

Diagnostic Assessment Form			
This information will only be used as part of a comprehensive evaluation of the child.			
Date of Assessment:		Procedure Code:	
Student's Name:		Age:	Sex: M F
Grade:		Date of Birth:	
Medicaid ID #:		School Name:	Phone #:
Parent/Guardian Name:	Last Name:	Home Phone #:	Work #:
Address:		Student's Insurance Information:	
City:	State:	Zip Code:	Date of Admission/Start: Date RBHS:
Emergency Contact Name:	Relationship:	Home Phone #:	Follow-up Assessment: Cell Phone #:
Preferred Language:			
Biological Parent History			
Parent Relationship: (check one): Single: ☐ Married: ☐ Divorced: ☐ Remarried: ☐ Separated: ☐			
Mother Name:		Father Name:	
Legal Guardian Family History			
Legal Guardian Name:		Relationship to Student:	
Child Adopted:	Date/Year:	Child in Legal Custody of:	
Foster Care:	Date/Year:	Caseworker Name:	
County:	State:	Caseworker Name:	
List of everyone who lives in the home:		Language spoken in the home:	
Name:	Age:	Relationship:	
Name:	Age:	Relationship:	
Name:	Age:	Relationship:	
Name:	Age:	Relationship:	

Reason for Referral for The Diagnostic Assessment		
Presenting Complaint/Reason for Referral/Reason for Assessment/ Reason for Continued Services:		
Family Issues:		
Please describe any significant changes or ongoing problems in the family or home environment that may have affected the child's behavior.		
Have any of the blood relatives on the child's mother or father's side (including siblings) ever had Behavioral Health problems similar to those the child has? If so, describe:		
Describe any problematic child relationship with immediate and/or extended family members.		
Does the child have positive influences or relationships with immediate and extended family members?		
Is the child being placed outside the home due to family issues? Yes ☐ No ☐		
Comment(s):		
List Student's Medical History to include list of Medications:		
Is the child in good health? Yes ☐ No ☐ Allergies? Yes ☐ No ☐		
List Allergy Medications:		
Family Doctor: Phone #: Date of Last Physical:		
If the child's history includes any of the following problems, please indicate the problem with a mark.		
Problem: Sleep ☐ Eye ☐ Ear infection ☐ Diabetes ☐ Measles ☐ Scarlet Fever ☐ Mumps ☐ Problem/Date: Head injury ☐	Pneumonia ☐ High BP ☐ Headaches ☐ Appetite ☐ TB ☐ Kidney ☐ Liver ☐ Lungs ☐ Intestinal ☐	Chronic cold ☐ Allergies ☐ Asthma ☐ Tonsillectomy ☐ Blackouts ☐ Glandular ☐ Disturbance ☐ Extreme fatigue ☐ Bipolar ☐

Body injury ☐	Immune ☐	Anxiety ☐
Convulsions ☐	Hep B ☐	Intellectual ☐
Seizures ☐	Hep C ☐	Disabilities ☐
Sickle cell ☐	ADHD ☐	Birth Defects ☐
Thyroid ☐	CD ☐	Autism ☐
Cancer ☐	OD ☐	Other ☐
Stomach ☐	Depression ☐	
Describe any surgery the child has had:		
MD Specialist:	Phone:	Last Visited:
Describe any other serious illnesses, accident, falls, or deformities not already mentioned:		
Current medication prescribed for child: Dosage, frequency, reason for Rx:		
Rx 1:	Dosage:	Frequency:
Reason for Rx:	How long on Rx:	Did Rx Work:
Rx 2:	Dosage:	Frequency:
Reason for Rx:	How long on Rx:	Did Rx Work:
Rx 3:	Dosage:	Frequency:
Reason for Rx:	How long on Rx:	Did Rx Work:
List previous medications prescribed for child: Dosage, frequency, reason for Rx.		
Rx 1:	Dosage:	Frequency:
Reason for Rx:	How long on Rx:	Did Rx Work:
Rx 2:	Dosage:	Frequency:
Reason for Rx:	How long on Rx:	Did Rx Work:
Mental Health History:		
Is the child deemed to be at risk of psychiatric hospitalization or out-of-home placement? Yes ☐ No ☐		
Comment(s):		
In the last 90 days has the child exhibited behavior(s) that included at least one intervention by crisis response, social services, or law enforcement? Yes ☐ No ☐		
Comment(s):		
Frequency of behavior in the past 3 months: Daily ☐ 3-4 times a week ☐ At least ten (10) times a month ☐ Other ☐		
At what age did these behaviors begin?		
Has the child ever received Mental Health Treatment in the Past: Yes ☐ No ☐ If yes, please complete the table below.		

Attach any medical documentation, if applicable.				
In/Out Patient Treatment	Location	Date of Treatment	Diagnosis	Type of Treatment
Comments:				
Relationships with Other Children:				
How well does the child get along with siblings (brothers/sisters)? Excellent ☐ Good ☐ Poor ☐				
Does the child seek friendships with other children? Yes ☐ No ☐ Sometimes ☐				
Is the child sought by other children for relationships? Yes ☐ No ☐ Sometimes ☐				
Does the child play primarily with other children? His/Her own age ☐ Younger ☐ Older ☐				
Does the child participate in group activities? Yes ☐ No ☐ Sometimes ☐				
List Sports/Club/Extracurricular activities?				
What does the child do for fun?				
What does the child do to relax or calm down?				
Social and Cultural Concerns:				
Where was the child born?				
Is there anyone who may assist the parent with raising the child or has a significant relationship with the child? Yes ☐ No ☐ If yes, please explain.				
Does the child have problems with any of the following? Please explain.				
Gender Identity?	Yes ☐	No ☐	If yes, please explain.	
Sexual Orientation?	Yes ☐	No ☐	If yes, please explain.	
Spiritual Beliefs?	Yes ☐	No ☐	If yes, please explain.	
Child's Concerns:				

Does the child have any other issues, concerns, or worries that were not asked already during the interview?	
Yes ☐ No ☐ If yes, please explain.	
What else is important that the child would like to report?	
What would the child like to see happen or change because of services?	
Academic History:	
Rate the child's school experience related to academic learning as: Good ☐ Average ☐ Fair ☐ Poor ☐	
Type of Class: Regular ☐ Mainstream ☐ Special Education ☐	
Did the child have trouble learning with: Reading ☐ Written Language ☐ Mathematics ☐	
Has the child ever had to repeat a grade? If so, which grade(s)?	
Need for discipline: None ☐ Infrequent ☐ Frequent ☐	
Office referrals ISS ☐ OSS ☐ Expulsions ☐ Detention ☐	
Attendance: Regular attendance ☐ Misses often/excused ☐ Misses often/unexcused ☐	
Reason for absences: Illnesses ☐ Truancy ☐ Other ☐ Specify Other:	
Please list any other school(s) the child has attended this year:	
School: City:	Grade Attended: State:
School: City:	Grade Attended: State:
School: City:	Grade Attended: State:
Comment about previous school and list the child's favorite subjects:	
Rate the child's overall school experience related to behavior as: Good ☐ Average ☐ Fair ☐ Poor ☐	
Elementary:	Good ☐ Average ☐ Fair ☐ Poor ☐
Middle:	Good ☐ Average ☐ Fair ☐ Poor ☐
High:	Good ☐ Average ☐ Fair ☐ Poor ☐
What other agencies are involved with this student? Juvenile Court Involvement ☐ Department of Social Services ☐ Mental Health ☐	

Other ☐			
If yes to any of the above, please explain:			
Does the child like school? Always ☐ Sometimes ☐ Rarely ☐ Never ☐			
Explain:			
Briefly describe any other classroom behavioral problems:			
Justification for Authorization – Risk Factors that interfere with the ability to function in a daily living, personal relationships, school and recreational settings that will assist in determining medical necessity for services or the need for an additional assessment or referral for services.			
Behavioral Health/Mental Health Risk Factors			
Risk Factor	Yes ☐	No ☐	High ☐ Mod ☐ Low ☐
Regression in self-care skills	Yes ☐	No ☐	High ☐ Mod ☐ Low ☐
Bullying from others in school	Yes ☐	No ☐	High ☐ Mod ☐ Low ☐
Inability to attend school without support	Yes ☐	No ☐	High ☐ Mod ☐ Low ☐
Regression in age-appropriate skills	Yes ☐	No ☐	High ☐ Mod ☐ Low ☐
Lack of Parental Guidance	Yes ☐	No ☐	High ☐ Mod ☐ Low ☐
Fighting in school	Yes ☐	No ☐	High ☐ Mod ☐ Low ☐
Alternative Educational Placement	Yes ☐	No ☐	High ☐ Mod ☐ Low ☐
School Suspension of Expulsion	Yes ☐	No ☐	High ☐ Mod ☐ Low ☐
Home Bound Suspension	Yes ☐	No ☐	High ☐ Mod ☐ Low ☐
Defiance, violation of rules	Yes ☐	No ☐	High ☐ Mod ☐ Low ☐
Discipline by ISS or OSS	Yes ☐	No ☐	High ☐ Mod ☐ Low ☐
Involved with Law Enforcement	Yes ☐	No ☐	High ☐ Mod ☐ Low ☐
Involved with Child Placement Agency	Yes ☐	No ☐	High ☐ Mod ☐ Low ☐
Other Behavioral Health/Mental Health Risk Factors			
List more than one descriptor, if applicable. Elaborate on any problem areas in the space provided.			
Appearance & Hygiene	Meticulous ☐ Neat ☐ Clean ☐ Disheveled ☐ Bizarre ☐ Body Odor ☐ Comments:		
Motor Activity	Appropriate to situation ☐ Over-active ☐ Tremor ☐ Tics ☐ Poor coordination ☐ Repetitive ☐		

	Lethargic ☐ Comments:
Attitude During Interview	Cooperative ☐ Oppositional Hostile ☐ Dramatic ☐ Guarded ☐ Irritable ☐ Withdrawn ☐ Silly ☐ Comments:
Affect	Appropriate to situation ☐ Blunted ☐ Flat ☐ Tearful ☐ Incongruent ☐ Expansive ☐ Comments:
Mood	Happy ☐ Euthymic ☐ Anxious ☐ Depressed ☐ Angry ☐ Hopeless ☐ Suspicious ☐ Passive ☐ Comments:
Speech	Normal rate and tone ☐ Slow ☐ Fast ☐ Soft ☐ Loud ☐ Pressured ☐ Slurred ☐ Stuttering ☐ Comments:
Hallucinations	No Auditory ☐ Command ☐ Visual ☐ Tactile ☐ Denies ☐ Comments:
Orientation/Level of Consciousness	Alert ☐ Oriented to ☐ Person ☐ Place ☐ Time ☐ Situation ☐ Clouded ☐ Confused ☐ Comments:
Judgement	Able to make sound decisions ☐ Usually able to make sound decisions ☐ Poor decision making, adversely affects self ☐ Poor decision making, adversely affects others ☐ Comments:
Memory (use example)	Intact ☐ Poor remote ☐ Poor recent ☐ Poor immediate ☐ Comments:
Justification for Authorization – Risk Factors that interfere with the ability to function in a daily living, personal relationships, school and recreational setting that will assist in determining medical necessity for services or the need for an additional assessment or referral for services.	
Check applicable boxes and enter a code by the “T” = Time for when the behavior was last exhibited: 24 = within last 24 hours, ds=few days, w = last 7 days, m = last 30 days or month.	
Homicide Risk Assessment:	
Experienced Persistent ideation:	Yes ☐ No ☐ T:
Made threats to harm others:	Yes ☐ No ☐ T:
Made gestures to harm others:	Yes ☐ No ☐ T:
Engaged in rehearsing homicidal acts:	Yes ☐ No ☐ T:
Suicide Risk Assessment	
Made an attempt of suicide:	Yes ☐ No ☐ T:

Made threats to harm self: Yes ☐ No ☐ T:		
Talked with therapist or other staff about suicide intentions/thoughts: Yes ☐ No ☐ T:		
Made a clear statement of intent to others: Yes ☐ No ☐ T:		
Has written a suicide note: Yes ☐ No ☐ T:		
Described a practical/available method or plan: Yes ☐ No ☐ T:		
Has given away an important personal possession: Yes ☐ No ☐ T:		
Established access to means/methods: Yes ☐ No ☐ T:		
Self-Mutilation: Yes ☐ No ☐ T:		
Other Risky Behaviors (specify)		
Gang affiliations: Yes ☐ No ☐ T:		
Fire setting: Yes ☐ No ☐ T:		
History of violence: Yes ☐ No ☐ T:		
Violence towards animals: Yes ☐ No ☐ T:		
Urgent risk for: Homicide Yes ☐ No ☐ T: Suicide Yes ☐ No ☐ T:		
Actions taken based on Urgency:		
Justification for Authorization – Risk Factors that interfere with the ability to function in a daily living, personal relationships, school and recreational settings that will assist in determining medical necessity for services or the need for an additional assessment or referral for services.		
Trauma History		
Exposure to Physical Abuse, Sexual abuse, Anti-Social Behavior, or Other Traumatic Events:		
History of trauma: Yes ☐ No ☐		
Child was a: Victim ☐ Witness ☐ Perpetrator ☐	Physical ☐	Signs Reported: None ☐ Symptoms ☐ Denies ☐ Acknowledges ☐
Child was a: Victim ☐ Witness ☐ Perpetrator ☐	Sexual ☐	Signs Reported: None ☐ Symptoms ☐ Denies ☐ Acknowledges ☐
Child was a: Victim ☐ Witness ☐ Perpetrator ☐	Emotional ☐	Signs Reported: None ☐ Symptoms ☐ Denies ☐ Acknowledges ☐
Child was a:	Mental ☐	Signs Reported:

Victim ☐ Witness ☐ Perpetrator ☐		None ☐ Symptoms ☐ Denies ☐ Acknowledges ☐
Child was a: Victim ☐ Witness ☐ Perpetrator ☐	Accident ☐	Signs Reported: None ☐ Symptoms ☐ Denies ☐ Acknowledges ☐
Child was a: Victim ☐ Witness ☐ Perpetrator ☐	Natural Disaster ☐	Signs Reported: None ☐ Symptoms ☐ Denies ☐ Acknowledges ☐
Child was a: Victim ☐ Witness ☐ Perpetrator ☐	Violence ☐	Signs Reported: None ☐ Symptoms ☐ Denies ☐ Acknowledges ☐
Child was a: Victim ☐ Witness ☐ Perpetrator ☐	Neglect ☐	Signs Reported: None ☐ Symptoms ☐ Denies ☐ Acknowledges ☐
Child was a: Victim ☐ Witness ☐ Perpetrator ☐	Other Type of Abuse ☐ Explain:	Signs Reported: None ☐ Symptoms ☐ Denies ☐ Acknowledges ☐
Describe Issues Identified: Nightmares ☐ Flashbacks ☐ Startle Reflex ☐ Avoidance ☐ Anger ☐ Depression ☐ Anxiety ☐		
Comments:		
History of Substance Use: Yes ☐ No ☐		
Alcohol: Beer ☐ Wine/Wine Cooler ☐ Liquor ☐ 100% Proof Alcohol ☐ How much? How often?		
Cannabis: Joint ☐ Blunt ☐ Other ☐ How much? How often?		
Sedatives: Xanax ☐ Klonopin ☐ Ativan ☐ Ecstasy ☐ Valium ☐		

Other ☐ _____ How much? _____ How often? _____		
<i>Stimulants:</i> Crack ☐ Cocaine ☐ Methamphetamine ☐ Speed ☐ Other ☐ _____ How much? _____ How often? _____		
<i>Hallucinogens:</i> LSD ☐ Mushrooms ☐ Mescaline ☐ Other ☐ _____ How much? _____ How often? _____		
<i>Opiates:</i> Heroin ☐ Codeine ☐ Morphine ☐ Percocet ☐ Oxycodone ☐ Other ☐ _____ How much? _____ How often? _____		
<i>Inhalants:</i> Gasoline ☐ Kerosene ☐ Nail Polish Remover ☐ Aerosol Spray ☐ Computer Cleaning ☐ Duster ☐ How much? _____ How often? _____		
<i>Nicotine:</i> Cigarettes ☐ Snuff ☐ Chewing Tobacco ☐ Other ☐ How much? _____ How often? _____		
<i>Other Substance Use:</i> Yes ☐ No ☐ If yes, please specify: _____		
Experience blackouts? Yes ☐ No ☐ If yes, describe: _____		
Withdrawal symptoms (seizures, DT's etc.) Yes ☐ No ☐ If yes, describe: _____		
Legal involvements related to substance use? Yes ☐ No ☐ If yes, describe: _____		
Is alcohol/drug use something that needs to be addressed in treatment? Yes ☐ No ☐ If yes, please describe: _____		
Family History of substance abuse? Yes ☐ No ☐ If yes, describe: _____		
DSM-5 CODE or ICD-10 CODE (Must include both code and description.)		
DSM-5 Code:	ICD-10 Code:	Description:
DSM-5 Code:	ICD-10 Code:	Description:
DSM-5 Code:	ICD-10 Code:	Description:
Treatment recommendation, if applicable: Describe or list the type of services and why the services are medically necessary. Medically necessary means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. Medical records on the student should substantiate the need for services, include all findings and information supporting medical necessity, and entail all treatment provided.		
Recommended Services	Frequencies	

Attach additional notes and reports: (Behavior Health Screening if applicable)	
If a referral for psychological testing is needed, list the reason(s) below. An LPHA must make the referral for the test. The psychological testing prior authorization form must be submitted to the MCO for approval before the test is administered.	
Is there a need to refer Behavioral Health services to an outside organization? Yes ☐ No ☐	
What type of referral will be made? Mental Health ☐ Private Provider ☐ Parent will Decide ☐	
Will a Behavior Modification Plan (BMP) be written? Yes ☐ No ☐	
Comment:	

MHP Staff Name: _____ MHP Signature: _____ Date: _____

LPHA Name: _____ LPHA Signature: _____ Date: _____