



**SFDPH Clinical Documentation Tools:
Assessment & Clinical Formulation Prompts (from DHCS and BHS)**

What is an Assessment?

In Specialty Mental Health Services (SMHS), an assessment is a service activity we conduct to determine if the client meets medical necessity for our services.

How Does Title 9 Define an Assessment? (CCR Title 9, §1810.204)

“Assessment” means a service activity designed to evaluate the current status of a beneficiary’s mental, emotional, or behavioral health. Assessment includes but is not limited to one or more of the following: mental status determination, analysis of the beneficiary’s clinical history; analysis of relevant cultural issues and history; diagnosis; and the use of testing procedures.”

What are DHCS’ 11 Required Elements for an Assessment? (MHP Boilerplate Contract 2013-2018)

1. Presenting Problem: Describe the client’s presenting complaint and history. You must include the current level of functioning and symptoms. Also address any relevant family history and current family information.
2. Relevant Mental Health Conditions and psychosocial factors: Describe the factors that affect the client’s physical health and mental health including, as applicable; living situation, daily activities, social support, cultural and linguistic factors, and history of trauma or exposure to trauma;
3. Mental Health History: Describe the client’s prior treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data such as previous mental health records and relevant psychological testing or consultation reports.
4. Medical History: Describe the relevant physical health conditions reported by the beneficiary or a significant support person. Include name and address of current source of medical treatment. For children and adolescents the history must include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports
5. Medications: Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. The assessment must include documentation of the absence or presence of allergies or adverse reactions to medications and documentation of an informed consent for medications;
6. Substance Exposure/Substance Use: Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter drugs, and illicit drugs
7. Client Strengths: Documentation of the beneficiary’s strengths in achieving client plan goals related to the beneficiary’s mental health needs and functional impairments as a result of the mental health diagnosis
8. Risks: Situations that present a risk to the beneficiary and/or others, including past or current trauma
9. A mental status examination: A mental status examination
10. A Complete Diagnosis: A diagnosis from the current ICD-code must be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data; including any current medical diagnoses
11. Additional clarifying formulation information, as needed: Additional clarifying formulation (clinical/diagnostic formulation) information, as needed



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CYF Assessment Prompts for Client Aged 0 -4

1. **[Presentation]** Describe the client's current presentation (include symptoms, behaviors, onset, duration, severity and family response to current situation):
2. **[Impact on Functioning]** Describe impact of the mental health problem on self-care, home, pre-school and community. Please note whether the impairments are due to symptoms/behavior of the included DSM-5 diagnosis:
3. **[Relevant History]** Describe the precipitating events and other significant life events leading to current situation (e.g., caregiver divorce, immigration, level of acculturation-assimilation, losses, moves, social changes, financial difficulties):
4. **[Cultural Factors]** Describe the cultural factors which may influence presenting problems as viewed by child/youth/parent/caregiver and clinician (may include ethnicity, race, religion, spiritual practice, sexual orientation, caregiver SES, living environment):
5. **[Risk Behaviors]** Describe aggressive-violent behavior to self/others. Include the level of impairment impact on child's functioning in home, in day care/preschool, and in other community settings (e.g., school suspension, law enforcement/incarceration, crisis services and hospitalization). Describe any self-harming behaviors (e.g., head banging, or expressed thoughts, e.g., I hate myself; I want to die). Identify the date of onset; Self-destructive/suicidal behavior/danger to self (include level of impairment [e.g., ideation, plan, threats, attempts/gestures, crisis services, hospitalization]):
6. **[Substance Abuse]** Describe any substance/alcohol abuse (specify onset, type-including tobacco and caffeine), frequency and amount, and level of impairment (e.g., missing work/school, law enforcement/incarceration, family's level of concern and attempts to intervene):
7. **[Child Strengths & Supports]** Describe the client's individual strengths and supports. Also identify the family's strengths and needs:
8. **[Caregiver Strengths & Needs]** Describe family and community supports AND caregiver and foster caregiver strengths/needs:
9. **[Foster Caregiver]** Describe the foster caregiver's strengths:
10. **[Psychiatric History]** Obtain information on past treatment, including the Psychiatric provider, reason for treatment, date of treatment and outcome (was it helpful and why):
11. **[Current Medical]** Obtain Medical Provider type, name, phone number and the date any past records were requested:
12. **[Alternative Healing]** Obtain Alternative Healing provider name, reason for treatment, date of treatment and outcome (was it helpful and why):
13. **[Current Medications]** Provide the name, dosage, date started, date of last dose, effectiveness/side effects, and prescriber. Is a medication evaluation needed? Does the client follows a medication regimen as directed?
14. **[Medical History]** Describe past/current illnesses and medical conditions (including previous hospitalization), allergies. Identify the date of last physical exam and last dental exam:
15. **[Developmental History Risk Factors & Abuse/Trauma History]** Describe significant events in prenatal/birth/early childhood stages, as well as enduring or pervasive developmental or cognitive difficulties. Describe any abuse history (include type, age, and details of any neglect, and/or physical, sexual, and emotional abuse):
16. **[Abuse/Trauma]** Describe abuse history (include type, age, and details of any neglect, and/or physical, sexual, and emotional abuse):
17. **[Formal Service]** Obtain past/current involvement with and staff names for Special Educational Services, HSA, Court Ward, Probation Officer, AB3632, FIT, FMP, CSOC:



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18. **[Care Intensity & Organization]** Describe the level of intensity of services needed and as well as supports for access (e.g., transportation):

19. **[Mental Status Exam]** What is the client's current mental status (document clinical observations that address the appropriateness of client's appearance, response to situation, ability to regulate, motor functioning, language, expression, play, cognition and relatedness. Rate CANS items. (orientation, appearance, behavior, relatedness, level of alertness, speech, abnormal movements. Include a description of mood, affect, thought flow, thought content, delusions, hallucinations, intellectual functioning, insight/judgement, other mental status findings:



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CYF Assessment Prompts for Client Aged 5 - 18

1. **[Presentation]** Describe the client's current presentation (include symptoms, behaviors, onset, duration, severity and family response to current situation):
2. **[Impact on Functioning]** Describe the impact on self-care, home, school and community. Please note whether the impairments are due to symptoms/behavior of the included DSM-5 diagnosis:
3. **[Relevant History]** Describe the precipitating events and other significant life events leading to current situation (e.g., divorce, immigration, level of acculturation-assimilation, losses, moves, social changes, financial difficulties);
4. **[Cultural Factors]:** Describe the cultural factors which may influence presenting problems as viewed by child/youth/parent/caregiver and clinician (may include ethnicity, race, religion, spiritual practice, sexual orientation, caregiver SES, living environment):
5. **[Risk Behaviors]** Describe aggressive-violent behavior to others[(include level of impairment (e.g., school suspension, law enforcement/incarceration, crisis services and hospitalization)]; Describe self-destructive/suicidal behavior/danger to self (include level of impairment [e.g., ideation, plan, threats, attempts/gestures, crisis services, hospitalization]):
6. **[Substance Abuse]** Describe substance/alcohol abuse (specify onset, type-including tobacco and caffeine), frequency and amount, and level of impairment (e.g., missing work/school, law enforcement/incarceration, family's level of concern and attempts to intervene):
7. **[Child Strengths]** Describe the child's strengths and supports as well as the family strengths and needs:
8. **[Caregiver Strengths]** Describe the caregiver's strengths:
9. **[Foster Caregiver]** Describe the foster caregiver's strengths:
10. **[Psychiatric History]** Obtain information on past treatment, including the Psychiatric provider, reason for treatment, date of treatment and outcome (was it helpful and why);
11. **[Current Medical]** Obtain Medical Provider type, name, phone number and the date any past records were requested;
12. **[Alternative Healing]** Obtain Alternative Healing provider name, reason for treatment, date of treatment and outcome (was it helpful and why);
13. **[Current Medications]** Obtain current medication name, dosage, date started, date of last dose, effectiveness/side effects, and prescriber. Will the client need a medical evaluation? Does the client follow a medication regimen?
14. **[Medical History]** Describe past/current illnesses and medical conditions (including previous hospitalization), allergies. Identify the date of last physical exam and last dental exam;
15. **[Developmental History]** Describe significant events in prenatal/birth/early childhood stages, as well as enduring or pervasive developmental or cognitive difficulties. Describe significant events in prenatal/birth/early childhood stages, as well as enduring or pervasive developmental or cognitive difficulties. Describe significant events in latency stage (peer/sibling relations, extracurricular activities, delinquency):
16. **[Abuse/Trauma]** Describe any abuse history (include type, age, and details of any neglect, and/or physical, sexual, and emotional abuse):
17. **[Formal Service]** Obtain past/current involvement with and staff names for HSA, Court Ward, Probation Officer, Special Education, AB3632, FIT, FMP, CSOC;



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18. **[Mental Status Exam]** What is the client's current mental status (orientation, appearance, behavior, relatedness, level of alertness, speech, abnormal movements)? Include Mood, affect, thought flow, thought content, delusions, hallucinations, intellectual functioning, insight/judgement, other mental status findings:



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A/OA Assessment Prompts for Long Form

1. **[Presenting Problem]** Describe the presenting problem: (a) identifying info; (b) criteria to justify DSM dx including symptoms, behavior, impairments in functioning, duration, frequency and severity; (c) impact on life/behavior leading to the client to seek services; (d) client's chief goal; (e) cultural explanation problem/illness in client's own words (if EPSTD, state why child/youth will not progress developmentally as individually appropriate without treatment). If this is continued treatment, include the rationale (current/continuing symptoms, behaviors and/or impairments in functioning justifying current diagnoses, medical necessity and continued need for treatment.):
2. **[Risk Assessment]** Risk Assessment Narrative: Describe 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. **[Psychosocial and Family History and Relevant Conditions Affecting Physical and Mental Status]** Describe the client's living situation, family, employment, activities, social support immigration, physical health, etc. Make sure you identify how these impact the mental health diagnosis. Describe cultural Identification (race, ethnicity, spirituality, sexual orientation). Identify key events from childhood (where/who reared/lived in house where grew up, important/traumatic events, school experience and performance history of physical/sexual abuse, placement history) and adolescence (school and activities, friendships/relationships, sexual experiences, traumas, leaving home, placement history):
4. **[Mental Health History of Client & Family]** Obtain information on current/past conditions, treatment history, level of treatment, family history. Describe most effective treatment and problems with treatment. Include dates, duration, precipitant, and provider contact if known. Include all mental health services, hospitalizations, residential and day treatment, crisis services, case management, and psychological assessment. Obtain the number of PES Visits/Crisis Services/Inpatient Hospitalizations/IMD stays in the past year :
5. **[Substance Use]** Describe substance used (include alcohol, tobacco and caffeine as well as illicit, prescribed and over the counter drugs, if any). Has anyone annoyed/gotten on client's nerves by telling them to cut down/stop? Has client been waking up wanting to use? Has client felt she/he should cut down or stop using? Has client felt guilty/bad about how much she/he uses?:
6. **[Medical History & Physical Health Conditions]** Obtain information on last physical exam (and provider information), last dental exam (and provider information), dates/results of most recent PPD/chest x-ray/who read, with PPD history. Describe current treatment (if applicable). Describe allergies (include food, medications and other):
7. **[Medications]** Include all medications, name of prescriber and known allergies (per client report). Include previous medications and OTC medications if relevant. Also note medication adherence issues. Include both Psychotropic and Non-psychotropic:
8. **[Criminal Justice History]** Describe involvement with and types of incidents. Include dates, types of crimes/incidents of violence, involvement in parole/probation; and history of incarceration, if any. :
9. **[Mental Status Exam]** Mental Status Exam: (a) attitude; (b) appearance, (c) movement, (d) speech; (e) affect; (f) mood; (g) thought process/content, (h) insight/judgement, (i) memory and orientation, (j) suicidal/homicidal ideation, (k) intelligence, (l) hallucinations/illusions:



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CYF Prompts for Clinical Formulation

1. Your clinical formulation will include hypothetical reasons/context for presenting problems; if applicable, include any relevant cultural factors
2. Note any parent/guardian behaviors that contribute to infant/child presenting problems or impairments.
3. Describe target symptoms/focus of treatment (hypothetical reasons/context for presenting problems; if applicable, include any relevant cultural factors)
4. Describe Impairments and their relationship to symptoms
5. Describe interventions used and how they have reduced the impairment or symptoms (ONLY FOR UPDATES-- not clearly indicated)
6. Interventions to be used now, and why?

A/OA Prompts for Clinical Formulation

1. You will provide a clinical formulation, recommendation and disposition
2. Provide your current clinical information, hypothetical reasons/context for presentation problem that supports your recommendation for treatment with modality and frequency.
3. If assessment is an annual update, include client's progress to response to treatment plan objectives:

CYF and A/OA Prompts for P-I-R-P Format Progress Notes

1. Problem (focus of session)
2. Intervention (consistent with client's current status/plan of care goals)
3. Response (to intervention/progress toward POC)
4. Plan (plan changes, referrals, discharge planning)