



**COUNTY OF SANTA CRUZ
CHILDREN'S MENTAL HEALTH
SCREENING AND INTAKE**

MH STAFF USE ONLY
CASE #:

If Screening, complete sections ONE, TWO, THREE and TEN only. For face-to-face complete ENTIRE form.

SECTION ONE: CLIENT INFORMATION

Date: ___/___/___ Social Security #: ___-___-___ Dominant Language: Parent _____ Child _____

Child's Name: _____ D.O.B.: _____ Age: _____ Sex: _____ Ethnicity: _____

Birthplace (City & State): _____ School: _____ Spec. Ed. Highest grade completed: _____

Referral Source-Name: _____ Agency: _____ Phone: (____) _____

Current Therapist/Psychiatrist: _____ Phone: (____) _____

Present Placement-Address: _____ Phone: (____) _____

Present Living Arrangement: Group Home Foster Home Parent/Guardian Redwoods Other: _____

Parenting Arrangement: Two Parents/One Home Two Parents/Two Homes Single Parent (primarily) Other: _____

Custody Status: Both Parents Mother Father Guardian Ward Unknown Other: _____

Parent/Guardian: _____ Relationship: _____

Address: _____ Phone: _____

County of Residence: _____

Legal Consent: Parent 300 (Dependent) 602 (Ward) Adoption Agency Guardian Other: _____

Financial Status: Medi-Cal Insurance Other: _____

(Legal Guardian's County of Residence)

SECTION TWO: CURRENT RISK FACTORS

Rate the current applicable risk factors and presenting problem behaviors using the scale below.

Severity Rating Upon Entry: 1=Mild 5=Severe

Criminal activity (formal/informal probation/uncited criminal activity)	Sexual abuse or Hx	Tantrums/out of control	Poor Social Skills
Unstable living situation putting client at risk of placement	Physical abuse or Hx	Oppositions/defiant	Frequent lying
Gang Involvement	Suicidal thoughts	Runaway/curfew problems	Assaultive behavior
School problems (SARB referrals, falling grades, serious behavior)	Suicidal plan	Cruel to animals	Hyperactive/distractible
Substance abuse causing functional impairment in living skills	Suicidal attempt	Sexual acting out	Depressed/Withdrawn
History of placement or hospitalization during past year	Suicidal Hx	Aggressive (verbal/physical)	Enuretic/encopretic
Psychotic Symptomatology (hallucinations/delusions)	Self injury	Other: _____	

Rate overall risk of out-of-home placement (Referral Source Rating): High Medium Low

Further comments regarding risk factors and current emotional & behavioral problems (include multi-agency involvement, if known). PLEASE PRINT LEGIBLY.

SECTION THREE: CLIENT STRENGTHS

List personal strengths of child and/or family which may assist in treatment.

SECTION FOUR: SPECIAL SERVICES REQUESTED

Check if applicable.

STAR	Probation OP	GROW/PARK	Social Services OP (SIS/SAS)
Other SED	Intensive Family Support Services	School OP	Day Treatment
Court Assessment	TBS	Medication	Access Team

Please estimate date without Mental Health Services: _____

SECTION FIVE: PSYCHIATRIC HISTORY/PERTINENT BACKGROUND INFORMATION

Summarize developmental, psychosocial, psychiatric and medical issues. Include placement history, family constellation, etc. Attach court reports, if possible. PLEASE PRINT LEGIBLY.

Medical History:

Substance Abuse History:

SECTION SIX: MEDICATION(S)

#1 _____ Start Date: _____ Dosage: _____ Prescribing MD: _____

#2 _____ Start Date: _____ Dosage: _____ Prescribing MD: _____

SECTION SEVEN: MENTAL HEALTH EXAM

Hallucinations/Visions: _____
Appearance: _____ Behavior: _____
Mood/Affect: _____ Speech/Thought: _____
Orientation: _____ Judgment: _____
Memory: _____ Insight: _____
Other: _____

SECTION EIGHT: CLINICAL SUMMARY

PRIMARY PRESENTING PROBLEM:

In summary, if denying services, be specific about rationale (does not meet medical necessity, not at risk of out-of-home placement, etc.):

SECTION NINE: DSM IV DIAGNOSIS

Axis I: Primary _____ # _____ Secondary _____ # _____

Axis II: _____ # _____ Axis III: _____

Axis IV: _____ Axis V: _____

Target Population: HRA PROB 3632 Other SED Overall risk of out-of-home placement (Assessor's Rating): High Medium Low
Rate overall severity of mental health condition: Mild Moderate Severe

SECTION TEN: DISPOSITION

- A. Level of Mental Health needs identified:
I. No Mental Health needs identified. II. Uncomplicated Mental Health needs that can be met with outpatient counseling.
III. SED*-but low/no risk of out of home placement (has needs for system approach and has full scope Medi-Cal).
IV. SED-at risk or in need of out of home placement or hospitalization. V. Referral to Primary Care Physician.
- B. Services required to treat individual (check all that apply):

Level of Care				Services required to treat individual (check all that apply)				
Inpatient	Group Home	Ther. Foster Home	Foster Care	OUTPATIENT TREATMENT	Community Referral	Access Panel Provider		
					YSOPN	YSOPS	YSGROW	
	Relative/Parents Home	Self/Friends	HALL		YSOTHR	YSYWKS	PARCTN	PARCTS
				SOC Children's MH	HRA	PROB	SCHOOL	DAYT
STAR	TYLER	YSATL	UCDT	OTHSED	FAMSUP	COURT	PARKDT	UCTBS
				FQHCN	FQHCS			

C. Comments regarding Disposition:

Name/Title: _____ Date: _____