Print Form

Solano County Mental Health Plan - Network Provider

Biopsychosocial Assessment

Authorization Number: _____ **Clinician Name:** _____ **Date First Appt. Offered:** _____

Client Identifying Information

Full Name: _____ DOB: _____ Age: _____

Address: _____ Gender: ☐ Male ☐ Female ☐ Other

_____ Home Phone: _____ Work Phone: _____

Other name(s) used: _____ Ethnicity/Race: _____

Language: _____ Interpreter offered: ☐ Yes ☐ No ☐ Not applicable

Marital Status: _____ Emergency Contact (name & phone number): _____

Reason for Referral/Chief Complaint

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Developmental History (include any trauma history)

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Social, Cultural & Family History

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Individual &/or Family Strengths

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Substance Use History

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Client's Risk Assessment

Suicidality	☐ None	☐ Ideation	☐ Plan	☐ Intent w/o means	☐ Intent with means
Homicidality	☐ None	☐ Ideation	☐ Plan	☐ Intent w/o means	☐ Intent with means
Impulse Control	☐ Sufficient	☐ Moderate	☐ Minimal	☐ Inconsistent	☐ Explosive
Substance Abuse:	☐ None	☐ Abuse	☐ Dependence	☐ Unstable Remission	
Medical Risks:	☐ No	☐ Yes	If yes, explain:		

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Assault/Legal History

Other agency involvement: ☐ Yes ☐ No If yes, specify:

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Medical Information

Current Primary Medical Provider: Phone:

Address: Date of last exam:

Allergies: ☐ Yes ☐ No

Physical disabilities that require accommodations: ☐ Yes ☐ No If yes, specify:

Current Prescribed Medications and Over-the-Counter Medications

(include psycho-tropics, herbal remedies, nutritional supplements, etc):

Name	Dosage	Date Started	Last Dose	Results/Reactions (per client report)

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Past Prescribed, Over-the-Counter Medications

(include psycho-tropics, herbal remedies, nutritional supplements, etc):

Name	Dosage	Date Started	Last Dose	Results/Reactions (per client report)

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Mental Health Treatment History

(include outpatient and inpatient/hospitalization treatment):

Time Frame	Location	Type of Treatment	Provider	Client's Impression of Treatment

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Client Name: **Date of Birth:**

Mental Status Exam

Note consideration for cultural and age factors when applicable

Appearance	☐ **Appropriate grooming/ dress for age/culture**	☐ Younger than stated age ☐ Older than stated age	☐ Eccentric ☐ Unique features	☐ Seductive ☐ Meticulous	☐ Poor hygiene ☐ Unusual Physical Characteristics
Eye Contact	☐ **Normal for culture**	☐ Little	☐ Avoids	☐ Erratic	
Speech	☐ **Normal for age/situation** ☐ Loud ☐ Soft ☐ Overly talkative	☐ Brief responses ☐ Non-verbal ☐ Rapid ☐ Pressured	☐ Rambling ☐ Monotone ☐ Excessive profanity ☐ Slurred	☐ Stammer/stutter ☐ Vocal tic ☐ Other speech difficulty	
Attitude	☐ Responsive ☐ Engaging ☐ Cooperative ☐ Uncooperative	☐ Superficial ☐ Guarded/distant ☐ Provocative/limit testing ☐ Manipulative/deceitful	☐ Angry/hostile ☐ Shy/timid ☐ Dramatic ☐ Demanding/insistent	☐ Apathetic ☐ Isolated ☐ Withdrawn ☐ Dependent	
Behavior/ Motor Activity	☐ **Normal for age/situation** ☐ Slowed ☐ Overactive/restless	☐ E.P.S. ☐ Impulsive ☐ Agitated	☐ Unusual mannerism ☐ Akathesis ☐ Tremor	☐ Motor tic ☐ Other involuntary movement	
Mood	☐ **Within normal limits** ☐ Sad	☐ Happy ☐ Anxious	☐ Fearful ☐ Bored	☐ Irritable or angry ☐ Other	
Affect	☐ **Euthymic (normal)** ☐ Sad ☐ Tearful ☐ Overly Happy	☐ Irritable ☐ Angry ☐ Silly ☐ Anxious	☐ Fearful ☐ Bored ☐ Labile (rapidly shifting) ☐ Flat, blunted, constricted	☐ Incongruent with topic or thoughts ☐ Congruent with mood	
Perceptual Disturbance	☐ **None apparent** **Self-Perceptions:** ☐ Depersonalizations ☐ Ideas of Reference ☐ Derealization	**Hallucinations:** ☐ Visual ☐ Olfactory ☐ Tactile ☐ Auditory ☐ Command ☐ Persecutory ☐ Other	**Delusions** ☐ Persecutory ☐ Grandiose ☐ Religious ☐ Paranoid ☐ Somatic ☐ Nihilistic ☐ Being Controlled ☐ Other	**Ideation** ☐ Bizarre ☐ Suspicious ☐ Blames Others ☐ Assaultive Ideas ☐ Irrational/Excessive Worry ☐ Sexual Preoccupation ☐ Excessive/Inappropriate Guilt ☐ Excessive/Inappropriate Religiosity	☐ Phobic ☐ Obsessive ☐ Persecutory ☐ Magical Thinking
Thought Process Disturbance	☐ **None Apparent** **Serial 7's** ☐ Intact ☐ Poor	**Concentration** ☐ Intact **Impaired by:** ☐ Rumination ☐ Thought Blocking ☐ Clouding of Consciousness ☐ Fragmented	**Abstractions** ☐ Intact ☐ Concrete ☐ Overly Abstract	**Associations** ☐ Unimpaired ☐ Loose ☐ Tangential ☐ Circumstantial ☐ Confabulous ☐ Flight of Ideas ☐ Word Salad	
Thoughts of Harming Self or Others	☐ **None** ☐ Suicidal ideation ☐ Suicidal plan	☐ Thoughts or plan of non-lethal self-injury	☐ Thoughts or plan of harming another person		
Sensorium	**Oriented to:** ☐ Person ☐ Place ☐ Time ☐ Situation	**Intellectual functioning:** ☐ Average or higher ☐ Below average ☐ Borderline or below	**Alertness** ☐ Alert ☐ Clouded/Confused ☐ Other	**Memory intact for:** ☐ Immediate ☐ Recent ☐ Remote ☐ Poor	**Attention:** ☐ Good ☐ Fair ☐ Poor
Comments					
					☐ Continued on Addendum Page

Client Name: _____ **Date of Birth:** _____

Medical Necessity Criteria and Justification

Diagnostic Criteria (List included Title 9 diagnosis): _____

Impairment Criteria (must have ONE of the following impairments as a result of the included Title 9 diagnosis):

1. A significant impairment in an important area of life functioning, OR ☐ Yes ☐ No

2. A probability of significant deterioration in an important area of life functioning, OR ☐ Yes ☐ No

3. A probability that the child/youth will not progress developmentally as individually appropriate, OR ☐ Yes ☐ No

4. For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate. ☐ Yes ☐ No

Intervention Criteria (must meet 5,6, & 7 OR 7 & 8):

5. The focus of treatment is to address the condition identified in the Impairment Criteria. ☐ Yes ☐ No

6. It is expected the client will benefit from treatment by diminishing the impairment or preventing significant deterioration in an important area of life functioning. ☐ Yes ☐ No

7. The condition would not be responsive solely to physical health care based treatment. ☐ Yes ☐ No

8. For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate. ☐ Yes ☐ No

Provide brief description of impairments/presenting problems in activities of daily living, social, occupational/academic or other important area(s) of life functioning:

_____

_____

_____

_____

_____

Symptoms to Support Diagnosis (include DSM diagnostic criteria and functional impairment):

_____

_____

_____

_____

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Current Diagnosis(check only one Primary Diagnosis)

Axis I ☐ Pri ☐ Sec DSM Code: _____ Name: _____

Axis II ☐ Pri ☐ Sec DSM Code: _____ Name: _____

Axis III General Medical Condition ICD Code: _____ Name: _____

Axis IV Psychosocial and Environmental Problems ***Check all that apply*:**

☐ A. primary support group ☐ E. housing ☐ I. other psychosocial/environmental

☐ B. social environment ☐ F. economics ☐ J. inadequate information

☐ C. education ☐ G. access to health care

☐ D. occupational ☐ H. interaction with legal system

Axis V Current **GAF**: _____ Highest **GAF** (in past 12 months): _____

Client Name: _____ **Date of Birth:** _____

Proposed Treatment Plan

Treatment goals must be specific observable and/or specific quantifiable. You should be able to tell when the client has reached their goal, e.g. "as evidenced by…"

Goal #1: _____

_____

Proposed Method for Achieving Goal/Interventions: _____

_____

Proposed Duration: _____

_____

Goal #2: _____

_____

Proposed Method for Achieving Goal/Interventions: _____

_____

Proposed Duration: _____

_____

Proposed Treatment Level

Service Type		**Frequency**		**Totals**	
Individual Therapy:	☐ Monthly	☐ Every other week	☐ Weekly	**Total** Sessions Requested	_____
Group Therapy:	☐ Monthly	☐ Every other week	☐ Weekly	**Total** Sessions Requested	_____
Family Therapy:	☐ Monthly	☐ Every other week	☐ Weekly	**Total** Sessions Requested	_____

Signatures

The signatures below indicate that the client and provider have agreed to this plan and that the client was offered a copy of this plan.

Check one: ☐ Client *accepted* a copy of this plan ☐ Client *declined* a copy of this plan

Client Signature _____ Date _____

Provider Signature (must include Licensure/Degree) _____ Date _____

Parent/Caregiver/Guardian _____ Date _____

Print Provider Name and Licensure/Degree _____

If no client signature, document why and describe how the client/caregiver was involved in the development of this plan and how they have indicated agreement with the plan: _____

_____

_____

_____

Client Name: _____ **Date of Birth:** _____

Addendum Page

Additional Clinical Information

Signature & License | Print Name | Date

Client Name: _____ **Date of Birth:** _____