



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

**ADULT/OLDER ADULT ASSESSMENT**  
 Long form

Name:

BIS#:

RU#:

Date of assessment: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_

**1. PRESENTING PROBLEM** (include identifying info, criteria to justify DSM dx including symptoms, behavior, functional impairments, duration, frequency, and severity, impact on life/behavior leading to individual or family member requesting services. Indicate client's chief goal and cultural explanation of illness in client's own words.)


**1A. Behavioral Health Needs**

ND=no data, 0=no evidence, 1=history / sub-threshold, watch/prevent, 2=causing problems consistent with diagnosable disorder, 3=causing severe problems (if responses are in shaded area, complete specialty Trauma module)

Psychosis	ND	0	1	2	3		Eating disturbance	ND	0	1	2	3
Depression	ND	0	1	2	3		Antisocial behavior	ND	0	1	2	3
Anxiety	ND	0	1	2	3		Sleep disturbance	ND	0	1	2	3
Adjustment to trauma	ND	0	1	2	3		Interpersonal problems	ND	0	1	2	3
Impulse control	ND	0	1	2	3		Mania	ND	0	1	2	3
Anger control	ND	0	1	2	3							

**1B. Life Domain Functioning**

NA=not applicable (employment only), ND=no data, 0=no evidence, 1=history, mild 2=moderate, 3=severe problem in area (if responses are in shaded area, complete appropriate specialty module – either Employment or Intellectual functioning)

Physical/Medical	ND	0	1	2	3		Sexuality	ND	0	1	2	3
Family functioning	ND	0	1	2	3		Residential stability	ND	0	1	2	3
Recreational	ND	0	1	2	3		Legal	ND	0	1	2	3
Living skills	ND	0	1	2	3		Self-care	ND	0	1	2	3
Employment	NA	ND	0	1	2	3	Social functioning	ND	0	1	2	3
Transportation	ND	0	1	2	3		Intellectual	ND	0	1	2	3



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**2. DANGER TO SELF OR OTHERS** (circle appropriate rating) - (if responses are in shaded area, complete Danger to Self/Others specialty module)

Danger to self	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)
Danger to others	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)

**2A. Risk Behaviors**

ND=no data, 0=no evidence, 1=history, mild, 2=moderate, 3=severe (if responses are in shaded area, complete appropriate specialty module – either Sexually Aggressive Behavior or Criminal Behavior module)

Self-injurious behavior	ND	0	1	2	3	Other self harm	ND	0	1	2	3
Command hallucinations	ND	0	1	2	3	Gambling	ND	0	1	2	3
Sexual aggression	ND	0	1	2	3	Exploitation	ND	0	1	2	3
Criminal behavior	ND	0	1	2	3	Grave disability	ND	0	1	2	3

**2B. Risk Assessment** (Elaboration of ALL risk factors, note frustration tolerance, hostility, paranoia, violent thinking, and gambling risk behaviors. Also include factors that might lessen risk, such as client's commitment to self-control and involvement in treatment)


**3. CRIMINAL HISTORY**

Criminal Justice History/ Violent Incidents of Individual and/or Family	Within last 90 days		Past	
	Y	N	Y	N
Assault on persons				
Threat to persons				
Property Damage				
Weapons Involved				
Legal History				

Legal status (if applicable)	Within last 90 days		Past	
	Y	N	Y	N
Probation				
Parole				
Adjudicated				
Diversion				

**3A. Describe criminal justice involvement/incidents** (include estimate of community threat/safety, dates, types of crimes, outcomes)




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**4. SUBSTANCE USE**

4A. CAGE Substance Abuse Screener	No	Yes
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>Any "yes" answer may indicate a problem</b>		

**4B. Substance Abuse problem rating**

ND=no data, 0=no evidence, 1=history / sub-threshold, watch/prevent 2=causing problems consistent with diagnosable disorder, 3=causing severe problems  
 (if responses are in shaded area, complete Substance Abuse specialty module)

Substance use	ND	0	1	2	3

**4C. Indicate substances used, if applicable:**

- Alcohol   
  Marijuana   
  Cocaine/Crack   
  Amphetamines   
  Benzodiazepines   
  Opiates  
 Prescription Drugs   
  Caffeine   
  Tobacco/Nicotine   
  Inhalants   
  Other \_\_\_\_\_

Date of last use: \_\_\_\_\_ Longest period sober: \_\_\_\_\_

**4D. Substance use history narrative** (indicate current/past amount consumed, frequency, duration, treatment received, family history)


**5. CLIENT STRENGTHS** ND=no data, 0=Significant strength present, 1=Moderate level of strength present, 2=Mild level of strength present, 3=Strength not present

Family	ND	0	1	2	3	Job history	ND	0	1	2	3
Social connectedness	ND	0	1	2	3	Spiritual/religious	ND	0	1	2	3
Optimism/Hopefulness	ND	0	1	2	3	Community connection	ND	0	1	2	3
Talents/interest	ND	0	1	2	3	Natural supports	ND	0	1	2	3
Educational	ND	0	1	2	3	Resiliency	ND	0	1	2	3
Volunteering	ND	0	1	2	3	Resourcefulness	ND	0	1	2	3
Involvement in Recovery/ Motivation for treatment	ND	0	1	2	3						



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**5A. Describe Client Strengths**


**6. PSYCHIATRIC HISTORY – CLIENT & FAMILY**

(Current/past conditions, treatment history, level of treatment, family history. Include all mental health services, hospitalizations, residential and day treatment, crisis services, case management, and psychological assessment. Describe most effective treatment and problems with treatment. Include dates, duration, precipitant, and provider contact if known )


6A. \_\_\_\_\_ Number of inpatient hospitalizations/ IMD stays in past year

**7. MEDICATIONS**

Include all current medications, name of prescriber and known allergies (per client report).  
 Include previous medications and OTC medications if relevant. Also note medication compliance issues.

<i>Psychotropic:</i>	
<i>Non-Psychotropic:</i>	

**7A. Medication Compliance** NA=not applicable, client not on medications, ND=no data, 0=no problem, 1=inconsistent use/reminders needed, 2=somewhat non-adherent, 3=refusal or abuse of medications

Medication compliance	NA	ND	0	1	2	3
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**8. PSYCHOSOCIAL & FAMILY HISTORY**

*Family History*

*Cultural Identification (race, ethnicity, spirituality, sexual orientation)*

*Childhood (where, who reared/lived in house where grew up, important/traumatic events, school experience and performance, history of physical/sexual abuse, placement history)*

*Adolescence (school and activities, friendships/relationships, sexual experiences, traumas, leaving home, placement history)*

*Adulthood (military service, marriage/divorce, children, geographical changes, traumas, current relationship with family/significant others)*

*Aging Issues (retirement, grandchildren, support systems, sleep changes, losses)*

*Educational and Vocational history (first job, longest job, current structured activities, type of work, date/duration/agency/contact person/parents)*

**8A. Acculturation**

ND=no data, 0=no evidence, 1=minimal needs, 2=moderate needs, 3=severe needs

Language	ND	0	1	2	3	Identity	ND	0	1	2	3
Ritual	ND	0	1	2	3	Cultural stress	ND	0	1	2	3



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**9. MEDICAL HISTORY** (if physical done within last 12 months, please attach. If no physical, please complete)

A. Last Physical exam: \_\_\_\_\_ By whom/where: \_\_\_\_\_

B. Last dental exam: \_\_\_\_\_ By whom/where: \_\_\_\_\_

Date and results of most recent PPD or chest X-ray, with PPD history: \_\_\_\_\_

Results read by whom/where: \_\_\_\_\_

Treatment (if applicable): \_\_\_\_\_

Allergies:  Food: \_\_\_\_\_  Medications: \_\_\_\_\_  Other: \_\_\_\_\_  N/A

C. Relevant Medical History (complete checklist and comment below):

General Information: Weight Changes \_\_\_\_\_ Baseline Weight (if able to obtain) \_\_\_\_\_ BP \_\_\_\_\_

Cardiovascular/Respiratory:  Chest Pain  Hypertension  Hypotension  Palpitation  Smoking

Genital/Urinary/Bladder  Incontinence  Nocturia  Frequency  Retention  Urgency  
 Urinary Tract Infection

Gastrointestinal/Bowel:  Heartburn  Diarrhea  Constipation  Nausea  Vomiting  
 Ulcers  Laxative Use  Incontinence

Nervous System:  Headaches  Dizziness  Seizures  Memory  Concentration

Musculoskeletal:  Back pain  Stiffness  Arthritis  Mobility/Ambulation

Gynecology:  Pregnant  PID  Menopause  TBILOC

Skin:  Scar  Lesion  Lice  Dermatitis  Cancer

Endocrine:  Diabetes  Thyroid  Other: \_\_\_\_\_

Respiratory:  Bronchitis  Asthma  COPD  Other \_\_\_\_\_

Other:  Significant Accident/Injuries/Surgeries: \_\_\_\_\_

Hospitalizations: \_\_\_\_\_

Physical Disabilities: \_\_\_\_\_

Chronic Illness: \_\_\_\_\_

HIV disease: \_\_\_\_\_

Liver disease: \_\_\_\_\_

If Yes above, please describe \_\_\_\_\_

\_\_\_\_\_

D. Significant family medical history \_\_\_\_\_



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**10. MENTAL STATUS**

A) Attitude, B) Appearance, C) Movement, D) Speech, E) Affect F) Mood, G) Thought process/content, H) Insight/judgment, I) Memory and orientation, J) S/H ideation, K) Intelligence, L) Hallucinations/illusions


**11. DSM IV DIAGNOSIS**

Axis	Code	Description	Check if principal
Axis I: Clinical disorders (include substance abuse dx)			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
Axis II: Personality & Developmental disorders			<input type="checkbox"/>
			<input type="checkbox"/>
Axis III: Physical disorders			
Axis IV: Psychosocial and Environmental Problems (1-9)			
Axis V: GAF (0-100)			

**12. CLINICAL IMPRESSION, RECOMMENDATION, DISPOSITION**

(including medical necessity, hypothetical reasons/context for presenting problem, disposition):


Diagnosis made by Interviewer?  Yes  No    Specify other LPHA and date diagnosis made: \_\_\_\_\_

**13. SIGNATURES:**

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

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

\_\_\_\_\_  
 LPHA Signature



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## Specialty Modules – complete only if directed

### TRAUMA MODULE

ND=no data, 0=no evidence, 1=history, mild, 2=moderate, 3=severe

	Sexual abuse	ND	0	1	2	3
	Physical abuse	ND	0	1	2	3
	Emotional abuse	ND	0	1	2	3
	Medical trauma	ND	0	1	2	3
	Natural disaster	ND	0	1	2	3
	War affected	ND	0	1	2	3
	Terrorism affected	ND	0	1	2	3
	Witness to family violence	ND	0	1	2	3
	Witness to community violence	ND	0	1	2	3
	Victim/Witness – criminal acts	ND	0	1	2	3

### Adjustment to trauma

ND=no data, 0=no evidence, 1=history / sub-threshold, watch/prevent,  
 2=causing problems consistent with diagnosable disorder, 3=causing severe problems

	Affect Regulation	ND	0	1	2	3
	Intrusions	ND	0	1	2	3
	Attachment	ND	0	1	2	3
	Traumatic Grief/ Separation	ND	0	1	2	3
	Re-experiencing	ND	0	1	2	3
	Avoidance	ND	0	1	2	3
	Numbing	ND	0	1	2	3
	Dissociation	ND	0	1	2	3



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**EMPLOYMENT/VOCATIONAL/CAREER MODULE**

ND=no data, 0=no evidence, 1=history, mild, 2=moderate problems, 3=severe problems

	Job attendance	ND	0	1	2	3
	Job performance	ND	0	1	2	3
	Job relations	ND	0	1	2	3
	Career aspirations	ND	0	1	2	3
	Job time	ND	0	1	2	3
	Job skills	ND	0	1	2	3

**DEVELOPMENTAL NEEDS/INTELLECTUAL FUNCTIONING MODULE**

ND=no data, 0=no evidence, 1=history / sub-threshold, watch/prevent 2=causing problems consistent with diagnosable disorder, 3=causing severe problems

	Cognition	ND	0	1	2	3
	Communication	ND	0	1	2	3
	Developmental	ND	0	1	2	3

**DANGER TO SELF/OTHERS MODULE**

**Emotional Behavioral Risks**

ND=no data, 0=no evidence, 1=history, mild, 2=moderate, 3=severe

Frustration management	ND	0	1	2	3	Paranoid thinking	ND	0	1	2	3
Hostility	ND	0	1	2	3	Secondary gains from anger	ND	0	1	2	3
Violent thinking	ND	0	1	2	3						

**Resiliency factors regarding danger to self/other**

ND=no data, 0=Significant resiliency factor present 1=Moderate level of resiliency factor present, 2=Mild level of resiliency factor present 3=Resiliency factor not present

Aware of violence potential	ND	0	1	2	3	Commitment to self-control	ND	0	1	2	3
Response to consequences	ND	0	1	2	3	Treatment involvement	ND	0	1	2	3



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**SEXUALLY AGGRESSIVE BEHAVIOR MODULE**

ND=no data, 0=no evidence, 1=history, mild, 2=moderate, 3=severe

	Relationship	ND	0	1	2	3
	Physical force/threat	ND	0	1	2	3
	Planning	ND	0	1	2	3
	Age differential	ND	0	1	2	3
	Type of sex act	ND	0	1	2	3
	Response to accusation	ND	0	1	2	3

**CRIMINAL BEHAVIOR MODULE**

ND=no data, 0=no evidence, 1=history, mild, 2=moderate, 3=severe

	Seriousness	ND	0	1	2	3
	History	ND	0	1	2	3
	Arrests	ND	0	1	2	3
	Planning	ND	0	1	2	3
	Community safety	ND	0	1	2	3
	Legal compliance	ND	0	1	2	3
	Peer influences	ND	0	1	2	3
	Environmental influences	ND	0	1	2	3

**SUBSTANCE USE MODULE**

(indicate current/past, amt consumed, frequency, duration, treatment received, family history)

ND=no data, 0=no evidence, 1=history / sub-threshold, watch/prevent

2=causing problems consistent with diagnosable disorder, 3=causing severe problems

	Severity of use	ND	0	1	2	3
	Duration of use	ND	0	1	2	3
	Stage of recovery	ND	0	1	2	3
	Peer influences	ND	0	1	2	3
	Environmental influences	ND	0	1	2	3