, diabetes, hypertension, heart disease, or Chronic Obstructive Pulmonary Disease (COPD)? ☐ Yes ☐ No ☐ Unable to Assess

Food/Nutritional Concerns: ☐ None ☐ Yes (if yes, populate into "Concerns" table)

Chronic Pain: ☐ None ☐ Yes (if yes, populate into "Concerns" table)

CONCERNS			
Condition	Current and/or History	Being Treated?	Coordination Requested?
	☐ Current ☐ History	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Current ☐ History	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Current ☐ History	☐ Yes ☐ No	☐ Yes ☐ No

Comments:

PRESCRIBED MEDICATIONS				
Medication	**Dates**	**Prescribed By**	**Qty Prescribed**	**Number**

				of Refills
	Order Date: Days Remaining:			
Instructions:				
	Order Date: Days Remaining:			
Instructions:				
	Order Date: Days Remaining:			
Instructions:				
	Order Date: Days Remaining:			
Instructions:				
	Order Date: Days Remaining:			
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	Order Date: Days Remaining:			
Instructions:				
	Order Date: Days Remaining:			
Instructions:				

OTHER MEDICATIONS			
Medication:	Dosage:		Qty:
Medication Type: ☐ Non-psychotropic ☐ Other ☐ Psychotropic	Start Date:		End Date:
Instructions:	Reason:		
Physician Name:	Prescribing Physician Type:		
	☐ Clinical Nurse Specialist ☐ Primary Care Physician ☐ Psychiatric Inpatient/PHP/CRU ☐ Psychiatrist	☐ Hospital/ER ☐ Other ☐ Qualified Health Professional	
Medication:	Dosage:		Qty:
Medication Type: ☐ Non-psychotropic ☐ Other ☐ Psychotropic	Start Date:		End Date:
Instructions:	Reason:		
Physician Name:	Prescribing Physician Type:		
	☐ Clinical Nurse Specialist ☐ Primary Care Physician ☐ Psychiatric Inpatient/PHP/CRU ☐ Psychiatrist	☐ Hospital/ER ☐ Other ☐ Qualified Health Professional	
Medication:	Dosage:		Qty:
Medication Type: ☐ Non-psychotropic ☐ Other ☐ Psychotropic	Start Date:		End Date:
Instructions:	Reason:		
Physician Name:	Prescribing Physician Type:		
	☐ Clinical Nurse Specialist ☐ Primary Care Physician ☐ Psychiatric Inpatient/PHP/CRU ☐ Psychiatrist	☐ Hospital/ER ☐ Other ☐ Qualified Health Professional	
Medication:	Dosage:		Qty:
Medication Type: ☐ Non-psychotropic ☐ Other ☐ Psychotropic	Start Date:		End Date:
Instructions:	Reason:		
Physician Name:	Prescribing Physician Type:		

	☐ Clinical Nurse Specialist ☐ Primary Care Physician ☐ Psychiatric Inpatient/PHP/CRU ☐ Psychiatrist	☐ Hospital/ER ☐ Other ☐ Qualified Health Professional

Are you taking these medications as directed? ☐ Yes ☐ No ☐ N/A
If no, explain:

Do you feel your medications are helpful? ☐ Yes ☐ No ☐ N/A
If no, explain:

Medication Administration Needs

☐ Administers own medications independently ☐ Administers own medications with supervision
☐ Medications are administered ☐ No Medications

ADVERSE REACTIONS		
Drug/Allergen:	**Reported By:** ☐ Consumer ☐ Hospital ☐ Doctor ☐ Nurse ☐ Family ☐ Other	**Severity** ☐ Not Assessed ☐ Mild ☐ Severe ☐ Life-Threatening ☐ **This is an Allergy**
Reactions:		
Notes:		**Start:**
Drug/Allergen:	**Reported By:** ☐ Consumer ☐ Hospital ☐ Doctor ☐ Nurse ☐ Family ☐ Other	**Severity** ☐ Not Assessed ☐ Mild ☐ Severe ☐ Life-Threatening ☐ **This is an Allergy**
Reactions:		
Notes:		**Start:**

☐ **Health Screen (CMHCM-822)**

MENTAL HEALTH HISTORY

Has consumer ever received services from CMHCM? ☐ Yes ☐ No
If yes, describe:

Has consumer ever received any other outpatient mental health services? ☐ Yes ☐ No
If yes, describe:

Has consumer ever taken medication for a mental health condition? ☐ Yes ☐ No
If yes, describe:

Does the consumer have a Residential Placement history? ☐ Yes ☐ No
If yes, describe:

Has consumer ever been hospitalized for mental health reasons? ☐ Yes ☐ No

If "No" is chosen, section ends. If "Yes," add inpatient episodes

MENTAL HEALTH TREATMENT EPISODES

Reason for Mental Health Inpatient Treatment:

Hospital/Facility Name:

Treatment Date(s*) (approximate)*:

Response to Treatment(s):

Describe Relapse History:

Reason for Mental Health Inpatient Treatment:

Hospital/Facility Name:

Treatment Date(s*) (approximate)*:

Response to Treatment(s):

Describe Relapse History:

Reason for Mental Health Inpatient Treatment:

Hospital/Facility Name:

Treatment Date(s*) (approximate)*:

Response to Treatment(s):

Describe Relapse History:

APPEARANCE

☐ **Appropriate** ☐ **Disheveled** ☐ **Poor Hygiene** ☐ **Bizarre** ☐ **Inappropriate as to Weather** ☐ **Other**

Comments:

ORIENTATION

☐ **Oriented** ☐ **Person Impaired** ☐ **Place Impaired** ☐ **Time Impaired**

Comments:

INTELLECTUAL FUNCTIONING

☐ **Above Average** ☐ **Average** ☐ **Below Average** ☐ **Memory Impaired**

Comments:

THOUGHT PROCESS

☐ **Within Normal Limits** ☐ **Slowed** ☐ **Perseveration** ☐ **Flight of Ideas** ☐ **Loose Associations**
☐ **Tangential** ☐ **Ideas of Reference** ☐ **Circumstantial** ☐ **Impaired Concentration** ☐ **Other**
Comments:

THOUGHT CONTENT

☐ **Relevant** ☐ **Delusions** - Describe Delusions:
☐ **Obsessions** ☐ **Grandiose** ☐ **Other**
Comments:

HALLUCINATIONS

☐ **None** ☐ **Auditory** ☐ **Gustatory** ☐ **Visual** ☐ **Somatic** ☐ **Tactile** ☐ **Olfactory** ☐ **Command**
Comments:

BEHAVIOR

☐ **Appropriate** ☐ **Restless** ☐ **Agitated** ☐ **Bizarre** ☐ **Tearful** ☐ **Lethargic** ☐ **Pressured Speech**
☐ **Slowed Speech** ☐ **Atypical Eye Contact** ☐ **Other**
Comments:

AFFECT

☐ **Appropriate** ☐ **Depressed** ☐ **Hopeless** ☐ **Flat** ☐ **Fearful** ☐ **Labile** ☐ **Anxious** ☐ **Angry**
☐ **Elated** ☐ **Other**
Comments:

JUDGMENT/REASON

☐ **Within Normal Limits** ☐ **Impaired** ☐ **Other**
Comments:

ENERGY

☐ **Within Normal Limits** ☐ **Increased** ☐ **Decreased**
Comments:

WEIGHT

☐ **Within Normal Limits** ☐ **Loss 1-10- Pounds** ☐ **Loss 10+ Pounds** ☐ **Gain 1-10 Pounds** ☐ **Gain 10+ Pounds**
Comments:

APPETITE

☐ **Within Normal Limits** ☐ **Decreased** ☐ **Increased**
Comments:

SLEEP

☐ **No Sleep Issues** ☐ **Difficulty Falling Asleep** ☐ **Difficulty Staying Asleep**
☐ **Falls Asleep During Normal Wake Times** ☐ **Awakens Poorly Rested** ☐ **Wets Bed**

☐ **Sleepwalks** ☐ **Experiences Nightmares**

Comments:

DD PROXY MEASURES

☐ **DD Proxy Measures are not applicable**

Date: _____

For purposed of these data elements, when the term "support" is used, it means support from a paid or unpaid person or technological support needed to enable the individual to achieve his/her desired future. The kinds of support a person might need are:

- "Limited" means the person can complete approximately 75% or more of the activity without support and the caregiver provides support for approximately 25% or less of the activity.
- "Moderate" means the person can complete approximately 50% of the activity and the caregiver supports the other 50%.
- "Extensive" means the person can complete approximately 25% of the activity and relies on the caregiver to support 75% of the activity.
- "Total" means the person is unable to complete the activity and the caregiver is providing 100% of support.

PREDOMINANT COMMUNICATION STYLE

Indicate from the list below how the individual communicates most of the time:

☐ **English language spoken by the individual**
☐ **Assistive technology used** – Includes computer, other electronic devices or symbols such as Bliss Board or other "low tech" communication devices.
☐ **Interpreter used** – This includes a foreign language or American Sign Language (ASL) interpreter, or someone who know the individual well enough to interpret speech or behavior.
☐ **Alternative language used** – This includes a foreign language or sign language without an interpreter.
☐ **Non-language forms of communication used** – Gestures, vocalizations or behaviors.
☐ **No ability to communicate**.

ABILITY TO MAKE SELF UNDERSTOOD

Ability to communicate needs, both verbal and non-verbal, to family, friends or staff.
For reporting children 5 or younger—report "Rarely or Never Understood"" when understanding is limited to interpretation of every person-specific sounds or body language and/or a child age 5 or younger is not yet using verbal or non-verbal communication.

☐ **Always Understood** – Expresses self without difficulty.
☐ **Usually Understood** – Difficulty communication BUT if given time and/or familiarity can be understood, little or no prompting required.
☐ **Often Understood** – Difficulty communication AND prompting usually required.
☐ **Sometimes Understood** – Ability is limited to making concrete requests or understood only a very limited number of people.
☐ **Rarely or Never Understood** – Understanding is limited to interpretation of very person-specific sounds or body language.

SUPPORT WITH MOBILITY

For reporting children 5 or younger – report "Moderate Support" if a child scoots, crawls, creeps on hands and knees, or walks a few steps independently or when holding hands with caregiver. Report "Extensive Support" if a child is primarily carried or transported by a caregiver.

☐ **Independent** – Able to walk (with or without an assistive device) or propel wheelchair and move about.
☐ **Guidance/Limited Support** – Able to walk (with or without an assistive device) or propel wheelchair and move about with guidance, prompting, reminders, stand by support, or with limited physical support.
☐ **Moderate Support** – May walk very short distances with support but uses wheelchair as primary method of mobility, needs moderate physical support to transfer, move the chair, and/or shift positions in chair or bed.
☐ **Extensive Support** – Uses wheelchair exclusively, needs extensive support to transfer, move the wheelchair, and/or shift positions in chair or bed.
☐ **Total Support** – Uses wheelchair with total support to transfer, move the wheelchair, and/or shift positions or may be unable to sit in a wheelchair, needs total support to shift positions throughout the day.

MODE OF NUTRITIONAL INTAKE

For reporting children 5 or younger – report "Modified Independent" if child is bottle fed or eats foods specially prepared by the caregiver to accommodate current developmental needs.

☐ **Normal –** Swallows all types of foods.
☐ **Modified Independent** – e.g., liquid is sipped, takes limited solid food, need for modification may be unknown.
☐ **Requires diet modification to swallow solid food** – e.g., mechanical diet (e.g., puree, minced) or only able to ingest specific foods.
☐ **Requires modification to swallow liquids** – e.g., thickened liquids
☐ **Can swallow only pureed solids AND thickened liquids.**
☐ **Combined oral and parenteral or tube feeding.**
☐ **Enteral feeding into stomach** – e.g., G-tube or PEG tube
☐ **Enteral feeding into jejunum** – e.g., J-tube or PEG-J tube
☐ **Parenteral feeding only** – includes all types of parenteral feedings, such as total parenteral nutrition (TPN).

SUPPORT WITH PERSONAL CARE

Ability to complete personal care, including bathing, toileting, hygiene, dressing and grooming tasks, including the amount of help required by another person to assist. This measure is an overall estimation of the person's ability in the category of personal care. If the person requires guidance only for all tasks but bathing, where he or she needs extensive support, score "Guidance/Limited Support" to reflect the overall average ability. The person may or may not use assistive devices like shower or commode chairs, long-handled brushes, etc. Note: Assistance with medication should NOT be included.

☐ **Independent** – Able to complete all personal care tasks without physical support.
☐ **Guidance/Limited Support** – Able to perform personal care tasks with guidance, prompting, reminding or with limited physical support for less than 25% of the activity.
☐ **Moderate Physical Support** – Able to perform personal care tasks with moderate support of another person.
☐ **Extensive Support** – Able to perform personal care tasks with extensive support of another person.
☐ **Total Support** – Requires full support of another person to complete personal care tasks (unable to participate in tasks).

RELATIONSHIPS

Indicate whether or not the individual has "natural supports" defined as persons outside of the mental health system involved in his/her life who provide emotional support or companionship.

☐ **Extensive Involvement** – such as daily emotional support/companionship
☐ **Moderate Involvement** – such as several times a month up to several times a week
☐ **Limited Involvement** – such as intermittent or up to once a month
☐ **Involved in Planning or Decision-Making** – but does not provide emotional support/companionship
☐ **No Involvement**

STATUS OF FAMILY/FRIEND SUPPORT SYSTEM

Indicate whether current (unpaid) family/friend caregiver status is at risk in the next 12 months; including instances of caregiver disability/illness, aging, and/or relocation. "At Risk" means caregiver will likely be unable to continue providing the current level or help, or will cease providing help altogether but no plan for replacing the caregiver's help is in place.

☐ **Caregiver status is not at risk**
☐ **Caregiver is likely to reduce current level of help provided**
☐ **Caregiver is likely to cease providing help altogether**
☐ **Family/friends do no currently provide care**
☐ **Information unavailable**

SUPPORT FOR ACCOMMODATING CHALLENGING BEHAVIORS

Indicate the level of support the individual needs, if any, to accommodate challenging behaviors. "Challenging Behaviors" include those that are self-injurious, or place others at risk of harm. (Support includes direct line of sight supervision.)

☐ **No challenging behaviors or no support needed**
☐ **Limited Support, such as support up to once a month**
☐ **Moderate Support, such as support once a week**
☐ **Extensive Support, such as support several times a week**
☐ **Total Support – Intermittent, such as support once or twice a day**
☐ **Total Support – Continuous, such as full-time support**

PRESENCE OF A BEHAVIOR PLAN

Indicate the presence of a behavior plan during the past 12 months.

☐ **No Behavior Plan**

☐ **Positive Behavior Support Plan or Behavior Treatment Plan without restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee.**
☐ **Behavior Treatment Plan with restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee.**

USE OF PSYCHOTROPIC MEDICATIONS

Fill in the number of anti-psychotic and other psychotropic mediations the individual is prescribed. See the codebook for further definition of "anti-psychotic" and "other psychotropic" and a list of the most common medications.

Number of Antipsychotic Medications ☐

Psychiatric medications primarily used to manage psychosis

Number of Other Psychotropic Medications ☐

Includes anti-convulsant, anti-anxiety, anti-depressant, ADHD, Bi-Polar, OCD, and other psychiatric medications prescribed

MAJOR MENTAL ILLNESS (MMI) DIAGNOSIS

This measure identified major mental illnesses characterized by psychotic symptoms or severe affective symptoms. Indicate whether or not the individual has one or more of the following major mental illness diagnoses: Schizophrenia, Schizophreniform Disorder, or Schizoaffective Disorder (ICD code 295.xx); Delusional Disorder (ICD code 297.1); Psychotic Disorder NOS (ICD code 298.9); Psychotic Disorder due to a general medical condition (ICD codes 293.81 or 293.82); Dementia with delusions (ICD code 294.42); Bipolar I Disorder (ICD codes 296.9x, 296.4x, 296.5x, 296.6x, or 296.7x); or Major Depressive Disorder (ICD codes 296.2x and 296.3x). The ICD code must match the codes provided above. Note: Any digit or no digit at all, may be substituted for each "x" in the codes.

☐ **One or more MMI diagnosis present**
☐ **No MMI diagnosis present**

SATISFACTION WITH SERVICES RENDERED

☐ **Satisfaction with services, supports and/or treatment not discussed**
☐ **Satisfaction with services, supports and/or treatment discussed; consumer or representative satisfied**
☐ **Satisfaction with services, supports and/or treatment discussed; consumer or representative not satisfied**

Explanation (use direct quotes from consumer, when possible):

DIAGNOSIS

A physician will need to co-sign this document if updates are made to Axis I or II diagnoses, or the Diagnostic Summary.

Sequence	ICD-10	Description	Status Date	Status
☐ *Primary* ☐ *Secondary* ☐ *Tertiary* ☐ *Quaternary* ☐ *Quinary*		 **Specifier:**		☐ *Active* ☐ *Inactive* ☐ *In Remission* ☐ *Resolved* ☐ *Ruled Out* ☐ *Rule Out*
Sequence	**ICD-10**	**Description**	**Status Date**	**Status**
☐ *Primary* ☐ *Secondary* ☐ *Tertiary* ☐ *Quaternary* ☐ *Quinary*		 **Specifier:**		☐ *Active* ☐ *Inactive* ☐ *In Remission* ☐ *Resolved* ☐ *Ruled Out* ☐ *Rule Out*
Sequence	**ICD-10**	**Description**	**Status Date**	**Status**
☐ *Primary* ☐ *Secondary* ☐ *Tertiary* ☐ *Quaternary* ☐ *Quinary*		 **Specifier:**		☐ *Active* ☐ *Inactive* ☐ *In Remission* ☐ *Resolved* ☐ *Ruled Out* ☐ *Rule Out*
Sequence	**ICD-10**	**Description**	**Status Date**	**Status**
☐ *Primary*				☐ *Active*

☐ *Secondary* ☐ *Tertiary* ☐ *Quaternary* ☐ *Quinary*		**Specifier:**		☐ *Inactive* ☐ *In Remission* ☐ *Resolved* ☐ *Ruled Out* ☐ *Rule Out*
Sequence	**ICD-10**	**Description**	**Status Date**	**Status**
☐ *Primary* ☐ *Secondary* ☐ *Tertiary* ☐ *Quaternary* ☐ *Quinary*				☐ *Active* ☐ *Inactive* ☐ *In Remission* ☐ *Resolved* ☐ *Ruled Out* ☐ *Rule Out*
		Specifier:		

GAF

Current GAF: _____ GAF Date: _____

DIAGNOSTIC SUMMARY

ADDITIONAL INFORMATION

Co-Occurring Consumer Quadrant

☐ 1- Less Severe Mental Disorder/Less Severe Substance Disorder
☐ 2 – More Severe Mental Disorder/Less Severe Substance Disorder
☐ 3 – Less Severe Mental Disorder/More Severe Substance Disorder
☐ 4 – More Severe Mental Disorder Order and More Severe Substance Disorder

Co-Occurring Consumer Quadrant Comments:

LOCUS

LOCUS Composite Score: _____

Assessment Date:

DESIGNATIONS

I/DD Designation
☐ Yes ☐ No ☐ Not Evaluated

MI or SED Designation
☐ Yes ☐ No ☐ Not Evaluated

Detailed SMI or SED Status
☐ SMI ☐ SED ☐ Neither SMI nor SED ☐ Not Evaluated

Primary Designation
☐ I/DD ☐ MI/SMI/SED

Co-Occurring Disorder/Integrated Substance Use and Mental Health Treatment
☐ Yes, client with co-occurring SU and MH problems is being treated with an integrated treatment plan by an integrated team
☐ No, client does NOT have a co-occurring SU and MH problem and is NOT being treated with integrated treatment plan by integrated team
☐ Client with co-occurring SU and MH problems is NOT currently receiving integrated treatment

ASSESSMENT TOOL USED

☐ **LOCUS** ☐ **CAFAS** ☐ **PECFAS** ☐ **SIS** ☐ **None**

Based on your clinical opinion, what is the acuity of this individual's need for services at this time?
☐ Routine ☐ Urgent ☐ Emergent

DISPOSITION

☐ Consumer is eligible for CMHCM services
☐ Consumer is not eligible for services and a referral elsewhere was provided
☐ Consumer is not eligible and no referral was made
☐ Consumer is eligible but chose not to continue to seek CMHCM services
☐ Waiting List (for general fund consumers only)

Comments:

SIGNATURES

Staff Signature/Credentials	*Date*
Supervisor Signature/Credentials	*Date*
Physician Signature/Credentials	*Date*