CRIMINAL JUSTICE RELATED ASSESSMENT

Please complete – prior to appointment pre-appointment packet,

Diagnostic Assessment -Client

Patient Information

Patient Name:

DOB:

Date of Assessment:

Referral Details

Reason for Criminal Action/Court Referral:

Referral Source/County Probation/Court Agent:

Informed Consent Provided: ☐ Yes ☐ No

Doctors Name

My physician's name is: _____ The medical clinic which I go to is: _____
I am currently having medical problems or symptoms: _____No _____Yes, (specify):

Medications

Name of medication	The reason I take this medication	The dose I take each time	The frequency with which I take this medication	The last dose I took was (when)	The date I first began taking this medication was	I am taking this medication as prescribed
						_____Yes _____No
						_____Yes _____No
						_____Yes _____No
						_____Yes _____No
						_____Yes _____No

Medical Conditions

_____I've had a head injury	Describe:
_____I've had seizures or convulsions	Describe:
_____I've had serious illness	Describe:
_____I've had surgery(s)	Describe:
_____I've had other serious injuries	Describe:
_____I've been hospitalized	Describe:
_____There have been medical problems in my parents, brothers, or sisters	Describe:
_____I've had/have physical or sexual dysfunctions	Describe

Ideations

I have recently experienced a desire or urge to kill myself. _____Yes _____No I have attempted to kill myself in the past. _____Yes _____No

I am currently experiencing thoughts or urges to injure or harm myself _____ _____Yes _____No I have engaged in self-injurious or harmful behaviors _____Yes _____No

I have recently experienced a desire or urge to seriously harm or kill someone else.

_____Yes _____No

I have attempted to harm/hurt other people in the past (hitting, shoving, choking, punching, kicking, etc.)

_____Yes _____No

I have a history of violent or destructive behavior

_____Yes _____No

Presenting Problem

Summary of Presenting Problem:

Mental Health & Medical History

Any Previous Diagnoses:

Previous Treatment: ☐ None ☐ Inpatient ☐ Outpatient ☐ Therapy ☐ Medications

Hospitalizations: ☐ Yes ☐ No If yes, explain: _____

Ever had 72hrs or Emergency Holds:_____

Every been contact by law enforcement/or social work related to emergency hold: ☐ Yes ☐ No If yes, explain: _____

As a youth (if adult) have your parents every hospitalized your related to mental health: ☐ Yes ☐ No If yes, explain: _____

Medical Conditions: _____

Family History of Medical Conditions: _____

Biological Parents:

- Mother_____ Deceased ☐ Yes ☐ No
  - Deceased ☐ Yes ☐ No
  - Mental Health Conditions - ☐ Yes ☐ No ☐ Unk. ☐ Suspected
  - If Yes, Unk, or Suspected Describe:

- Father_____
  - Deceased ☐ Yes ☐ No
  - Mental Health Conditions - ☐ Yes ☐ No ☐ Unk. ☐ Suspected
  - If Yes, Unk, or Suspected Describe:
- Step-parent -1 _____
  - Deceased ☐ Yes ☐ No
  - Mental Health Conditions - ☐ Yes ☐ No ☐ Unk. ☐ Suspected
  - If Yes, Unk, or Suspected Describe:
- Step-parent -2 _____
  - Deceased ☐ Yes ☐ No
  - Mental Health Conditions - ☐ Yes ☐ No ☐ Unk. ☐ Suspected
  - If Yes, Unk, or Suspected Describe:

Biological Siblings of Both Parents - ☐ Yes ☐ No

Sibling 1 _____

Deceased ☐ Yes ☐ No
Mental Health Conditions - ☐ Yes ☐ No ☐ Unk. ☐ Suspected
If Yes, Unk, or Suspected Describe:

Sibling 2 _____

Deceased ☐ Yes ☐ No
Mental Health Conditions - ☐ Yes ☐ No ☐ Unk. ☐ Suspected
If Yes, Unk, or Suspected Describe:

Sibling 3 _____

Deceased ☐ Yes ☐ No
Mental Health Conditions - ☐ Yes ☐ No ☐ Unk. ☐ Suspected
If Yes, Unk, or Suspected Describe:

Sibling 4 _____

Deceased ☐ Yes ☐ No
Mental Health Conditions - ☐ Yes ☐ No ☐ Unk. ☐ Suspected
If Yes, Unk, or Suspected Describe:

Do you have children:

Child _____
- Age_____

- Deceased ☐ Yes ☐ No
- Mental Health Conditions - ☐ Yes ☐ No ☐ Unk. ☐ Suspected
- If Yes, Unk, or Suspected Describe:

Child _____
- Age_____
- Deceased ☐ Yes ☐ No
- Mental Health Conditions - ☐ Yes ☐ No ☐ Unk. ☐ Suspected
- If Yes, Unk, or Suspected Describe:

Child _____
- Age_____
- Deceased ☐ Yes ☐ No
- Mental Health Conditions - ☐ Yes ☐ No ☐ Unk. ☐ Suspected
- If Yes, Unk, or Suspected Describe:

Criminogenic Factors and History

☐ Number of arrests if known _____

☐ Involvement with Child Welfare System (CPS)

1) Victim_____
2) Witness_____
3) Subject_____

☐ Months in Jail or Prison_____

☐ Out of State Arrests/Convictions_____

☐ Violations of probation resulted_____

☐ What is the serious charges you have ever been arrested for?

☐ Were you charged via criminal complaint or arrested? ☐ Yes ☐ No

☐ Do you have any other pending criminal charges? ☐ Yes ☐ No

☐ Do you have a Attorney of Record –

- Public Defender _____- (Name/email) (ROI)
- Private Attorney_____-(Name/email) (ROI)

☐ How long were involved with criminal trial/action case:

- _____- Years
- _____- Months

☐ Violations of probation resulted_____

☐ Did you plead guilty ☐ Yes ☐ No

☐ Do you have social support: ☐ Yes ☐ No

If yes:

☐ Do you have social connection to a faith/religion or religious ideology: ☐ Yes ☐ No

If yes: (Faith/Church/Frequency)

☐ Were you raised in a strict religious household: ☐ Yes ☐ No

☐ Domestic Violence (not resulting in arrest) ☐ Yes ☐ No

☐ Are you a victim of Criminal Sexual Conduct (rape): ☐ Yes ☐ No

☐ Are you a victim of child abuse (neglect/abuse/sexual abuse): ☐ Yes ☐ No

Living Situation & Social History

Current Housing: ☐ Stable ☐ Unstable

Period of Homelessness: ☐ Yes ☐ No

Living With: ☐ Alone ☐ Family ☐ Roommates ☐ Supervised Setting

Employment Status: ☐ Employed ☐ Unemployed ☐ Student ☐ Retired

- Current Employer_____
- Years of Service_____
- Any work related discipline_____
- Ever been terminated_____
- Any allegations of harassment_____
- Every been unemployed_____
- Length of being unemployed_____ yrs/months
- Highest level of education:

Substance Use History

Substances Used: ☐ Alcohol ☐ Cannabis ☐ Cocaine ☐ Meth ☐ Opioids ☐ Other

- Substance/last time used:
- If active use:
    - What_____
    - Frequency _____
    - When do you use substances_____

Current Use: ☐ Active ☐ In Remission ☐ Denied Use

Every been to substance abuse treatment ☐ Yes ☐ No

    - If yes, -
    - How many times_____
    - What was the substance your addressed _____

Other Social/Life Factors:

Exercise: ☐ Yes ☐ No

Sleep: (quality)

Sleep: (length in hours)

How long does it take to go to sleep:

Do you have a smart phone/Internet Capable phone: ☐ Yes ☐ No

Do you have social media: ☐ Yes ☐ No

If yes: how many hours a day do you spend on social media

What do you use social media for:

Does your social support network aware of your arrest: ☐ Yes ☐ No

Do you have a private therapist: ☐ Yes ☐ No

Mental Status Exam

Appearance: ☐ Well-Groomed ☐ Disheveled Speech: ☐ Normal ☐ Pressured

Mood: ☐ Euthymic ☐ Anxious ☐ Depressed Affect: ☐ Appropriate ☐ Flat

Thought Process: ☐ Logical ☐ Disorganized SI/HI: ☐ Denied ☐ Present

General Diagnostic Information – Client/Filled

Depression Symptoms

☐ Depressed Mood

☐ Anhedonia

☐ Fatigue

☐ Insomnia/Hypersomnia

☐ Appetite Change

☐ Feelings of Worthlessness

☐ Guilt

☐ Difficulty Concentrating

☐ Suicidal Thoughts

☐ Add more that you think apply:

Anxiety Symptoms

☐ Excessive Worry

☐ Restlessness

☐ Irritability

☐ Muscle Tension

☐ Panic Attacks

☐ Avoidance Behaviors

☐ Difficulty Concentrating

☐ Add more that you think apply:

PTSD Symptoms

☐ Intrusive Thoughts

☐ Nightmares

☐ Flashbacks

☐ Hypervigilance

☐ Exaggerated Startle

☐ Avoidance

☐ Negative Mood/Beliefs

☐ Add more that you think apply:

Manic Symptoms

☐ Elevated Mood

☐ Grandiosity

☐ Decreased Need for Sleep

☐ Racing Thoughts

☐ Impulsivity

☐ Pressured Speech

☐ Add more that you think apply:

ADHD Symptoms

☐ Inattention

☐ Hyperactivity

☐ Impulsivity

☐ Difficulty Sustaining Attention

☐ Forgetfulness

☐ Fidgeting

☐ Add more that you think apply:

Psychosis Symptoms

☐ Delusions

☐ Hallucinations

☐ Disorganized Thinking

☐ Paranoia

☐ Add more that you think apply:

Other Emotional/Behavioral Symptoms

☐ Anger Outbursts

☐ Self-Injury

☐ Obsessions/Compulsions

☐ Substance Use

☐ Eating Issues

☐ Add more that you think apply:

By signing this agreement, I am agreeing to pay Matthew J. Stiehm. as a Pre-Licensed Therapist here after the consultant:

Case/Client Name: _____

Nature and Purpose of Diagnostic Consultation:

The purpose of consultation is for County Probation Officer/Agent and their agent, and you to have limiting access to professional advice from a mental health. The Consultant will not be called to testify without a specific and separate Agreement to do so. The Consultant is limited in-scope to providing a diagnostic assessment which may include the review of case; files, other records, meetings or potentially collateral contact to provide feedback, and information sources to assist in the creation of this Diagnostic Assessment.

Records and Confidentiality:

All information shared with Matthew "Matt" J. Stiehm, dba Minnesota Blue Line Therapy and Haberdashery; is confidential to the extent of law, related to conditions of probation, court order, and other holdings that would command it related to court(s)/legal actions.

The client will be the custodian of records once completed, which will include a written report, copies of scored assessment/summaries, handwritten notes and any all information. Although Matthew "Matt" J. Stiehm, dba Minnesota Blue Line Therapy and Haberdashery; is not providing clinical services in his role as Consultant he is a Pre-Licensed Professional Clinical Counselor and is therefore considered by state law to be a mandated reporter (Minn. Stat. §572.08). Consultant is obligated to report to the proper authorities any evidence of physical or sexual abuse or neglect of minors, elders, or vulnerable adults; or any direct threat to harm oneself or another person.

Fees and Cancellation Policy:

The fees for these services are paid at a rate of $500.00 for services. All monies will be paid prior to appointment.

Upon completion of the oral interview/assessment – all reports will be completed within 48hrs, works hours exclude national holidays that align with the United States Federal Government (not the State of Minnesota).

Your signature below indicates that you have read and understood this document, and that any questions have been answered to your satisfaction.

_____ _____ _____

Signature Print Name Date

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE AND EXCHANGE OF CLIENT INFORMATION

Street Address, City, State and Zip Code

TO: _____ ☐ N/A

Name Organization Dates of Treatment/Service

Telephone/Fax/Email

Name(s) DOB

I authorize and request the disclosure of the information identified below for the purpose of review and evaluation in connection with professional services rendered as indicated herein. I expressly request that the designated record custodian of all entities identified above disclose full and complete information including the

following:

Medical:

- ☐ Verbal consultation with the provider(s).
- ☐ All medical records, meaning every page in my record, including records received from other medical providers.
- ☐ All laboratory reports or results regarding blood, urine or breath testing for alcohol or drugs.
- ☐ All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
- ☐ All records pertaining to mental health services.
- ☐ Other: _____

Non-medical:

- ☐ Verbal consultation with the named persons(s)
- ☐ Legal Information
- ☐ School information, records, reports
- ☐ Other: _____

You are authorized to release and exchange the identified information with:

Dr. Matthew J. Stiehm

Addresses Pending/Email:
mnbluelinetherapy@gmail.com

The information requested under this Authorization for Release and Exchange of Information shall be exchanged with Dr. Lysne for the following purpose:

- ☐ Custody Evaluation Parenting
- ☐ Consultation Mediation
- ☐ Coaching
- ☐ Early Neutral Evaluation (SENE)
- ☐ Psychotherapy
- ☐ Other: _____

- In the absence of an express restriction to specific dates of treatment or service, this authorization specifically includes records prepared prior to the date of this authorization and records prepared after the date of this authorization for as long as this authorization is valid.
- I understand the information to be released or exchanged may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). I authorize the release or disclosure of this type of information.
- This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records, the restrictions on which have been specifically considered and expressly waived.

I understand the following:

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.

b. The information released in response to this authorization may be re-disclosed to other parties.

c. My medical treatment or payment for my medical treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein and shall be as valid as the original. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

Printed Name Printed Name Signature

_____ _____ _____

Minnesota Law & HIPAA-Compliant Release of Information Form

Authorization for Disclosure of Protected Health Information (PHI)

Business/Provider Name: Dr. Matthew J. Stiehm dba MN Blue Line Therapy and Haberdashery
Address: Confidential Location
Phone: _____ Fax: _____

Client Information

Full Name: _____
Date of Birth: _____
Phone Number: _____
Address: _____

Recipient of Information

I authorize the release of my protected health information to:

Name/Organization: _____
Address: _____
Phone: _____ Fax: _____

Information to Be Disclosed (Check all that apply)

☐ Diagnostic Assessment / Mental Health Evaluation
☐ Treatment Plan / Progress Notes
☐ Psychiatric / Medication Records
☐ Psychotherapy Notes*
☐ Medical Records (specify): _____
☐ Substance Use Disorder Information**
☐ School / Legal / Court Documents
☐ Other (specify): _____
*Must be authorized separately under HIPAA (42 USC § 164.508(a)(2))
**Requires consent under 42 CFR Part 2 for federal SUD programs

Purpose of Disclosure (Check all that apply)

☐ Continuity of Care
☐ Legal / Court Requirement
☐ Personal Use
☐ Case Management
☐ Insurance / Billing
☐ Probation / Parole / Corrections
☐ Employment
☐ Other: _____

Authorization Duration

This authorization:

☐ Expires on: _____
☐ Remains in effect until revoked in writing

Client Rights and Acknowledgments

- I understand this release complies with HIPAA (45 CFR Parts 160 & 164) and Minnesota Statutes §144.292 and §13.384–13.386.
- I understand that I may revoke this authorization at any time in writing. Revocation does not apply to records already released.
- I understand that if the person or entity receiving this information is not a health care provider or plan covered by HIPAA, the information may be re-disclosed and may no longer be protected by HIPAA.
- I understand I have the right to inspect and receive a copy of the information to be disclosed.
- I understand that treatment, payment, or eligibility for benefits may not be conditioned on my signing this authorization unless allowed by law.
- I understand that Minnesota law requires additional protections for mental health records, HIV status, and alcohol or drug treatment information, and those will only be released if specifically authorized.

Client Authorization

Signature of Client: _____ Date: _____
Signature of Legal Representative (if applicable): _____
Relationship to Client: _____

Additional Information that you think is relevant:

Minnesota Legal References

HIPAA: 45 CFR §164.508
Minnesota Health Records Act: Minn. Stat. §144.291–144.298
Mental Health Records: Minn. Stat. §13.384
Chemical Dependency (SUD) Records: 42 CFR Part 2
Minor Consent Laws: Minn. Stat. §144.343

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ADULTS ONLY WHODAS QUESTIONNAIRE 2.0

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, or problems with alcohol or drugs. For each question, please circle only one response.

In the past 30 days, how much difficulty did you have in:					
Standing for long periods such as 30 minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
Taking care of your household responsibilities?	None	Mild	Moderate	Severe	Extreme or cannot do
Learning a new task, for example learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme or cannot do
How much of a problem did you have joining in community activities (for example, festivities, religious, or other activities) in the same way as anyone else can?	None	Mild	Moderate	Severe	Extreme or cannot do
How much have you been emotionally affected by your health problems?	None	Mild	Moderate	Severe	Extreme or cannot do

In the past 30 days, how much difficulty did you have in:					
Concentrating on doing something for ten minutes	None	Mild	Moderate	Severe	Extreme or cannot do
Walking a long distance such as a mile (or equivalent)?	None	Mild	Moderate	Severe	Extreme or cannot do
Washing your whole body?	None	Mild	Moderate	Severe	Extreme or cannot do
Getting dressed?	None	Mild	Moderate	Severe	Extreme or cannot do
Dealing with people you do not know?	None	Mild	Moderate	Severe	Extreme or cannot do
Maintaining a friendship?	None	Mild	Moderate	Severe	Extreme or cannot do
Your day-to-day work?	None	Mild	Moderate	Severe	Extreme or cannot do

Overall, in the past 30 days, how many days were these difficulties present?	**Record number of days _____**
In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health conditions?	**Record number of days _____**
In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health conditions?	**Record number of days _____**

JUVENILES ONLY

WORLD HEALTH ORGANIZATION DISABILITY ASSESSMENT SCHEDULE CHILDREN AND YOUTH VERSION (WHODAS-Child)

This question asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems may be short or long-lasting, injuries, mental or emotional problems. Think back over the past 30 days and answer these questions, thinking about how much difficulty you (or your child) had doing the following activities.

In the past 30 days, how much difficulty did you have in:					
Understanding and communicating					
Concentrating on doing something for ten minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
Remembering to do important things?	None	Mild	Moderate	Severe	Extreme or cannot do
Analyzing and finding solutions to problems in day-to-day life?	None	Mild	Moderate	Severe	Extreme or cannot do
Learning a new task, for example, learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme or cannot do
Generally understanding what people say?	None	Mild	Moderate	Severe	Extreme or cannot do
Starting and maintaining a conversation?	None	Mild	Moderate	Severe	Extreme or cannot do
Getting around					
Standing for long periods, such as 30 minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
Standing up from sitting down?	None	Mild	Moderate	Severe	Extreme or cannot do
Moving around inside your home?	None	Mild	Moderate	Severe	Extreme or cannot do
Getting out of your home?	None	Mild	Moderate	Severe	Extreme or cannot do
Walking a long distance, such as a kilometer (or equivalent)?	None	Mild	Moderate	Severe	Extreme or cannot do
Self-care					
Washing your whole body?	None	Mild	Moderate	Severe	Extreme or cannot do
Getting dressed?	None	Mild	Moderate	Severe	Extreme or cannot do
Eating?	None	Mild	Moderate	Severe	Extreme or cannot do
Staying by yourself for a few days?	None	Mild	Moderate	Severe	Extreme or cannot do

Getting along with people					
Dealing with people you do not know?	None	Mild	Moderate	Severe	Extreme or cannot do
Maintaining a friendship?	None	Mild	Moderate	Severe	Extreme or cannot do
Getting along with people who are close to you?	None	Mild	Moderate	Severe	Extreme or cannot do
Making new friends?	None	Mild	Moderate	Severe	Extreme or cannot do
Sexual activities?	None	Mild	Moderate	Severe	Extreme or cannot do
Life activities - Household					
Taking care of your household responsibilities?	None	Mild	Moderate	Severe	Extreme or cannot do
Doing most important household tasks well?	None	Mild	Moderate	Severe	Extreme or cannot do
Getting all of the household work done that you need to do?	None	Mild	Moderate	Severe	Extreme or cannot do
Getting your household work done as quickly as needed?	None	Mild	Moderate	Severe	Extreme or cannot do
Life activities – School/Work					
If you (your child) work (paid, non-paid, self-employed) or go to school, complete the below section. If not, skip to Participation in Society.					
Because of your health condition, in the past 30 days, how much difficulty did you have in:					
Your day-to-day work/school?	None	Mild	Moderate	Severe	Extreme or cannot do
Studying for important school tests?	None	Mild	Moderate	Severe	Extreme or cannot do
Doing you most important work/school tasks well?	None	Mild	Moderate	Severe	Extreme or cannot do
Getting all of the work done that you need to do?	None	Mild	Moderate	Severe	Extreme or cannot do
Getting your work done as quickly as needed?	None	Mild	Moderate	Severe	Extreme or cannot do
Participation in society					
How much of a problem did you have in joining in community activities (for example, festivities, religious, or other activities) in the same way as anyone else can?	None	Mild	Moderate	Severe	Extreme or cannot do
How much of a problem did you have because of barriers or hindrances around you?	None	Mild	Moderate	Severe	Extreme or cannot do
How much of a problem did you have living with dignity because of the attitudes and actions of others?	None	Mild	Moderate	Severe	Extreme or cannot do

How much time did you spend on your health condition or its consequences?	None	Mild	Moderate	Severe	Extreme or cannot do
How much have you been emotionally affected by your health condition?	None	Mild	Moderate	Severe	Extreme or cannot do
How much has your health been a drain on the financial resources of you or your family?	None	Mild	Moderate	Severe	Extreme or cannot do
How much of a problem did your family have because of your health problems?	None	Mild	Moderate	Severe	Extreme or cannot do
How much of a problem did you have in doing things by yourself for relaxation or pleasure?	None	Mild	Moderate	Severe	Extreme or cannot do