



**City and County of San Francisco**  
**Department of Public Health**  
 COMMUNITY BEHAVIORAL HEALTH SERVICES

**INITIAL RISK ASSESSMENT (Face to face)**

Name:

BIS # (if any):

RU #:

1. Date of assessment: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_

New to this clinic       Currently open in CBHS, Where \_\_\_\_\_       Previously seen CBHS (now closed)

**2. Demographics**

Client DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  Male     Female     Transgender

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Tel: \_\_\_\_\_

**3. Presenting Problem (check all that apply)**

- |   |  |
|---|--|
| <input type="checkbox"/> Depression, hopelessness, decreased energy                                   | <input type="checkbox"/> Substance Abuse   |
| <input type="checkbox"/> Sleep Disturbance  | <input type="checkbox"/> Residential instability/Risk of homelessness            |
| <input type="checkbox"/> Eating Disturbance   | <input type="checkbox"/> Victim of abuse, physical, sexual and/or severe neglect |
| <input type="checkbox"/> Anxiety, fear, panic, agitation  | <input type="checkbox"/> Victim of domestic violence                             |
| <input type="checkbox"/> Mania, elevated mood   | <input type="checkbox"/> Oppositional, beyond parental control, runaway          |
| <input type="checkbox"/> Psychosis, unreal thoughts or beliefs, auditory and/or visual hallucinations | <input type="checkbox"/> Hyperactivity   |
| <input type="checkbox"/> Adjustment to trauma/major stressors, separation, loss, death, job, school   | <input type="checkbox"/> Physical/Medical  |
| <input type="checkbox"/> Anger Control  | <input type="checkbox"/> Medications   |
| <input type="checkbox"/> Impulse Control  | <input type="checkbox"/> Employment/School functioning                           |
| <input type="checkbox"/> Family relationship problems   | <input type="checkbox"/> Other, describe below                                   |

FOR ALL AREAS CHECKED, DESCRIBE ONSET, DURATION, AND SEVERITY OF SYMPTOMS/IMPAIRMENTS, INCLUDING RELEVANT HISTORY AND SIGNIFICANT LIFE EVENTS:


**4. Risk Assessment (circle appropriate rating)**

<b>Danger to self</b>	None (0)	History but no recent intent, ideation or feasible plan (1)	Recent ideation, intention, plan that is feasible and/or history of a potentially lethal attempt (2)	Current ideation or command hallucinations re self-harm, current intent, plan that is immediately accessible and feasible, and or history of multiple potentially lethal attempts (3)
<b>Danger to others</b>	None (0)	History but no recent gesture or ideation (1)	Recent homicidal ideation, physically harmful aggression or dangerous fire setting, but not in past 24 hours. Has plan to harm others that is feasible (2)	Acute homicidal ideation with an accessible, feasible plan of physically harmful aggression, or command hallucinations involving harm of others. Or intentionally set fire that placed others at significant risk of harm (3)

4A. Other Risk Factors    Grave disability     No     Yes      Command hallucinations     No     Yes

4B. Previous Psychiatric Hospitalization:  No     Yes – Date/reason of last hosp: \_\_\_\_\_

4C. Risk Assessment (ELABORATION OF ALL RISK FACTORS, NOTE FRUSTRATION TOLERANCE, HOSTILITY, PARANOIA, AND VIOLENT THINKING)


1. IF CLIENT MEETS TARGET POPULATION, THIS AUTHORIZES THE PRE-AUTH. PERIOD OF 2 MONTHS/15 HOURS FOR ADULTS/OA AND 3 MONTHS/24 HOURS FOR CYF
2. IF CASE IS NOT OPENED, FORM SHOULD BE STORED IN A CONFIDENTIAL LOCKED FILE IN ALPHABETICAL ORDER.
3. THIS IS AN INITIAL RISK ASSESSMENT. FURTHER SESSION(S) MAY BE NECESSARY TO COMPLETE A FULL CLINICAL DATABASE ASSESSMENT.



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**5. Current Mental Status**

<b>Mood</b>	<input type="checkbox"/> Depressed	<input type="checkbox"/> Anxious	<input type="checkbox"/> Euphoric	<input type="checkbox"/> Other
<b>Affect</b>	<input type="checkbox"/> Appropriate	<input type="checkbox"/> Inappropriate		
<b>Thought process/content</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Loose/Tangential	<input type="checkbox"/> Grandiose	<input type="checkbox"/> Paranoid
<b>Hallucinations:</b>	<input type="checkbox"/> Auditory	<input type="checkbox"/> Visual	<input type="checkbox"/> Other	
<b>Orientation:</b>	<input type="checkbox"/> Time	<input type="checkbox"/> Person	<input type="checkbox"/> Place	
<b>Cognitive</b>	<input type="checkbox"/> Memory problem	<input type="checkbox"/> Lack of insight	<input type="checkbox"/> Poor judgment	<input type="checkbox"/> Concrete thinking
Comments: _____				

**6. Substance Use History:** Ever Used?  No  Yes >>>> Is client  In remission  Currently intoxicated  Relapsed  
 Date of last use \_\_\_\_\_ Longest time sober \_\_\_\_\_

Indicate substances used, if applicable:  Alcohol  Marijuana  Cocaine/Crack  Amphetamines  Benzodiazepines  
 Opiates  Prescription Drugs  Caffeine  Tobacco/Nicotine  Inhalants  Other \_\_\_\_\_

Has client experienced severe withdrawal symptoms in past (hospitalization, DTs, seizures)?  No  Yes  
 Is client currently experiencing severe withdrawal symptoms?  No  Yes

<b>Substance Abuse Screener</b> For any substance client endorses ever using ask: In the last three months...		
Have you felt you should cut down or stop [drinking/using substance]?	No	Yes
Has anyone annoyed you or gotten on your nerves by telling you to cut down or stop [drinking/using substance]?	No	Yes
Have you felt guilty or bad about how much you [drink /use substance]?	No	Yes
Have you been waking up wanting to [drink /use substance]?	No	Yes

<b>7. Legal Issues</b>	Court Mandated Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes	Probation/Parole: <input type="checkbox"/> No <input type="checkbox"/> Yes	History of arrest: <input type="checkbox"/> No <input type="checkbox"/> Yes
<b>8. Mental Health</b>	Currently linked <input type="checkbox"/> No <input type="checkbox"/> Yes Where?	Conserved <input type="checkbox"/> No <input type="checkbox"/> Yes	History of treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Current psych meds <input type="checkbox"/> No <input type="checkbox"/> Yes
<b>9. Physical Health</b>	Linked to PCP <input type="checkbox"/> No <input type="checkbox"/> Yes Where?		Current non-psych meds <input type="checkbox"/> No <input type="checkbox"/> Yes

**10. Medical Necessity/Need for Services in CBHS?**  No  Yes (If no, provide NOA-A for SF MediCal clients) Uninsured SMI?  No  Yes

**11. Provisional DSM IV Diagnosis:** Axis I: \_\_\_\_\_ Axis II: \_\_\_\_\_  
 Axis III: \_\_\_\_\_ Axis IV: \_\_\_\_\_ GAF: \_\_\_\_\_

**12. Disposition:**

Medication Evaluation When: \_\_\_\_\_  Continuing Assessment at this clinic When: \_\_\_\_\_  
 Requires Hospitalization (5150) due to:  Danger to Self  Danger to Others  Grave Disability  
 Refer to other Mental Health Clinic – Where: \_\_\_\_\_ When: \_\_\_\_\_

Refer to:  None  Substance Abuse  Primary Care Physician  Private Provider Network  Community Social Services

Comments: \_\_\_\_\_

Staff Name (print): \_\_\_\_\_

\_\_\_\_\_  
 Date: \_\_\_\_\_ Date: \_\_\_\_\_  
 Clinician/Staff signature (if not LPHA, must have a LPHA co-signer): LPHA Signature

Service Code: \_\_\_\_\_ FF/TT: \_\_\_\_\_ LOC  Office  Field  Home