Humboldt County Department of Health & Human Services
Children & Family Services
Administrative Offices
2440 6th Street, Eureka, CA 95501
phone: (707) 476-4700 | fax: (707) 445-6254

1238–Youth Behavioral Health Assessment

Client Name: **Client DOB:** **Client ID:**

Assessment Date: Assessment Time:

Assessor's Name: Assessing Practitioner's Licensure:

Service Program/Provider:

Location of Service (eg. Field, home, office):

Sources of Information:

Interpreter: ☐ Yes ☐ No Name of Interpreter:

Client Information

Preferred Language: Language(s) Spoken at Home:

Paint a picture of the client, include typical activities:

Parents, Caregivers, Siblings

Does Client have a known caregiver available to them: ☐ Yes ☐ No

Parent/Caregiver/Natural Support A- Name:
Relationship: Phone:

Parent/Caregiver/Natural Support B- Name:
Relationship: Phone:

Parent/Caregiver/Natural Support C- Name:
Relationship: Phone:

Parent/Caregiver/Natural Support D- Name:
Relationship: Phone:

Additional siblings/notes:

Residential information:

Referral

Date of Referral: Referral Source:

Referral Reason:

Other Agency Involvement:

Legal Issues

Current Legal Issues:

CWS/Probation Case Status

☐ ER ☐ FM ☐ FR ☐ PP ☐ Adoptions
☐ Probation ☐ N/A

Social Worker Name: Probation Officer Name:

Social Worker Contact: Probation Officer Contact:

Offense History Narrative if applicable:

Concerns and Diagnosis

Primary Concerns/Target Symptoms

Client's and Caregiver's Perspective:

Psychiatric Symptoms and Behavior:

Diagnosis/Functional Impairments

Primary Dx (description):

Secondary Dx (Description):

Tertiary Dx (Description):

How Symptoms impact Client's life:

Family History and Natural Supports

Family/Social History:

Natural supports and resources:

Parent/Caregiver– CANS
Parent/Caregiver/Natural Support Strength and Needs – CANS-Humboldt items

Caregiver Name: Relationship:

0= strength/no evidence of problem; 1 = useful/monitor; 2 = requires action;
3 = requires immediate action - - - - - (Rate highest level in past 30 days)

Supervision
☐0 ☐1 ☐2 ☐3

Medical/Physical
☐0 ☐1 ☐2 ☐3

Involvement with Care
☐ 0 ☐1 ☐2 ☐3

Mental Health
☐0 ☐1 ☐2 ☐3

Knowledge
☐0 ☐1 ☐2 ☐3

Substance Use
☐0 ☐1 ☐2 ☐3

Social Resources
☐0 ☐1 ☐2 ☐3

Developmental
☐0 ☐1 ☐2 ☐3

Residential Stability
☐0 ☐1 ☐2 ☐3

Safety
☐0 ☐1 ☐2 ☐3

Family Rel. to the System
☐0 ☐1 ☐2 ☐3

Organization
☐0 ☐1 ☐2 ☐3

Legal Involvement
☐0 ☐1 ☐2 ☐3

Caregiver Name: Relationship:

0= strength/no evidence of problem; 1 = useful/monitor; 2 = requires action;
3 = requires immediate action - - - - - (Rate highest level in past 30 days)

Supervision
☐0 ☐1 ☐2 ☐3

Medical/Physical
☐0 ☐1 ☐2 ☐3

Involvement with Care
☐ 0 ☐1 ☐2 ☐3

Mental Health
☐0 ☐1 ☐2 ☐3

Knowledge
☐0 ☐1 ☐2 ☐3

Substance Use
☐0 ☐1 ☐2 ☐3

Social Resources
☐0 ☐1 ☐2 ☐3

Developmental
☐0 ☐1 ☐2 ☐3

Residential Stability

☐0 ☐1 ☐2 ☐3

Safety

☐0 ☐1 ☐2 ☐3

Family Rel. to the System

☐0 ☐1 ☐2 ☐3

Organization

☐0 ☐1 ☐2 ☐3

Legal Involvement

☐0 ☐1 ☐2 ☐3

Caregiver Name:

Relationship:

0= strength/no evidence of problem; 1 = useful/monitor; 2 = requires action;
3 = requires immediate action - - - - - (Rate highest level in past 30 days)

Supervision

☐0 ☐1 ☐2 ☐3

Medical/Physical

☐0 ☐1 ☐2 ☐3

Involvement with Care

☐ 0 ☐1 ☐2 ☐3

Mental Health

☐0 ☐1 ☐2 ☐3

Knowledge

☐0 ☐1 ☐2 ☐3

Substance Use

☐0 ☐1 ☐2 ☐3

Social Resources

☐0 ☐1 ☐2 ☐3

Developmental

☐0 ☐1 ☐2 ☐3

Residential Stability

☐0 ☐1 ☐2 ☐3

Safety

☐0 ☐1 ☐2 ☐3

Family Rel. to the System

☐0 ☐1 ☐2 ☐3

Organization

☐0 ☐1 ☐2 ☐3

Legal Involvement

☐0 ☐1 ☐2 ☐3

Caregiver Name:

Relationship:

0= strength/no evidence of problem; 1 = useful/monitor; 2 = requires action;
3 = requires immediate action - - - - - (Rate highest level in past 30 days)

Supervision

☐0 ☐1 ☐2 ☐3

Medical/Physical

☐0 ☐1 ☐2 ☐3

Involvement with Care

☐ 0 ☐1 ☐2 ☐3

Mental Health

☐0 ☐1 ☐2 ☐3

Knowledge

☐0 ☐1 ☐2 ☐3

Substance Use

☐0 ☐1 ☐2 ☐3

Social Resources
☐ 0 ☐ 1 ☐ 2 ☐ 3

Developmental
☐ 0 ☐ 1 ☐ 2 ☐ 3

Residential Stability
☐ 0 ☐ 1 ☐ 2 ☐ 3

Safety
☐ 0 ☐ 1 ☐ 2 ☐ 3

Family Rel. to the System
☐ 0 ☐ 1 ☐ 2 ☐ 3

Organization
☐ 0 ☐ 1 ☐ 2 ☐ 3

Legal Involvement
☐ 0 ☐ 1 ☐ 2 ☐ 3

Cultural Factors – CANS

Cultural Factors

Acculturation – CANS-Humboldt items

0 = no evidence; 1 = history or suspicion: monitor; 2 = interferes with functioning; action needed; 3 = disabling, dangerous: immediate or intensive action

(Rate the highest level from past 30 days)

Language
☐ 0 ☐ 1 ☐ 2 ☐ 3

Cultural Stress
☐ 0 ☐ 1 ☐ 2 ☐ 3

Traditions and Rituals
☐ 0 ☐ 1 ☐ 2 ☐ 3

Cultural factors impacting Client:

Life Functioning – CANS

Life Functioning Domain – CANS-Humboldt items

0 = no evidence; 1 = history or suspicion: monitor; 2 = interferes with functioning; action needed; 3 = disabling, dangerous: immediate or intensive action

(Rate the highest level from past 30 days)

Family Functioning
☐ 0 ☐ 1 ☐ 2 ☐ 3

School Achievement
☐ 0 ☐ 1 ☐ 2 ☐ 3

Living Situation
☐ 0 ☐ 1 ☐ 2 ☐ 3

School Attendance
☐ 0 ☐ 1 ☐ 2 ☐ 3

Social Functioning
☐ 0 ☐ 1 ☐ 2 ☐ 3

Medical/Physical
☐ 0 ☐ 1 ☐ 2 ☐ 3

Developmental/Intellectual
☐ 0 ☐ 1 ☐ 2 ☐ 3

Sexual Development
☐ 0 ☐ 1 ☐ 2 ☐ 3

Decision Making
☐ 0 ☐ 1 ☐ 2 ☐ 3

Sleep
☐ 0 ☐ 1 ☐ 2 ☐ 3

School Behavior
☐ 0 ☐ 1 ☐ 2 ☐ 3

Client Strengths – CANS

Client Strengths and Resources

Child Strengths – CANS – Humboldt items

0 = Centerpiece strength; 1 = Useful strength; 2 = Identified strength; 3 = No evidence

(Rate the highest level from past 30 days)

Family Strengths
☐ 0 ☐ 1 ☐ 2 ☐ 3

Cultural Identity
☐ 0 ☐ 1 ☐ 2 ☐ 3

Interpersonal
☐ 0 ☐ 1 ☐ 2 ☐ 3

Community Life
☐ 0 ☐ 1 ☐ 2 ☐ 3

Educational Setting
☐ 0 ☐ 1 ☐ 2 ☐ 3

Natural Supports
☐ 0 ☐ 1 ☐ 2 ☐ 3

Talents and Interests
☐ 0 ☐ 1 ☐ 2 ☐ 3

Resiliency
☐ 0 ☐ 1 ☐ 2 ☐ 3

Spiritual/Religious
☐ 0 ☐ 1 ☐ 2 ☐ 3

Relationship Permanence
☐ 0 ☐ 1 ☐ 2 ☐ 3

Client Strengths and Resources:

Client Behavior/Emotional Needs – CANS

Child Behavioral/Emotional Needs – CANS-Humboldt items

0 = no evidence; 1 = history or suspicion: monitor; 2 = interferes with functioning: action needed; 3 = disabling, dangerous: immediate or intensive action needed.

(Rate the highest level from the past 30 days)

Psychosis (Thought Disorder)
☐ 0 ☐ 1 ☐ 2 ☐ 3

Conduct
☐ 0 ☐ 1 ☐ 2 ☐ 3

Impulsivity/Hyperactivity
☐ 0 ☐ 1 ☐ 2 ☐ 3

Substance Use
☐ 0 ☐ 1 ☐ 2 ☐ 3

Depression
☐ 0 ☐ 1 ☐ 2 ☐ 3

Anger Control
☐ 0 ☐ 1 ☐ 2 ☐ 3

Anxiety
☐ 0 ☐ 1 ☐ 2 ☐ 3

Adjustment to Trauma
☐ 0 ☐ 1 ☐ 2 ☐ 3

Oppositional
☐ 0 ☐ 1 ☐ 2 ☐ 3

Emotional and/or Physical Dysregulation
☐ 0 ☐ 1 ☐ 2 ☐ 3

Client Strengths and Needs Symptom Narratives

Depression, Strengths and Needs
☐ Client not exhibiting symptoms

Depression Symptoms Narrative:

Anxiety Strengths and Needs
☐ Client not exhibiting symptoms

Anxiety Symptoms Narrative:

Sleep, Appetite and Elimination Strengths and Needs

☐ Client not exhibiting symptoms

Sleep, Appetite and Elimination Symptoms Narrative:

Thought and Perception Strengths and Needs

☐ Client not exhibiting symptoms

Thought and Perception Strengths and Needs Narrative:

Activity, Attention and Impulse Strengths and Needs

☐ Client not exhibiting symptoms

Activity, Attention and Impulse Strengths and Needs Narrative:

Conduct Strengths and Needs

☐ Client not exhibiting symptoms

Conduct Symptoms Narrative:

Attachment Strengths and Needs

☐ Client not exhibiting symptoms

Attachment Strengths and Needs Narrative:

Sexual Background Strengths and Needs

☐ Client not exhibiting symptoms

Sexual Background Strengths and Needs Narrative:

Sexual development, sexual orientation or gender identity:

Mental Abilities: Strengths and Needs

☐ Client not exhibiting neurocognitive symptoms

Neurocognitive Symptoms Narrative:

Education and School

Current School:

Grade (year)

☐ Pre-school	☐ Kindergarten	☐ 1
☐ 2	☐ 3	☐ 4
☐ 5	☐ 6	☐ 7
☐ 8	☐ 9	☐ 10
☐ 11	☐ 12	☐ College

Usual Grades

☐ Exceptional	☐ Above Average
☐ Average	☐ Below Average
☐ Failing	

Academic Strengths:

Academic Needs:

Previous Schools:

Has child been held back a grade?
☐ Yes ☐ No
If held back, which year(s)?:

Has child ever been expelled from school?
☐ Yes ☐ No
If expelled, which year(s)?:

If child was ever held back/expelled, please explain:

Does child have a current IEP in place?
☐ Yes ☐ No

Does child have a 504 plan in place?
☐ Yes ☐ No

Has child ever qualified for Special Education?
☐ Yes ☐ No
If yes, what year(s) qualified for Special Education:

Has child ever been considered for Special Education?
☐ Yes ☐ No

Is child receiving Special Education services now?
☐ Yes ☐ No

If yes to any of the above, please describe:

School Attendance

Absent due to illness?
☐ Never ☐ Seldom ☐ Frequently

Absent due to suspension?
☐ Never ☐ Seldom ☐ Frequently

Absent due to truancy?
☐ Never ☐ Seldom ☐ Frequently

Has child been referred to School Attendance Review Board?
☐ Yes ☐ No

Additional school concerns/challenges:

Development

Developmental Status

Pregnancy/Delivery/Perinatal Issues?

☐ Yes ☐ No

If yes, please describe pregnancy/delivery/perinatal issues:

Infancy/Toddler Issues?
☐ Yes ☐ No

If yes, please describe infancy/toddler issues:

Attachment Issues?
☐ Yes ☐ No

If yes, please describe attachment issues:

Major childhood illnesses?
☐ Yes ☐ No

If yes, please describe childhood illnesses:

Puberty Issues?
☐ Yes ☐ No

If yes, please describe puberty issues:

Sleep, eating, or social problems in the first 5 years?
☐ Yes ☐ No

If yes, please describe sleep, eating or social issues:

Motor, Sensory, Pica or Curiosity issues?
☐ Yes ☐ No

If yes, describe Motor, Sensory, Pica or Curiosity issues:

Relationship issues – Parents, Siblings, Communication
☐ Yes ☐ No

Describe Relationship issues – Parents, Siblings, Communication:

Other development notes:

Early Development CANS

Early Development (ED) 0-5 (Complete only if youth is under 6 y/o) – CANS- Humboldt items

0 = no evidence; 1 = history or suspicion: monitor; 2 = interferes with functioning: action needed;
3 = disabling, dangerous: immediate or intensive action

Prenatal Care
☐ 0 ☐ 1 ☐ 2 ☐ 3

Labor and Delivery
☐ 0 ☐ 1 ☐ 2 ☐ 3

Birth Weight
☐ 0 ☐ 1 ☐ 2 ☐ 3

Failure to Thrive
☐ 0 ☐ 1 ☐ 2 ☐ 3

Attachment Difficulties
☐ 0 ☐ 1 ☐ 2 ☐ 3

Regulatory
☐ 0 ☐ 1 ☐ 2 ☐ 3

Resiliency (Persistence and Adaptability)
☐ 0 ☐ 1 ☐ 2 ☐ 3

Playfulness
☐ 0 ☐ 1 ☐ 2 ☐ 3

Relationship Permanence
☐ 0 ☐ 1 ☐ 2 ☐ 3

Atypical Behaviors
☐ 0 ☐ 1 ☐ 2 ☐ 3

Early Education
☐ 0 ☐ 1 ☐ 2 ☐ 3

Social and Emotional Functioning
☐ 0 ☐ 1 ☐ 2 ☐ 3

Exploited
☐ 0 ☐ 1 ☐ 2 ☐ 3

Exposure
☐ 0 ☐ 1 ☐ 2 ☐ 3

Self-Harm (12 months to 5 years old)
☐ 0 ☐ 1 ☐ 2 ☐ 3

Family Spiritual/Religious
☐ 0 ☐ 1 ☐ 2 ☐ 3

Caregiver Emotional Responsiveness
☐ 0 ☐ 1 ☐ 2 ☐ 3

Caregiver Adjustment to Traumatic Experience
☐ 0 ☐ 1 ☐ 2 ☐ 3

TAY – CANS

Transitional Age Youth (TAY) (Complete only if youth is over 15 y/o) **– CANS-Humboldt Items**

0 = no evidence; 1 = history or suspicion: monitor; 2 = interferes with functioning: action needed;
3 = disabling, dangerous: immediate or intensive action

(Rate the highest level from past 30 days)

Independent Living Skills
☐ 0 ☐ 1 ☐ 2 ☐ 3

Transportation
☐ 0 ☐ 1 ☐ 2 ☐ 3

Gender Identity
☐ 0 ☐ 1 ☐ 2 ☐ 3

Sexual Orientation
☐ 0 ☐ 1 ☐ 2 ☐ 3

Parental/Caregiving Roles
☐ 0 ☐ 1 ☐ 2 ☐ 3

Medication Compliance
☐ 0 ☐ 1 ☐ 2 ☐ 3

Personality Disorder
☐ 0 ☐ 1 ☐ 2 ☐ 3

Educational Attainment
☐ 0 ☐ 1 ☐ 2 ☐ 3

Intimate Relationships
☐ 0 ☐ 1 ☐ 2 ☐ 3

Victimization/Exploitation
☐ 0 ☐ 1 ☐ 2 ☐ 3

Medical History

Current Primary Medical Provider

Provider name:

Provider address:

Provider phone:

Last physical exam
☐ Within Past 12 Months ☐ More than 12 Months ☐ Unknown ☐ No-Explain Below

Last dental exam
☐ Within Past 12 Months ☐ More than 12 Months ☐ Unknown ☐ No-Explain Below

Are there any health concerns?
☐ Unknown/None Reported ☐ No ☐ Yes-Explain Below

Non-Medication Allergies
☐ Unknown/None Reported ☐ No ☐ Yes-Explain Below

Medication Allergies
☐ Unknown/None Reported ☐ No ☐ Yes-Explain Below

Health/medical concerns with daily impact and/or explanations from above:

Medications

Has youth had medications prescribed?

☐ Yes ☐ No ☐ Unknown

If applicable, record current and past Rx below:

Medication 1:
Dosage:
☐ Current Prescription ☐ Past Prescription
Comments/Side effects:

Medication 2:
Dosage:
☐ Current Prescription ☐ Past Prescription
Comments/Side effects:

Medication 3:
Dosage:
☐ Current Prescription ☐ Past Prescription
Comments/Side effects:

Medication 4:
Dosage:
☐ Current Prescription ☐ Past Prescription
Comments/Side effects:

Medication 5:
Dosage:
☐ Current Prescription ☐ Past Prescription
Comments/Side effects:

Medication 6:
Dosage:
☐ Current Prescription ☐ Past Prescription
Comments/Side effects:

Medication 7:
Dosage:
☐ Current Prescription ☐ Past Prescription
Comments/Side effects:

Medication compliance issues?
☐ No ☐ N/A ☐ Yes

If yes, please describe:

Trauma

Any known traumatic events?
☐ Yes ☐ No ☐ Unknown

Potentially Traumatic Experience – CANS

Potentially Traumatic/Adverse Childhood Experiences – CANS-Humboldt items

No = No evidence of any trauma of this type; Yes = Exposure/experienced a trauma of this type

Sexual Abuse
☐ Yes ☐ No

Physical Abuse
☐ Yes ☐ No

Emotional Abuse
☐ Yes ☐ No

Neglect
☐ Yes ☐ No

Medical Trauma
☐ Yes ☐ No

Disruption in Caregiving/Attachment Losses
☐ Yes ☐ No

Witness to Family Violence
☐ Yes ☐ No

Witness to Community/School Violence
☐ Yes ☐ No

Natural or Manmade Disaster
☐ Yes ☐ No

War/Terrorism Affected
☐ Yes ☐ No

Victim/Witness to Criminal Activity
☐ Yes ☐ No

Parental Criminal Behaviors
☐ Yes ☐ No

Trauma Narrative:

How did the child experience the events? What were the effects?

How has the child's resilience helped them?

Intergenerational trauma needs?

Substance Abuse

Substance Abuse (either current or past)

☐ Yes ☐ No ☐ Unknown

If Yes to Substance Abuse, complete section below

Substance 1:
Age substance was first used:
Currently uses: ☐ Yes ☐ No
Perceived problem: ☐ Yes ☐ No ☐ Unknown
Date last used:
How often used in the past year?
☐ Never ☐ Once or Twice ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily

Substance 2:
Age substance was first used:
Currently uses: ☐ Yes ☐ No
Perceived problem: ☐ Yes ☐ No ☐ Unknown
Date last used:
How often used in the past year?
☐ Never ☐ Once or Twice ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily

Substance 3:
Age substance was first used:
Currently uses: ☐ Yes ☐ No
Perceived problem: ☐ Yes ☐ No ☐ Unknown
Date last used:
How often used in the past year?
☐ Never ☐ Once or Twice ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily

Substance 4:
Age substance was first used:
Currently uses: ☐ Yes ☐ No
Perceived problem: ☐ Yes ☐ No ☐ Unknown
Date last used:
How often used in the past year?
☐ Never ☐ Once or Twice ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily

Substance 5:
Age substance was first used:
Currently uses: ☐ Yes ☐ No
Perceived problem: ☐ Yes ☐ No ☐ Unknown
Date last used:
How often used in the past year?
☐ Never ☐ Once or Twice ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily

Comments about substance abuse:

Family history of substance abuse:

Prenatal substance exposure?
☐ Yes ☐ No

Describe the prenatal substance exposure:

Risk

Risk Assessment

☐ None identified

Child Risk Behaviors – CANS

Child Risk Behaviors – CANS-Humboldt items

0 = no evidence; 1 = history or suspicion: monitor; 2 = interferes with functioning: action needed;
3 = disabling, dangerous: immediate or intensive action

(Rate the highest level from past 30 days)

Suicide Risk
☐ 0 ☐ 1 ☐ 2 ☐ 3

Runaway
☐ 0 ☐ 1 ☐ 2 ☐ 3

Non-Suicidal Self-Injurious Behavior
☐ 0 ☐ 1 ☐ 2 ☐ 3

Sexual Aggression
☐ 0 ☐ 1 ☐ 2 ☐ 3

Other Self-Harm (Recklessness)
☐ 0 ☐ 1 ☐ 2 ☐ 3

Delinquent Behavior
☐ 0 ☐ 1 ☐ 2 ☐ 3

Danger to Others
☐ 0 ☐ 1 ☐ 2 ☐ 3

Intentional Misbehavior
☐ 0 ☐ 1 ☐ 2 ☐ 3

Describe current/history of danger to self:

Describe current/history of danger to others:

Additional Risk Factors

Document situations presenting to child or others:

Is a Safety Plan in place?
☐ Yes ☐ No

Psychiatric Treatment History

Client Treatment History

Previous outpatient mental health services?
☐ Yes ☐ No ☐ Unknown

When/Where were previous outpatient mental health services?:

How did previous treatment go for you?:

Previous psychiatric hospitalization?
☐ Yes ☐ No ☐ Unknown

Number of psychiatric hospitalizations in last 6 months:

Most recent date of psychiatric hospitalization:

Previous diagnosis (if yes, list in comments)
[ ] Yes [ ] No [ ] Unknown

Use of traditional or alternative healing practices?
[ ] Yes [ ] No [ ] Unknown

Psychological Testing?
[ ] Yes [ ] No [ ] Unknown
Date of Psychological Testing if known:
Psychological Testing examiner if known:

Neurological Testing?
[ ] Yes [ ] No [ ] Unknown
Date of Neurological Testing if known:
Neurological Testing examiner if known:

Psychiatric Treatment History Additional Information:

Plans, Services and Referrals

Services level
☐ Level 1 ☐ Level 2 ☐ Level 3

Please list planned services/referrals:

Form Status and Assessment

Date of Assessment completion:

State Client ID Number (CIN):

Client's Age at assessment:

Provider #:

CWS Client ID Number:

Assessment Type:

☐ Initial ☐ Reassessment ☐ Urgent ☐ Discharge ☐ Administrative Close