CHILDREN'S
UNIFORM MENTAL HEALTH ASSESSMENT

Child's Name:	**Guardian Name:**
Child's DOB:	**Parent(s)/Caregiver(s) Names:**
Assessing Program:	**Address:**
Assessing Agency: NNCAS	
Assessment Date:	**Telephone Numbers:**
Revision Date:	**Home:**
Assessing Professional:	**Cell:**
Professional Title:	**Work:**

MODULE 1: PRESENTING CONCERNS

I. Reason For Seeking Services *(in their own words)* Indicate reporter(s):

Parent/Caregiver/Guardian Reason for Seeking Services :

Child Reason for Seeking Services :

Referral Source Reason for Seeking Services :

Describe symptoms reported per Level 1 Cross-Cutting Symptom Measures as appropriate and administer Level 2 Cross-Cutting Scales as needed. (Forms at www.psychiatry.org/dsm5)

Complete the following symptom checklists:

Does the child manifest persistent disruptive behaviors sufficient to jeopardize home or school placement?

- ☐ Impulsive verbal outbursts
- ☐ Constant challenging of authority
- ☐ Requires total attention
- ☐ Wanders the house at night
- ☐ Fails to respond to limit setting/discipline
- ☐ None of these
- ☐ Excessive non-compliance
- ☐ Requires constant supervision in activities
- ☐ Jealous of caregivers relations w/others
- ☐ Excessive truancy
- ☐ Other *(specify)*

If other, specify:

Comment:

Has the child exhibited bizarre or unusual behavior in the last 90 days?

☐ Fire-setting
☐ Excessive, compulsive self-stimulating behavior
☐ Hallucinations (including alcohol/drug)
☐ None of these
☐ Cruelty to animals
☐ Excessive/compulsive self-injury behavior
☐ Other *(specify)*

If other, specify: _____

Comment: _____

Does the child experience any sleeping problems? ☐ Yes ☐ No

Select all that apply:

☐ Falling asleep ☐ Staying asleep ☐ Early awakening ☐ Loss of consciousness
☐ Nightmares ☐ Night terrors ☐ Sleep walking ☐ Not applicable

If yes, where does the child fall asleep and what is used to help sleep (TV, parent, video, radio, bottle, pacifier, other)?

_____

Does the child experience: ***(select all that apply)***

☐ Appetite control problems ☐ Bladder incontinence ☐ Bowel incontinence ☐ Not applicable

Describe the child's general strengths: _____

MODULE 2: CURRENT SITUATION

II. Safety Concerns

1. Has the child been a danger to others?

   ☐ Assaultive toward others
   ☐ Other *(specify)*
   ☐ Sexual assault, molestation, or attempt
   ☐ None of these

   If other, specify: _____

   Comment: _____

2. Has the child been a danger to self? ☐ Yes ☐ No If yes, specify below:
   Reckless, puts self in danger. ☐ Yes ☐ No If yes, explain:

   Suicide Ideation (*Verbal or Written*): ☐ Yes
   When? _____
   Why? _____
   Duration: _____

Suicide Plan: ☐ Yes

When? _____

Why? _____

Specificity? _____

Courage to carry out? _____

Preparation to make attempt? _____

Available means to carry out plan? _____

Giving away possessions? _____

Suicide Gesture: ☐ Yes

When? _____

Why? _____

Suicide Attempt: ☐ Yes

When? _____

Why? _____

How? _____

Access to Firearms: ☐ Yes ☐ No If yes, explain: _____

Other: ☐ Yes ☐ No If other, specify: _____

Safety Concerns General/Update Comments: _____

III. Family and Home Environment

1. With whom does the child live? _____

If foster home:

a. How long has the child lived in your home? _____
b. How many beds are you licensed for? _____
c. Do you intend to bring more children into your home? ☐ Yes ☐ No

2. As a family/caregiver, what strengths and positive influences do you find in your current living arrangement/relationships? _____

3. What is the child's current living situation, physical arrangements, others living in the home?

a. Has the child been homeless in the past 30 days? ☐ Yes ☐ No

4. How would you characterize the child's relationships and interactions with the family/caregivers, siblings, and/or others living in the home? _____

5. What stressors can you identify in your current family's living arrangement/relationships? _____

6. In what social/recreational activities or hobbies does the child engage? _____

7. Are there any social/recreational activities or hobbies the family does together? _____

8. Do you have any personal, religious, spiritual or cultural practices or beliefs that you want taken into account when working with you and your child? _____

9. Is there anything else you would like us to know? _____

Family and Home Environment General/Update Comments: _____

MODULE 3: HISTORY

IV. Child's Developmental History

Mother's Health During Pregnancy/Birth:

1. **In the three months before pregnancy**, did the mother use any alcohol, tobacco, drugs, or prescribed medications? ☐ Yes ☐ No ☐ Unknown ☐ Probable

   If yes, specify. If probable, explain. _____

2. **During the pregnancy**, did the mother continue to use alcohol, tobacco, drugs, or prescribed medications?

   ☐ Yes ☐ No ☐ Unknown ☐ Probable

   If yes, specify. If probable, explain. _____

3. **Did the mother:** *(select all that apply)*

   ☐ Have a routine pregnancy
   ☐ Have a complicated pregnancy
   ☐ Med/Emotional problems during pregnancy
   ☐ Have an Rh factor incompatibility
   ☐ Receive medications to ease labor pain
   ☐ Unknown

If complicated, explain. _____

_____

_____

If medical or emotional, explain. _____

_____

_____

List medications used: _____

_____

4. **Mother's age at time of child's birth?** _____
5. **Was the child born on schedule?** ☐ Yes ☐ No ☐ Unknown
   Was the child born on schedule comments: _____

   _____
6. **What was the duration of labor (in hours)?** _____
7. **Was the delivery:**
   ☐Normal ☐Induced ☐Breech ☐Vacuum Extraction ☐Cesarean ☐Unknown ☐Forceps
8. Any health complications for mother following the birth: ☐ Yes ☐ No
   If yes, describe:

   _____

Mother's Health During Pregnancy/ Birth General/Update Comments: _____

_____

Child's Post Natal Health:

9. Following birth, did the baby have any immediate health problems? ☐ Yes ☐ No
   If yes, describe: _____

   _____
10. Any problems during infancy regarding: *(select all that apply)*
    ☐ Feeding ☐ Colic ☐ Excessive crying
    ☐ Sleep pattern difficulties ☐ Infant responsiveness ☐ Activity levels
    ☐ Other health concerns ☐ No unusual problems during infancy ☐ Unknown
    If other health concerns, describe: _____

    _____

    _____

Child's Milestones

11. **At what age did the child:** *(enter in months)*

Begin to sit up? _____ Sit Up Attained: ☐ Yes ☐ No	Use single words?*(e.g., "mama", "dada")* _____ Single Words Attained: ☐ Yes ☐ No
Begin to crawl? _____ Crawl Attained: ☐ Yes ☐ No	String two or more words together? _____ String Two Words Together Attained: ☐ Yes ☐ No
Begin to walk? _____ Walk Attained: ☐ Yes ☐ No	Toilet trained *(bowel)*? ☐ Yes ☐ No How long did it take? _____
	Toilet train *(bladder)?* ☐ Yes ☐ No How long did it take? _____

Comment: _____

_____

For the client's age group, check all symptoms that apply:

0-18 months:

- ☐ Excessive crying
- ☐ Cannot be consoled by caregiver
- ☐ Other *(specify)* _____
- ☐ Arching/stiffening when held or touched
- ☐ Needs assistance to initiate/maintain sleep
- ☐ None of these

Comment: _____

18-36 months / Any of the above, plus

- ☐ Extremely destructive, dangerous behavior
- ☐ Persistent, intentional aggression
- ☐ Excessive, persistent self-stimulating behavior
- ☐ Challenging / does not follow directions
- ☐ None of these
- ☐ Excessive frequent tantrums
- ☐ Excessive/persistent self-injury behavior
- ☐ Absence of fear or awareness of danger
- ☐ Other *(specify)* _____

Comment: _____

3-5 years / Any of the above, plus

- ☐ Unintelligible speech
- ☐ Doesn't play, interact with peers
- ☐ Clear loss of previously attained skills
- ☐ None of these
- ☐ Excessively withdrawn
- ☐ Unusual eating patterns or non-food items
- ☐ Other *(specify)* _____

Comment: _____

12. How would you rate the child regarding his/her:

	Excellent	Good	Fair*	Poor*
Hearing	☐	☐	☐	☐
Vision	☐	☐	☐	☐
Gross motor coordination	☐	☐	☐	☐
Fine motor coordination	☐	☐	☐	☐
Speech articulation	☐	☐	☐	☐
Emotional regulation	☐	☐	☐	☐
Sensory Integration	☐	☐	☐	☐

*Describe any difficulties: _____

Child Developmental History General/Update Comments: _____

V. Trauma History

1. Has the child experienced any of the following stressful events? *(select all that apply)*
   - ☐ Family divorce/separation
   - ☐ Death in a close relationship
   - ☐ Family move
   - ☐ Unknown
   - ☐ Family accident or illness
   - ☐ Parent or caregiver job change
   - ☐ Family financial problems
   - ☐ Death in the family
   - ☐ Child changes schools
   - ☐ Other significant event

   Describe, including how long ago: _____

2. Has the child ever feared that she/he will be injured or killed?
☐ Yes ☐ No ☐ Unknown If yes, describe: _____

3. Has the child ever feared that a family member or anyone else will be injured or killed?
☐ Yes ☐ No ☐ Unknown If yes, describe: _____

4. Has the child had a history of accidents or repeated accidents?
☐ Yes ☐ No ☐ Unknown If yes, describe: _____

5. Has the child ever been bullied at home, school, in the neighborhood or on social media?
☐ Yes ☐ No ☐ Unknown If yes, describe: _____

6. Has the child experienced or been exposed to extreme, violent behaviors?
☐ Physical abuse victim ☐ Witnessed physical abuse ☐ Sexual abuse victim
☐ Witnessed sexual abuse ☐ Domestic violence victim ☐ Witnessed domestic violence
☐ Other *(specify)* ☐ None of these
If other, specify: _____

Describe, including how long ago: _____

Trauma History General/Update Comments: _____

VI. Medical History

1. How would you characterize the child's general medical condition? _____

2. Does the child have: *(select all that apply)*
☐ Asthma ☐ Allergies ☐ Diabetes
☐ Heart problems ☐ Obesity ☐ Seizures
☐ Other chronic health problems ☐ No chronic health problems
If other, please describe: _____

3. When was the child's last physical examination? _____

Results? _____

4. Are the child's immunizations current? ☐ Yes ☐ No ☐ Unknown
   If no, explain: _____
5. Does the child see a doctor regularly? ☐ Yes ☐ No ☐ Unknown
   If yes, describe: _____
6. Has the child ever been hospitalized for a medical condition? ☐ Yes ☐ No ☐ Unknown
   If yes, how often, for what condition, duration and outcome? _____

   Describe and include any previous surgeries: _____
7. Has the child ever had an accident or injury resulting in: *(select all that apply)*
   ☐ Head trauma ☐ Headaches ☐ Blurred vision
   ☐ Loss of consciousness ☐ Not applicable ☐ Unknown
8. Any other medical or physical issues regarding the child that should be noted? ☐ Yes ☐ No
   If yes, describe: _____
9. Any medical or physical issues regarding the child's family/caregivers that should be noted? ☐ Yes ☐ No
   If yes, describe: _____

Medical History General/Update Comments: _____

VII. Substance Abuse History

1. Does the child have a current/past history of substance use? ☐ Yes ☐ No ☐ Unknown

   (select all that apply)

   ☐ Alcohol ☐ Barbiturates ☐ Tranquilizers
   ☐ Caffeine ☐ Nicotine ☐ Amphetamines
   ☐ Cocaine ☐ Methamphetamine ☐ Ecstasy
   ☐ Heroin/opium ☐ Morphine ☐ Methadone
   ☐ LSD ☐ Mescaline ☐ PCP
   ☐ Marijuana ☐ Hashish ☐ Other: _____

   Describe frequency and duration (Clinician consider using substance use screening tool):
2. Have there been any legal/other consequences of the child's substance abuse?
   ☐ Yes ☐ No ☐ Not Applicable
   If yes, describe:

3. Do the child's family/caregivers have a current/past history of substance abuse?
☐ Yes ☐ No ☐ Unknown
Identify family member role(s) and details including treatment outcomes. _____

4. Have there been any legal/other consequences of family/caregiver substance abuse?
☐ Yes ☐ No ☐ Not Applicable
If yes, describe: _____

5. Has the child had any alcohol or substance abuse treatment, to include: *(select all that apply)*
☐ Medications management ☐ Alcoholics/Narcotics Anonymous ☐ Outpatient care
☐ Inpatient care ☐ Not applicable
Outcomes? _____

6. Has the client used any tobacco product in the past 30 days?
☐ Yes ☐ No ☐ Unknown

7. Has the client used alcohol in the past 30 days?
☐ Yes ☐ No ☐ Unknown

8. Did the client begin using illicit prescription drugs in the past 30 days?
☐ Yes ☐ No ☐ Unknown

9. If the client received prescription drug misuse treatment, was there a significant reduction or no further use?
☐ Yes ☐ No ☐ Not Applicable

10. Did the client begin using marijuana in the past year?
☐ Yes ☐ No ☐ Unknown

11. If the client received treatment for marijuana use, was there a significant reduction or no further use?
☐ Yes ☐ No ☐ Not Applicable

VIII. Child's Sexual History

1. Has the child reached puberty? ☐ Yes ☐ No ☐ Unknown

2. Has the child expressed a particular sexual orientation? ☐ Yes ☐ No ☐ Unknown
If expressed: _____

3. Has the child given any signs that they identify with a gender that is not consistent with their biological sex?
☐ Yes ☐ No ☐ Unknown

4. Is the child sexually active? ☐ Yes ☐ No ☐ Unknown
If yes, describe, including health safety issues: _____

5. Has the child received sex education? ☐ Yes ☐ No ☐ Unknown
If yes, describe: _____

6. Has the child ever engaged in any inappropriate sexual behavior? ☐ Yes ☐ No ☐ Unknown

If yes, describe: _____

Child's Sexual History General/Update Comments: _____

IX. Child's Legal History

1. Has the child ever been or involved with: *(select all that apply)*
   - ☐ Detained/arrested by law enforcement
   - ☐ On parole/probation/court supervision
   - ☐ None applicable
   - ☐ Gone to Court/Juvenile Master
   - ☐ Detention/County/State Training School
2. Does your family have current or past involvement with the Child Welfare System? ☐ Yes ☐ No
   Comment: _____
3. Does your child have an assigned social worker? ☐ Yes ☐ No
   Name: _____ Telephone: _____
4. Does your child have an assigned probation officer? ☐ Yes ☐ No
   Name: _____ Telephone: _____
5. DWI or DUI arrest for youth? ☐ Yes ☐ No If yes, how many? _____

Child's Legal History General/Update Comments: _____

X. Mental Health History

1. Has the child received any mental health services to include the following? *(select all that apply)*
   - ☐ Therapeutic foster plcmnt
   - ☐ Crisis intervention
   - ☐ Peer support
   - ☐ Treatment home
   - ☐ Day treatment
   - ☐ Psychosocial rehab
   - ☐ Inpatient care
   - ☐ Emergency shelter
   - ☐ Outpatient treatment
   - ☐ Basic skills training
   - ☐ Family support
   - ☐ Other

   Identify Other: _____

   Note when occurred, duration and outcome: _____
2. Has the child ever received a mental health diagnosis? ☐ Yes ☐ No ☐ Unknown
   If yes, describe: _____
3. Has the child had psychological testing in the past? ☐ Yes ☐ No ☐ Unknown
   What tests, when, results/scores: _____

4. Has the child ever been prescribed medications(s) for psychological, emotional or behavioral problems?
☐ Yes ☐ No ☐ Unknown If yes, describe below:

Medication	Psychotropic	Non-Psychotropic	Dosage Form	Frequency	Start Date	End Date	Prescribing Physician

5. Describe any history of mental health diagnoses and treatment for family members, including the outcome of treatment:

General/Update Comments:

XI. Child's Education History and Current Status

1. Describe the child's educational strengths and resources:
2. List daycare, preschools, schools attended:
3. Child's current grade level:
4. Describe how the child is currently functioning academically:
5. Describe the child's behaviors in school and abilities/difficulties in getting along with teachers/principals:
6. Describe the child's ability to get along with classmates:

Has the child: *(check all that apply)*

7. ☐ Been asked to leave daycare/preschool? ☐ Yes ☐ No
Reason:
8. ☐ Repeated any grades? ☐ Yes ☐ No
Reason:

9. ☐ Received special tutoring? ☐ Yes ☐ No
Reason and results: _____

10. ☐ Been suspended from school? ☐ Yes ☐ No
How often/reasons: _____

11. ☐ Had any involvement or incidents with school system law enforcement? ☐ Yes ☐ No
How often/reasons: _____

12. ☐ Been expelled from school? ☐ Yes ☐ No
Reason: _____

13. ☐ Been in special education program? ☐ Yes ☐ No
Duration: _____

14. ☐ Attended learning disabilities class, behavioral emotional disorder class, Resource room, Speech/Language therapy, other? ☐ Yes ☐ No
Description: _____

15. ☐ A current IEP/504? ☐ Yes ☐ No

16. ☐ Had psychological testing in school? ☐ Yes ☐ No
If yes, what tests, when, results/scores: _____

Child's Education History and Current Status General/Update Comments: _____

MODULE 4: MENTAL HEALTH ASSESSMENT

XII. Current Mental Health Status

Appearance	☐ Appropriate ☐ Unkempt Other:	☐ Neat ☐ Disheveled	☐ Bizarre ☐ Other *(specify)*	
Behavior	☐ Appropriate ☐ Rigid ☐ Decreased expression ☐ Psychomotor retardation Other:	☐ Loud ☐ Domineering ☐ Provocative ☐ Uncooperative	☐ Slumped ☐ Tense ☐ Accelerated expression ☐ Restless	☐ Soft spoken ☐ Submissive ☐ Suspicious ☐ Other *(specify)*
Mood	☐ No impairment ☐ Hopeless ☐ Anxious ☐ Labile ☐ Elated Other:	☐ Fearful ☐ Angry ☐ Inappropriate ☐ Depressed ☐ Sad	☐ Apprehensive ☐ Hostile ☐ Blunted ☐ Mood swings ☐ Other *(specify)*	

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Perception	☐ No impairment ☐ Auditory hallucinations ☐ Delusions ☐ Distorted thinking ☐ Other type of hallucinations *(specify)* Other:	☐ Magical thinking ☐ Paranoia ☐ Visual hallucinations ☐ Grandiosity
Intelligence Functioning	☐ No Impairment ☐ Blackouts ☐ Seizures	*Impaired:* ☐ Abstract thinking ☐ Attention Span ☐ Concentration ☐ Conscious ☐ Intelligence
Orientation	☐ No Impairment	*Disoriented to:* ☐ Person ☐ Place ☐ Time ☐ Other *(specify)*:
Insight	☐ Acknowledgement of problem ☐ Minimizing	☐ Blaming others ☐ Other *(specify)*:
Judgment	☐ Intact	*Impaired to:* ☐ Make reasonable decisions ☐ Manage daily activities
Memory	☐ No Impairment	*Impaired:* ☐ Immediate Recall ☐ Recent ☐ Remote ☐ Other *(specify)*:
Thinking	☐ No impairment ☐ Obsessions ☐ Confused ☐ Thought flow decreased ☐ Ideas of influence Other:	☐ Ideas of reference ☐ Compulsions ☐ Suicidal ideation ☐ Depersonalization ☐ Homicidal ideation	☐ Associational disturbance ☐ Phobias ☐ Delusions ☐ Thought flow increase ☐ Other *(specify)*

Current Mental Status General/Update Comments: _____

_____

_____

_____

_____

_____

XIII. Summary and Recommendations

1. Clinician summary of assessment findings and identification of current family strengths and needs:

2. Summary of family/caregiver and child expectations for intervention and anticipated outcomes:

3. Clinical recommendations regarding treatment approach:

4. Discharge Planning: