CONFIDENTIAL To be completed by Network Providers: Placer County Systems of Care **BIOPSYCHOSOCIAL ASSESSMENT** Authorization Number: New Staff Member: **Update** Division/Office: Name of individual being assessed: _____ Date of assessment: _____ Who was present during assessment? Location of assessment: ______ If minor, attach "Authorization to Treat Minor." 1. **Presenting Problem(s) and Requested Service(s):** What is the client's presenting problem / why are they here? (in client's own words when possible) B. Describe precipitating events: C. What service(s) is the client asking for? 2. Lifespan / Developmental History: Health at birth: A. B. Developmental milestones: Within normal limits (use this box for adults only, complete section if child)

Other lifespan / developmental issues: (include mid-life, senior/elder, other issues)

Special services received during lifetime:

C.

D.

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Clien	it Name	:	Case Number:						
3.	Educ	ation and Occupation:	:						
	A.	School currently atte	ending, if applicable:		Grade:				
	В.	Education history: (i.	nclude learning problems, school issu	es). Highest grade completed:					
	C.	Occupation and emp	ployment history: (present and pas	t, include # of years worked, and red	asons for periods of unemployment)				
	D.	Occupational skills	/ training:						
4.		ly of Origin History:							
	A.	Family's current and	d past psychiatric history:						
	В.	Family's and client'	s physical / sexual / emotional al	ouse history:					
	C.	Family's substance	use / abuse history:						
5.		t's Current and Signif tual Supports/Affiliati	icant Past Social Supports, Farons:	mily Supports, Significant Ro	elationships, Religious and				
6.			Client is Involved With or is Receive of the agency and primary contact						
7.	Clien	t's Legal History: (A]	TTACH RELEASES)						
		nformal Probation	☐ Formal Probation	Parole	Child Welfare Services				
		Conservatorship	D.U.I.	Restraining order	☐ None reported				
	(desc	ribe and, if currently invo	lved, give name of probation officer	, parole office, or case manager a	nd estimated start and end dates)				

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t Name	:				_ Case Num	ıber:	
	t's Substance Use:	(alcohol and ot	her drugs, check al	l that apply)	☐ No substan	ce use reported	
☐ To	affeine obacco ver-the-counter me rescription medicat ther; please identif	dication	Alcohol Inhalants Hallucinogens Marijuana	☐ Sed	nulants latives nquilizers caine	☐ Barbitu ☐ Methan ☐ Opiate: ☐ Methan	mphetamines s
S	Substance	Age of 1st Use	Amount/ Frequency	Duration of Use	Date of Last Use	Period of Heaviest Use	Amount Used Last 24 hrs.
5	dibstance	1st Usc	Frequency	or osc	Last Osc	Treaviest Osc	Last 24 ms.
C.			when you stop usi		the response?		
E.					Yes No (A' No (A' ed, dates of service;		SES)
	t's Mental Health		• `	^			
A.	Current and pas	t psychiatric his	story:	∐ Clie	nt reports no psyc	hiatric history	
B.	Current service	provider(s):					
C	Past sarvina pro	vider(s): (incl	da in_nationt out =	ationt movido	namos datos thera	ogutio internantions	and outcomes)

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CO	NE	ID	EN	TT	AT.

Name:			Case N	lumber:			
Client reports no Client reports no	outstanding med	ical problems	medical conditions, including allergies) (ATTACH RELEASES)				
Primary Care Physicia	n's name and pho	one #:					
Date of last physical e	xamination:						
List alternative treatme	ents/therapies: (i.e						
If Lab Tests Were D	Oone, Describe Ro	esults: Not applie	cable				
Medication History:			4 11 12 4				
A. Current psychiatri Drug Name	Dose/ Frequency	Benefit/ Side Effects	reported by client Prescribed By: (Dr.'s Name)	When Prescribed?	When is Next Refill Required		
Drug I tume	Trequency	Side Effects	(Div 5 Turne)	Treserroeu.	Tterm require		
P. Poet psychiatric m	andications:	None	raparted by client				
B. Past psychiatric m	nedications: Dose/	None Benefit/	reported by client Prescribed By:	When	When is Next		
B. Past psychiatric m				When Prescribed?			
	Dose/	Benefit/	Prescribed By:				
	Dose/	Benefit/	Prescribed By:				
	Dose/	Benefit/	Prescribed By:				
	Dose/	Benefit/	Prescribed By:				
Drug Name C. Other medications	Dose/ Frequency	Benefit/ Side Effects None	Prescribed By: (Dr.'s Name)	Prescribed?			
Drug Name C. Other medications	Dose/ Frequency S: atric prescriptions of	Benefit/ Side Effects None	Prescribed By: (Dr.'s Name) reported by client ions, i.e., homeopathic, herba	Prescribed?	Refill Required		
Drug Name C. Other medications	Dose/ Frequency	Benefit/ Side Effects None	Prescribed By: (Dr.'s Name)	Prescribed?	Refill Required When is Next		
Drug Name C. Other medications (include non-psychia	Dose/ Frequency S: atric prescriptions of Dose/	Benefit/ Side Effects None in the standard alternative medicate Benefit/	Prescribed By: (Dr.'s Name) reported by client ions, i.e., homeopathic, herba	Prescribed? the remedies of t	Refill Required		
Drug Name C. Other medications (include non-psychia	Dose/ Frequency S: atric prescriptions of Dose/	Benefit/ Side Effects None in the standard alternative medicate Benefit/	Prescribed By: (Dr.'s Name) reported by client ions, i.e., homeopathic, herba	Prescribed? the remedies of t	Refill Required		
Drug Name C. Other medications (include non-psychia	Dose/ Frequency S: atric prescriptions of Dose/	Benefit/ Side Effects None in the standard alternative medicate Benefit/	Prescribed By: (Dr.'s Name) reported by client ions, i.e., homeopathic, herba	Prescribed? the remedies of t	Refill Required When is Next		
Drug Name C. Other medications (include non-psychia	Dose/ Frequency S: atric prescriptions of Dose/	Benefit/ Side Effects None in the standard alternative medicate Benefit/	Prescribed By: (Dr.'s Name) reported by client ions, i.e., homeopathic, herba	Prescribed? the remedies of t	Refill Required When is Next		
Drug Name C. Other medications (include non-psychio) Drug Name	Dose/ Frequency S: atric prescriptions of Dose/ Frequency	Benefit/ Side Effects None in the state of	Prescribed By: (Dr.'s Name) reported by client ions, i.e., homeopathic, herba Prescribed By: (Dr.'s Name)	Prescribed? al remedies) When Prescribed?	Refill Required		
Drug Name C. Other medications (include non-psychia	S: atric prescriptions of Dose/ Frequency	Benefit/ Side Effects None in the state of	Prescribed By: (Dr.'s Name) reported by client ions, i.e., homeopathic, herba	Prescribed? al remedies) When Prescribed?	Refill Required When is Next		
Drug Name C. Other medications (include non-psychio) Drug Name	Dose/ Frequency S: atric prescriptions of Dose/ Frequency	Benefit/ Side Effects None in the state of	Prescribed By: (Dr.'s Name) reported by client ions, i.e., homeopathic, herba Prescribed By: (Dr.'s Name)	Prescribed? al remedies) When Prescribed?	When is Next Refill Required When is Next Refill Required		
Drug Name C. Other medications (include non-psychio) Drug Name	S: atric prescriptions of Dose/ Frequency	Benefit/ Side Effects None in the state of	Prescribed By: (Dr.'s Name) reported by client ions, i.e., homeopathic, herba Prescribed By: (Dr.'s Name)	Prescribed? al remedies) When Prescribed?	Refill Required		

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Key:	Severity Ra	_	Mild Less Than 1 Moi		oderate 6 Months	3 = Severe 3 = 7 - 11 Months	4 - Mores	Than 1 Va
	Duration R			<u> </u>	O MONTHS	3 – 7 - 11 Wonths	4 = More 7	I II ali I Te
1 4	:_4_	Sev	verity Du	ıration	D:1	fd	Severity	Dura
1. Anx	ety c Attacks				. Bizarre l . Bizarre l			
3. Phol					. Paranoid			
	essive Compul	sive			. Gender l			
	atization				. Eating D			-
6. Dep	ression			20	. Poor Jud	lgement		
	aired Memory					Support System		
	Self Care Ski	lls				erpersonal Skills		
	of Interest				. Conduct			
	of Energy				. School F			
	nal Dysfunction p Disturbance	<u> </u>			. Family I	iving Problems		
	etite Disturbar	ice				Body Movements		-
	ght Change					-		
Please de	Status: (please	describe client's	above in detail: s physical appear tactile hallucina	rance, motor be	havior, eye	contact, mood, affect, sj judgment, and orientat	peech pattern, t	thought
Mental S processes	Status: (please thought conten	describe client's t, audio / visual /	s physical appear tactile hallucina	rance, motor be	havior, eye	contact, mood, affect, s	peech pattern, t	chought
Mental S processes Assessm A. Curre	Status: (please thought conten ent of Risk: ent risk factors	describe client's t, audio / visual /	s physical appear tactile hallucina apply)	rance, motor be ttions, intellige	havior, eye nce, insight,	contact, mood, affect, s judgment, and orientat	peech pattern, t ion)	
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Mental Sprocesses Assessm A. Curre	Status: (please thought conten ent of Risk: ent risk factors	describe client's t, audio / visual /	s physical appear tactile hallucina apply)	rance, motor be utions, intellige	havior, eye nce, insight,	contact, mood, affect, s judgment, and orientat	peech pattern, t ion)	
Mental Sprocesses Assessm A. Curre Suic Hon	Status: (please thought content of Risk: ent risk factors idality:	describe client's t, audio / visual / (check all that None	s physical appear (tactile hallucina apply)	rance, motor be ations, intellige n	havior, eye nce, insight,	contact, mood, affect, sp. judgment, and orientat	peech pattern, t ion)	with mean
Mental Sprocesses Assessm A. Curre Suic Hon	Status: (please thought content of Risk: ent risk factors idality:	describe client's t, audio / visual / (check all that None	s physical appear (tactile hallucina apply) Ideation Ideation	rance, motor be ttions, intellige Definition Plan Plan Self	havior, eye nce, insight,	contact, mood, affect, sp. judgment, and orientat Intent w/o means Intent w/o means	peech pattern, t ion)	with mea
Mental Sprocesses Assessm A. Curre Suice Hon If ris	Status: (please thought content of Risk: ent risk factors idality: sk exists, clien	describe client's t, audio / visual / (check all that None None t is able to cont	s physical appear (tactile hallucina apply) Ideation Ideation	rance, motor be titions, intellige Plan Plan Self te Min	havior, eye nce, insight,	contact, mood, affect, sp. judgment, and orientat Intent w/o means Intent w/o means Others	peech pattern, to ion) Intent Explos	with mean
Mental Sprocesses Assessm A. Curre Suic Hon If ris Imp Subs	Status: (please thought content of Risk: ent risk factors idality: sk exists, client ulse control:	describe client's t, audio / visual / (check all that None None t is able to cont	apply) Ideation Ideation Tract not to harr Modera Abuse	rance, motor be titions, intellige Plan Plan Self te Min	havior, eye nce, insight, imal endence	contact, mood, affect, sp. judgment, and orientat Intent w/o means Intent w/o means Others Inconsistent	peech pattern, to ion) Intent Explos	with mea

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Clien	nt Name:	Case Number:
17.	Summary of Findings / Formulation: (ia differential diagnosis.)	dentify problem areas and underlying dynamics. Include information used to make
18.	Recommended Services: (check all that ap	oply.)
	☐ Individual therapy, frequency recommend ☐ Family therapy ☐ Collateral, describe reason: ☐ Group, specify type: ☐ Testing, specify type: (i.e., Conner's, Bed Day rehab / treatment	services needed. imary Care Physician By ASOC or CSOC Psychiatrist ded is times per month . Brief therapy Long-term therapy ck, etc.)
19.	Services Provided:	
	A. If community referrals were made	
20.	Are the Following Documents Attached? ☐ Releases as needed	ory for all minors under 12, minors 12 and older may consent for treatment if certain conditions apply) t, CARE-015a (mandatory) nandatory) 4 (mandatory)
	sment completed by:	
	nde licensure, degree, or job title):	Work Unit/
Print	Name:	Organization: Phone #
Super	rvisor's Signature:	Placer County Use Only Date:
•		ntensive - ASOC

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Placer County Systems of Care ICD-9-CM Diagnosis Form

Client Name:				_ Case	Number:	
Type of Diagnosis:	Admission D	ischarge 🔲 U	J pdate			
Axis I: Clinical Disorder	rs; Other Conditions	That May Be a F	ocus of Cl	inical Atte	ention (ICD-9-CM))
		-				
						a.
						b.
						b.
— — · — —	_					C.
	_					d.
Substance Abuse/Depend	encv.					
Does a substance abu		e exist?		□Y ₀	es No Unkn	own/Not Reported
If yes, which substance			buse diagi		ab [_c _d
Axis II: Personality Disc	orders; Mental Retard	lation (ICD-9-C	M)			
						Α
						e.
·	-					f
Covered Axis I or Axis II D						
Which Axis I or Axis II	Diagnosis is the Med	li-Cal covered IC	D-9 Diagr	nosis? 🗌	a	e ∏f
General Medical Condition	n: Summary by Client	Report or Medic	cal Record	Docume	ntation	
Allergies	☐ Carpal Tunnel	☐ Epilepsy/Seizure		☐ Migraine	es	☐ Physical Disability
☐ Anemia	☐ Chronic Pain	☐ Heart Disease		☐ Multiple		☐ Psoriasis
☐ Arterial Sclerotic Disease	Cirrhosis	☐ Hepatitis			ar Dystrophy	STDs
☐ Arthritis	Cystic Fibrosis	☐ Hypercholestora	alemia	_	eral Medical Condition	Stroke
☐ Asthma☐ Birth Defects	☐ Deaf/Hearing Impaired☐ Diabetes	☐ Hyperlipidemia		☐ Obesity ☐ Osteopo	vracia	☐ Tinnitus ☐ Ulcers
☐ Blind/Visually Impaired	☐ Digestive Disorders	☐ Hypertension☐ Hyperthyroid		☐ Osteopo	DIOSIS	☐ Unknown/
Cancer	☐ Ear Infections	☐ Infertility			on's Disease	Not Reported
Axis IV: Psychosocial a	nd Environmental Pr		TR) Che	eck ves or	no for each proble	·
Primary Support Group	☐ Yes ☐ No	Occupational	☐ Yes ☐ 1		Access to Health Car	
Social Environment	☐ Yes ☐ No	Housing	Yes 1		Legal System/Crime	
Educational	☐ Yes ☐ No	Economic	☐ Yes ☐ I	No	Other Problems	☐ Yes ☐ No
Trauma:						
Has the client witnessed						
witnessed or been a victi				ai, emotion	ai, or sexual abuse?	☐ No ☐ Unknown
Axis V: Global Assessn	nent of Functioning S	cale (GAF – DSI	M-IV TR)			
Current:	Highest in last 12	months:		Lowest	in last 12 months:	
Transcribed by:					Date	:
B. (1)						
Print Name of Diagnosi (Must be Master's level of					Date	¢
(IVIUSI DE IVIASIEI S IEVEI (n above,					
Signature of Licensed	Practitioner:				Date):
(Must include licensure a						-