KidConnections
Initial Mental Health Assessment- Assessment for Intervention Report
(Infant Toddler 0-24months)

Child’s Name ___________________________ Parent/Caregiver Name: ___________________________
Birthday: __/__/_________ Age: ___________ Adjusted Age___________
Date of the assessment: __/__/_________ Unicare #: ______________

Referral source:

☐ Family Court  ☐ Family Wellness Court  ☐ DDTC  ☐ DR ☐ Path 1  ☐ Path 2
☐ HRIF  ☐ IND  ☐ Kidscope  ☐ SARC  ☐ Pediatrician
☐ Early Start  ☐ Head Start  ☐ F5 Parent Workshop  ☐ F5 FRC  ☐ Head Start Non-PoP

Referring Person: ___________________________ Referrer Agency/School: ___________________________
Referrer Phone: ___________________________ Referrer E-Mail: ___________________________

Identifying Information and History:
Client description, referral reason, referral source
Family Members, Significant Individuals

Cultural Factors and Linguistic Considerations:
(e.g. ethnicity, immigration, language, religion, sexual orientation, etc. and ways these may influence treatment)

Presenting Concerns: (mental health/behavioral issues, developmental issues, current symptoms, stressors)
Mental Health History:
(onset, symptoms, previous treatment)
Risk Factors:

Psychosocial History:
Pregnancy history (planned, desired, expectations, believes, habits, complications):
Birth (labor, complications, hospitalization, diagnosis, prognosis, evolution, recovery, medical surveillance, trauma)
APGAR, hearing test, vision
Child Development: (developmental milestones) Exploring/interest
Abuse History
Parental Substance Abuse History
Previous Placement History (i.e., foster care, hospitals, relatives)
Family History/Caregivers
Educational information

Medical History:
Pediatrician Name: ___________________________ Phone #: ___________________________
Fax #: ___________________________
Significant medical problems or concern (by history)
Current medical problems/concerns
Allergies
Dietary Restrictions/Modifications
Medication/hospitalization
Nutritional Needs

Child and Family Strengths:
KidConnections
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Results of Screening Tools:

ASQ: C __/cut off: ___ GM ___/cut off: ___ FM ___/cut off: ___ PS ___/cut off: ___ S ___/cut off: ___.
ASQ-SE: ___/cut off: ___.
CBCL: ________________________________

Behavioral Observations

<table>
<thead>
<tr>
<th></th>
<th>Okay</th>
<th>Possible Concern</th>
<th>Concern</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temperament and character</td>
<td></td>
<td></td>
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<tr>
<td><strong>Physical Regulation</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>(Changes in State, Coloration, Muscle tone, Reflexes, Positioning, Sleeping, Feeding, Digestion, Breathing, Crying, Mouthing, Temperature Regulation)</td>
<td></td>
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<td></td>
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<tr>
<td>Eye gaze</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Exploring/ interest</td>
<td></td>
<td></td>
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<tr>
<td>Attention and concentration</td>
<td></td>
<td></td>
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<tr>
<td><strong>Emotional Regulation</strong></td>
<td></td>
<td></td>
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<tr>
<td>(Facial expression, Level of arousal, Activity, Alertness)</td>
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<tr>
<td>Attachment</td>
<td></td>
<td></td>
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<tr>
<td><strong>Affect, Mood and Preferences:</strong> (pleasure, distress, self soothing)</td>
<td></td>
<td></td>
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<tr>
<td><strong>Engagement Capacities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(communication, vocalization, social behavior, play)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of play (toddlers)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thought (toddlers)</td>
<td></td>
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<td></td>
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<tr>
<td>Autonomy and development of self (toddlers)</td>
<td></td>
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<td></td>
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<tr>
<td>Learning rules (toddlers)</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Attunement with primary caregiver</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Parent-child, physical connection and touch</td>
<td></td>
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</tr>
</tbody>
</table>
KidConnections
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Child’s Name ___________________ Parent/Caregiver Name: ___________________
Birthday: __ / __ / _____ Age: __________ Age: __________ Adjusted Age: ___________
Date of the assessment: __ / __ / _____ Unicare #: __________________

<table>
<thead>
<tr>
<th>Caregiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sense of mastery reading</td>
</tr>
<tr>
<td>infant cues</td>
</tr>
<tr>
<td>Sense of mastery meeting</td>
</tr>
<tr>
<td>infant basic needs, confidence</td>
</tr>
<tr>
<td>in parental role</td>
</tr>
<tr>
<td>Affection/ empathy</td>
</tr>
<tr>
<td>Facial expressions</td>
</tr>
<tr>
<td>Parent Emotional state</td>
</tr>
<tr>
<td>Social Support</td>
</tr>
<tr>
<td>Rhythm of Interactions</td>
</tr>
<tr>
<td>Affective flow</td>
</tr>
<tr>
<td>Parenting style</td>
</tr>
<tr>
<td>Level of stimulation of child</td>
</tr>
</tbody>
</table>

Mental Health Comments/Conclusions: (optional)

Interpretation of Scores/Conclusions:
Date of Screening:
Screening provided in:
☐ English ☐ Interpreter assisted in:
☐ Spanish ☐ Vietnamese ☐ Other:

Screening Tools
☐ Brigance Infant Toddler Screen                                      ☐ Observation of child
☐ Speech/Language Screen                                               ☐ Interview with
☐ Motor Screen                                                          ☐ Chart Review of ASQ and ASQ:SE scores
☐ Sensory Processing Screen                                            ☐ Edinburgh Depression Scale
☐ Other: _____________________ ☐ Parent Stress Index

Santa Clara County Mental Health Department
KidConnections Network of Care
Initial Mental Health Assessment
October 2015 MHD QI - Form #39

Program (Cost Center)_________________
Child's Name: ____________________________
Parent/Caregiver Name: _______________________
Birthday: __ / __ / __________
Date of the assessment: __ / __ / __________
Age: ___________  Adjusted Age: ___________
Unicare #: ______________________

**Developmental Screening Results**

<table>
<thead>
<tr>
<th></th>
<th>Okay</th>
<th>Possible Concern</th>
<th>Concern</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receptive Language / Communication under 18 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expressive Language / not used under 18 months</td>
<td></td>
<td></td>
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<tr>
<td>Muscle tone, reflexes,</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Gross motor skills (arm and leg movements)</td>
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<td></td>
<td></td>
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<tr>
<td>Fine motor skills (hand and finger movements)</td>
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<tr>
<td>Self help skills</td>
<td></td>
<td></td>
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<tr>
<td>Sensory Processing (self-regulation &amp; response to environment)</td>
<td></td>
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</tbody>
</table>

*CNS = Could Not Screen  *NS = Not Screened

**Comments:**

Communication

Motor

Sensory Processing

**Oral Peripheral Check:**

Observation of oral structures

Comments:

- □ Tonsils
- □ Teeth
- □ Tongue
- □ Palate

**Integrated Mental Health and Developmental Summary:**

**Areas of concern emerging from Assessment for Intervention:**

- □ Affect
- □ Autism spectrum
- □ Engagement
- □ Motor development
- □ Self regulation
- □ Attention
- □ Behavior
- □ Family system
- □ Parent / child interaction
- □ Anxiety
- □ Cognition and learning
- □ Health
- □ Parenting
- □ Social skills
- □ Attachment
- □ Concentration
- □ Mood
- □ Self care
- □ Temperament

Santa Clara County Mental Health Department
KidConnections Network of Care
Initial Mental Health Assessment
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## KidConnections
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<thead>
<tr>
<th>Birthday:</th>
<th>Age: ___________ Adjusted Age___________</th>
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Date of the assessment: | Unicare #: |
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</tbody>
</table>

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### Trauma

- [ ] Speech / language delay
- [ ] Vision / hearing
- [ ] No concerns

### Other:

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### Recommendations /Strategies for Continued Successful Development and Referrals:

<table>
<thead>
<tr>
<th>Anticipatory guidance</th>
<th>Dental</th>
<th>Early Start Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing</td>
<td>Home visitation</td>
<td>Targeted Diagnostic Assessment</td>
</tr>
<tr>
<td>Parent education</td>
<td>PHP</td>
<td>Preschool</td>
</tr>
<tr>
<td>SARC</td>
<td>School District:</td>
<td>Therapeutic services</td>
</tr>
<tr>
<td>Vision</td>
<td>__________________</td>
<td></td>
</tr>
</tbody>
</table>

### Other:

---

### Consultants/Participants:

- [ ] (MH Clinician)
  - Title, phone
  - Rosa Gonzalez
    - Bilingual Educator
    - (408) 243-7861 Ext. 246
  - Desiree Q Luong
    - Bilingual Educator
    - (408) 243-7861 Ext. 248
  - Mayra Arango
    - Bilingual Early Childhood Educator
    - (408) 243-7861 Ext. 240

- [ ] Rosie MacFarlane B.A. C.C.I. Permit
  - Bi-Lingual Preschool Resource Teacher
  - (408) 243-7861 RExt. 222

- [ ] Maggie Newman, MA, OTR/L
  - Occupational Therapist
  - (408) 243-7861 Ext.221

**Date of Report: ______________**
Child's Name: ____________________  Parent/Caregiver Name: ____________________
Birthday: __ / __ / __  Age: __________ Adjusted Age: __________
Date of the assessment: __ / __ / __  Unicare #: __________

This page is for internal KidScope documentation purposes only. PLEASE do not attach this page to the preceding report which is an effort to give families and service providers appropriate and user-friendly information.

### Medical Necessity Criteria

Have at least one of the following impairments as a result of a mental health disorder: A) A significant impairment in an important area of life functioning; B) A reasonable probability of significant deterioration in an important area of life functioning; C) Except as provided in Section 1830.210, a reasonable probability a child will not progress developmentally as individually appropriate. For the purpose of this Section, a child is a person under the age of 21 years.

Check all that apply:

<table>
<thead>
<tr>
<th>Area</th>
<th>Brief Description of Impairment (if checked)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health (e.g., physical condition, activities of daily living)</td>
<td></td>
</tr>
<tr>
<td>Daily Activities (e.g., work, school, leisure)</td>
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</tr>
<tr>
<td>Social Relationships (e.g., significant other, family, friends, support system)</td>
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<tr>
<td>Living Arrangement (e.g., homeless, maintaining current housing situation)</td>
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</tbody>
</table>

### DC 0-3 R Diagnosis (when applicable/appropriate)

<table>
<thead>
<tr>
<th>Axis</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Axis I</td>
<td></td>
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<tr>
<td>Axis II</td>
<td></td>
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<tr>
<td>Axis III</td>
<td></td>
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<tr>
<td>Axis IV</td>
<td></td>
</tr>
<tr>
<td>Axis V</td>
<td>Emotional and Social Functioning</td>
</tr>
</tbody>
</table>
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Diagnosis Summary

The name of the disorder according to DSM 5 classification followed by the numerical ICD-10 code and description.
Example: (Primary) DSM 5: Major Depressive Disorder, Moderate. ICD-10: F33.1, Major depressive disorder,
recurrent, moderate.

Each diagnosis must be stated clearly and legibly, and primary and secondary diagnosis (if applicable) must be
identified. Please follow the State guidelines for primary and secondary diagnoses for mental health clients. (Please
note that each diagnosis given and documented in this section must be substantiated and supported by symptoms,
behaviors, and functional impairments in the assessment form under the appropriate sections, usually under
presenting problems and medical necessity.)

Person completing Assessment:

_________________________________ ________                         _____
Signature                                     Discipline                          Date

Review/Approval by Licensed Professional of the Healing Arts (if different from above):

_________________________________ ________                         _____
Signature                                     Discipline                          Date