Assessment date: _____ **Member name:** _____
MRN: _____

Clear Sky Behavioral, LLC
Comprehensive Clinical Assessment

PROVIDER INFORMATION

Provider agency:	Evaluating clinician phone number:
Clinician name/credentials:	

MEMBER INFORMATION

Member name:		Record number:
Age:	Ethnicity:	Marital status:
Date of birth:	Medicaid number:	Receives SSI? ◯ Yes ◉ No

Address:	City:	State:	ZIP Code:
Phone number:	Resides with:		

Housing stability: ◯ Stable ◉ Unstable ◯ Homeless ◯ Housing unsafe ◯ History of instability

Housing type: ◯ Private residence ◯ Group Home ◉ Other:

Persons present at assessment:

LEGALLY RESPONSIBLE PERSON

Legally responsible person:		Participated in assessment? ◯ Yes ◉ No
Address:	City:	State: ZIP Code:
Home phone:	Cell phone:	Assessment results discussed? ◯ Yes ◯ No

REFERRAL AND BASIC HEALTH INFORMATION

Referred by:

HISTORY OF CLINICAL INTERVENTION

Assessment date: _____ **Member name:** _____
MID #: _____

REFERRAL AND BASIC HEALTH INFORMATION (CON'T)

CHRONOLOGICAL GENERAL HEALTH/BEHAVIORAL HISTORY (INCLUDE MH/SU/IDD)

Symptoms:

Treatment:

Treatment response:

Attitudes about treatment over time that may contribute to or inhibit recovery:

HISTORY OF MENTAL HEALTH/SUBSTANCE USE TREATMENT
(INCLUDE INPATIENT AND OUTPATIENT TREATMENT AND DATES)

DATE	PROVIDER/TYPE	OUTCOME

REVIEW OF RELEVANT DIMENSIONS

FAMILIAL (include any MH/SU history; immediate and prior family make-up):

Strengths:

Challenges:

Protective factors:

REVIEW OF RELEVANT DIMENSIONS (CON'T)

SOCIAL:

Strengths:

Challenges:

Protective factors:

PSYCHOLOGICAL:

Strengths:

Challenges:

Protective factors:

BIOLOGICAL:

Strengths:

Challenges:

Protective factors:

ENVIRONMENTAL:

Strengths:

Challenges:

Protective factors:

ENVIRONMENTAL AND PSYCHOSOCIAL FACTORS

(FACTORS POTENTIALLY CONTRIBUTING TO FUNCTIONAL STATUS)

Housing:

Legal:

Financial:

Nutrition:

Sleep:

Military status:	Informal supports: n/a

Recovery environment/barriers to treatment (include problems, risk of harm, functional status, etc.):

Assessment date: _____ **Member name:** _____
MID #: _____

ADDITIONAL INFORMATION

History of traumatic events (consider neglect/abuse, significant losses, domestic violence or exploitation):
History of concussion or Traumatic Brain Injury?
Cultural circumstances that may affect treatment?
DSS and/or legal history (consider arrests or probation/parole; include name of probation/parole officer and phone # if applicable):
Educational history (include current school, grade level completed, any school difficulties or special programs attended):
Learning disabilities:

DEVELOPMENTAL HISTORY

Did member's birth mother have problems during pregnancy?	○ Yes	◉ No
Were there birth complications?	○ Yes	◉ No
Was there maternal alcohol, illicit substance use or other risk exposure during pregnancy?	○ Yes	◉ No
Did the member meet developmental milestones on time?	◉ Yes	○ No
Did the member engage in age appropriate social interactions?	◉ Yes	○ No

DEVELOPMENTAL HISTORY REVIEW:

Self-care concerns:	◉ No known issues	○ Assessment needed
Language concerns:	◉ No known issues	○ Assessment needed
Learning concerns:	○ No known issues	○ Assessment needed
Mobility concerns:	◉ No known issues	○ Assessment needed
Self-direction concerns:	◉ No known issues	○ Assessment needed
Capacity for independent living concerns:	◉ No known issues	○ Assessment needed

Assessment date: _____ **Member name:** _____
MID #: _____

DEVELOPMENTAL HISTORY (CON'T)

Vocational history (include current employment, vocational training):

Co-morbidity (medical and/or psychiatric):

MEDICATIONS (PHYSICAL AND PSYCHIATRIC HEALTH)

MEDICATION NAME	DOSAGE	PRESCRIBING DOCTOR	STATUS	EFFECTIVENESS/SIDE EFFECTS
			○ Current ◉ History	
			○ Current ◉ History	
			○ Current ○ History	
			○ Current ○ History	
			○ Current ○ History	
			○ Current ○ History	

Alternative, natural and/or herbal medications:

Over-the-counter medications (current):

Allergies or adverse reactions: ☑ None

INTEGRATED AND PRIMARY CARE

(RECOMMENDED: TO BE COMPLETED BY HEALTHCARE PROFESSIONAL OR THROUGH REVIEW OF MEDICAL RECORD, AS AVAILABLE)

Primary care physician name:		**Phone number:**	
Member last physical examination:	**Height:**	**Weight:**	**BMI:**

Coordination with primary care physician (as evidenced by):

☑ Medication reconciliation:

☐ Coordination of PCP visit:

☐ Review of physical symptoms:

☐ Monitoring of physical symptoms:

Assessment date: _____ **Member name:** _____
MID #: _____

MENTAL STATUS ASSESSMENT

Appearance:	☑ Unremarkable	☐ Unkempt	☐ Atypical clothing	
Orientation:	☑ Person	☑ Place	☑ Date	☑ Situation
Insight:	○ Poor	◉ Average	○ Good	
Estimate of intellectual capacity:		○ Below average	◉ Average	○ Above average
Judgment:	◉ Poor	○ Average	○ Good	
Memory:	Short Term:	○ Impaired	◉ Not Impaired	
	Long Term:	○ Impaired	◉ Not Impaired	
Motor Activity:	☑ Unremarkable	☐ Restless	☐ Withdrawn	
Speech:	☑ Unremarkable	☐ Pressured	☐ Halting	☐ Nonverbal
	☐ Excessive	☐ Inarticulate	☐ Loud	☐ Soft
Mood & Affect:	☑ Unremarkable	☐ Anxious	☐ Depressed	☐ Sad
	☐ Hopeless/Helpless	☐ Crying	☐ Angry	☐ Guarded
	☐ Hostile	☐ Elevated	☐ Liable	☐ Blunted
	☐ Dull	☐ Flat	☐ Silly	
Thought Content:	☑ Unremarkable	☐ Delusional	☐ Ideas of Reference	☐ Loose Association
	☐ Obsessions	☐ Phobias	☐ Thought Insertion	☐ Blocking
Suicidal:	☐ Ideation	☐ Gesture	☐ Plan	
	☐ History	☑ None		
Homicidal:	☐ Ideation	☐ Intent	☐ Plan	☑ None
Description of SI/HI Ideation and Protective Measures Taken:				

Assessment date: _____ **Member name:** _____
MID #: _____

MENTAL STATUS ASSESSMENT (CON'T)

Behavior: ☑ Unremarkable

DEPRESSION	MANIA	ANXIETY	OTHER BEHAVIORS
☐ Decreased Pleasure	☐ Inflated Self-Esteem	☐ Agitated	☐ Impulsive
☐ Sleep + or -	☐ Agitated	☐ Panic Attacks	☐ Compulsive
☐ Appetite + or -	☐ Pleasure-seeking	☐ Restless	☐ Aggressive
☐ Weight + or -	☐ Racing Thoughts	☐ Fatigue	☐ Oppositional
☐ Isolation	☐ Talkative, Pressured Speech	☐ Poor Concentration	☐ Threatening
☐ Poor Concentration		☐ Muscle Tension	☐ Self-injurious
☐ Excessive Guilt			☐ Eating Issues: *Binge/Purge, Weight Concerns*
☐ Fatigue			☐ Sexualized Behavior: *Aggressive, Compulsive*

Hallucinations

☐ Auditory	☐ Command	☐ Olfactory
☐ Tactile	☐ Visual	☑ None

Mental Activity:

☑ Unremarkable	☐ Confused	☐ Flight of Ideas
☐ Grandiose	☐ Paranoid	☐ Dissociative
☐ Tangential	☐ Circumstantial	☐ Disorganization

SUBSTANCE USE

☐ **NONE**

NAME OF SUBSTANCE	AGE OF FIRST USE	ROUTE OF USE	FREQUENCY OF USE	AVERAGE PER USE	LAST USE
Alcohol		☐ Oral ☐ Smoke ☐ Inhale ☐ Inject ☐ Other: _____			
Marijuana		☐ Oral ☐ Smoke ☐ Inhale ☐ Inject ☐ Other: _____			
Cocaine		☐ Oral ☐ Smoke ☐ Inhale ☐ Inject ☐ Other: _____			

SUBSTANCE USE (CON'T)

Opiates (heroine, codeine, etc.)		☐ Oral ☐ Smoke ☐ Inhale ☑ Inject ☐ Other: _____			
Prescription pills		☐ Oral ☐ Smoke ☐ Inhale ☐ Inject ☐ Other: _____			
Hallucinogens		☐ Oral ☐ Smoke ☐ Inhale ☐ Inject ☐ Other: _____			
Other (club drugs, methamphetamines, inhalants)		☐ Oral ☐ Smoke ☐ Inhale ☑ Inject ☐ Other: _____			

Consequences from use:

When you use alcohol/drugs, do you use until you get: ☐ High ☐ Intoxicated ☐ Pass Out

Have you ever tried to quit using? ◉ Yes ○ No If YES, for how long?

What did you do?

Has your drinking/drug use resulted in any of the following:

Affected your relationship with significant other/family?	◉ Yes	○ No
Increased arguments?	◉ Yes	○ No
Separation or divorce due to substance use?	○ Yes	◉ No
Told by family/friends/work that you drink/use too much?	○ Yes	◉ No
Has your level of work decreased?	○ Yes	◉ No
Absences from work?	○ Yes	◉ No
Loss of job?	○ Yes	◉ No
Any health problems (i.e., liver problems, diabetes)?	○ Yes	◉ No

If YES, please specify:

Assessment date: _____ **Member name:** _____
MID #: _____

SUBSTANCE USE (CON'T)

Have you experienced:

Blackouts?	◯ Yes	If YES, how often?	⊙ No	
Overdoses?	⊙ Yes	If YES, how often?	◯ No	

The morning after, do you experience:

☐ Shaking ☐ Seizures ☐ Nausea ☐ Headaches ☐ Anxiety ☐ Insomnia ☐ Depression ☐ Sweating

Have you decreased your recreation activities that do not include using alcohol or other drugs?	◯ Yes	⊙ No
Have you ever been told by a doctor to stop using?	◯ Yes	⊙ No

Please check current level of functioning (SU):

☐ Tolerance ☐ Withdrawal ☐ Increased use ☐ Activities decreased

☐ Significant time spent to obtain/recover ☐ Unsuccessful efforts to cut down or quit

DIAGNOSTIC FORMULATION WITH ANALYSIS AND INTERPRETATION OF ASSESSMENT INFORMATION

(TO INCLUDE MH/SU/IDD DISORDERS, AS WELL AS PHYSICAL HEALTH CONDITIONS AND FUNCTIONAL IMPAIRMENTS, BIOSOCIAL FACTORS)

DSM V DIAGNOSTIC PROFILE

DX (primary):	1.
DX (additional):	2.
	3.
	4.
	5.
	6.
	7.
	8.
	9.
Psychosocial Stressors:	
LOCUS:	
CALOCUS:	
ASAM:	
SNAP/SIS:	

Assessment date: _____ **Member name:** _____
MID #: _____

DIAGNOSTIC FORMULATION (CON'T)

Strengths, Protective Factors, Problem Summary (may be addressed in Diagnostic Formulation above):	
Recommendations Based on CCA:	**Additional assessment needs?** **Recommended services:** **Specific evidence-based practices?**

Recommended Benefit Plan (Target Pop) not required for Medicaid (represents the client's principal or primary diagnosis and the main focus of treatment for the current episode of care):

- ○ Generic Assessment Payment (GAP)
- ○ Adult with Mental illness (AMI)
- ○ Adult Substance Use Women (ASWOM)
- ○ Adult Substance Use Treatment and Engagement (ASTER)
- ○ Adult Substance Use Injecting Drug User/Communicable Disease (ASCRD)
- ○ Adult with Developmental Disability (ADSN)
- ○ All Military Veterans and Family Members (AMVET)
- ○ Child with Serious Emotional Disturbance (CMSED)
- ○ Child with Developmental Disability (CDSN)
- ◉ Child with SA Disorder (CSSAD

Name and Credentials:

Signature: **Date:**