Name: **Medicaid ID #:** **Chart #:**

Self Assessment CCA-Part 1

Date: _____

General Health/Medical Information

Primary Care Physician Name: _____ Primary Care Practice Name: _____

Telephone number: _____

Are you pregnant? ☐ Yes ☐ No ☐ NA If yes, how many weeks: _____

If yes, OBGYN name: _____ Are you receiving prenatal care? ☐ Yes ☐ No

Have you ever been diagnosed with any of the following (if yes, please provide date of diagnosis):

Hepatitis B	☐ Yes ☐ No Date: _____	Tuberculosis (TB)	☐ Yes ☐ No Date: _____
Hepatitis C	☐ Yes ☐ No Date: _____	Diabetes	☐ Yes ☐ No Date: _____
Hepatitis D	☐ Yes ☐ No Date: _____	Head Injury	☐ Yes ☐ No Date: _____
HIV	☐ Yes ☐ No Date: _____		

Do you use tobacco? ☐ Yes ☐ No Are you interested in stopping? ☐ Yes ☐ No ☐ NA

Have you lost or gained a lot of weight recently? ☐ Yes ☐ No

Comments _____

_____

_____

Social History (family and other natural supports)

Marital Status
☐ Single ☐ Married ☐ Separated
☐ Widowed ☐ Domestic Partners ☐ Divorced

How many children do you have?
☐ 1 ☐ 2 ☐ 3
☐ 4 ☐ 5 ☐ 6+

Describe your current housing situation
☐ stable ☐ unstable/at risk of homelessness
☐ homeless

Who lives with you?

Please check anyone in your immediate *biological* family who has a mental illness or substance abuse issue:
☐ Mother ☐ Father ☐ Child
☐ Maternal Grandmother ☐ Paternal Grandmother ☐ Aunt
☐ Maternal Grandfather ☐ Paternal Grandfather ☐ Uncle

Describe how supportive your family and friends are of you being treated for a mental illness or substance abuse problem?
☐ Everyone is supportive ☐ Some are supportive ☐ Nobody is supportive
☐ I have no family or friends to speak of

Describe your involvement with church or other religious activities.
☐ Attend regularly, is a source of strength for me ☐ Attend once in awhile ☐ Never attend

Please check any areas of concern that may apply:

☐ Family rift ☐ Death of a loved one / close friend ☐ Divorce
☐ Emotional abuse ☐ Physical Abuse ☐ Separation
☐ Sexual abuse

Comments _____

_____

_____

Educational, Employment, and Military History

Highest grade completed _____ If employed, what type of work? _____

Please check all that apply:

☐ Frequent suspensions from school ☐ Unemployed ☐ Military Service
☐ Bullying others ☐ Difficulty keeping employment ☐ Family member in the military
☐ Being bullied by others ☐ On disability ☐ Combat experience
☐ Difficulty learning new concepts/ideas ☐ Wounded in combat
☐ Diagnosed learning disability
☐ IEP/504 plan

Comments _____

Name: **Medicaid ID #:** **Chart #:**

Legal History ☐ No Legal History, this is a strength for me (Please skip this Section)

Please check all that apply:

☐ Open/active court cases	What are the charges?	_____
☐ Currently scheduled for court?	Court Date	_____
☐ On probation	Until when?	_____
☐ Spent time in prison/jail	How long?	_____
☐ Under legal pressure to attend this program.		

Arrest History (what were you arrested for)	**Number of arrests**	**Most recent arrest date**
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

Comments _____

_____

_____

Please indicate any areas of concern or stress

Personal or Relational

- ☐ Sadness/Depression
- ☐ Crying spells
- ☐ Little or no interest in doing things
- ☐ Trouble falling asleep or staying asleep
- ☐ Sleeping too much
- ☐ Feeling tired or having little energy
- ☐ Poor appetite
- ☐ Overeating / eating too much
- ☐ Trouble focusing
- ☐ Feeling down about yourself or worthless
- ☐ More fidgety
- ☐ Moving more slowly than usual
- ☐ Grief/mourning following a loss
- ☐ Anger / Difficulty controlling temper
- ☐ Feeling alone
- ☐ Feeling anxious, nervous, fearful or scared
- ☐ Feeling guilty often
- ☐ Medical Problems
- ☐ Money trouble
- ☐ Problems with co-workers
- ☐ Thoughts of harming yourself
- ☐ Thoughts of harming others
- ☐ Alcohol or drug problems
- ☐ Sexual addiction
- ☐ Sexual concerns
- ☐ Trouble making everyday decisions
- ☐ Hearing things others don't hear
- ☐ Seeing things others don't see
- ☐ Feeling like people are out to get you
- ☐ Hard time getting along with others
- ☐ Intense moods and mood swings
- ☐ Panic Attacks
- ☐ Weight changes
- ☐ Eating concerns
- ☐ Body image concerns
- ☐ Spiritual / Religious issues
- ☐ Nightmares or distressing dreams
- ☐ Memories of a traumatic event
- ☐ Avoiding people, places or things that remind you of a painful event

Life adjustments

- ☐ Divorce or Separation
- ☐ Newly married/Remarried
- ☐ Blended family
- ☐ New baby
- ☐ Single parent
- ☐ New relationship
- ☐ Recent move/new school

Family

- ☐ Constant arguments
- ☐ Physical violence in home
- ☐ Custody/visitation issues
- ☐ Disagreements regarding parenting
- ☐ Child Defiance / Disobedience
- ☐ Abuse of a child
- ☐ Neglect of a child
- ☐ Communication problems
- ☐ Cheating on spouse/partner

Comments _____

_____

Mental Health Symptoms

☐ **Depression:** ☐ tearfulness ☐ sleep (too much or little) ☐ irritability ☐ fatigue ☐ weight gain/loss ☐ difficulty concentrating ☐ hopelessness ☐ worthlessness ☐ increase/decrease in appetite ☐ NA

Describe (include severity and duration): _____

☐ **Mania:** ☐ increased energy ☐ irritability ☐ racing thoughts ☐ euphoria ☐ overconfidence ☐ recklessness ☐ NA

Describe (include severity and duration): _____

☐ **Anxiety:** ☐ restlessness ☐ fatigue ☐ irritability ☐ tension ☐ worrying ☐ difficulty concentrating ☐ sleep disturbance ☐ NA

Describe (include severity and duration): _____

☐ **Psychosis:** ☐ delusions ☐ hallucinations ☐ disorganized speech ☐ disorganized or catatonic behavior ☐ affective flattening/alogia/avolition ☐ other negative symptoms ☐ NA

Describe: _____

Name: **Medicaid ID #:** **Chart #:**

☐ **Trauma:** ☐ re-experience of traumatic event ☐ avoids reminders of event ☐ emotional numbing ☐ detachment from others ☐ difficulty staying/falling asleep ☐ hypervigilance ☐ irritability/anger ☐ guilt/shame ☐ NA
Describe: _____

☐ **Obsessions:** ☐ recurrent & persistent thoughts/impulses/images ☐ seen as intrusive or inappropriate ☐ cause anxiety ☐ attempts to suppress/neutralize ☐ recognized as self-created (not delusional) ☐ intrusive/time consuming ☐ disrupts routine/functioning ☐ NA
Describe: _____

☐ **Compulsions:** ☐ repeated behaviors/mental acts ☐ "driven" to perform behaviors/acts ☐ intended to reduce stress or prevent another outcome ☐ not connected to stressor ☐ intrusive/time consuming ☐ disrupts with routine/functioning ☐ NA
Describe: _____

☐ **Borderline Personality:** ☐ frantic efforts to avoid abandonment ☐ intense/unstable relationships ☐ unstable self-image ☐ potentially harmful impulsivity (2+ areas) ☐ recurrent suicidal behaviors/gestures/threats ☐ mood lability ☐ chronic feelings of emptiness ☐ intense/inappropriate anger ☐ transient, stress-related paranoia/dissociation ☐ NA
Describe: _____

☐ **Inattention:** ☐ fails to pay attention/makes careless mistakes ☐ disorganized ☐ easily distracted ☐ does not seem to listen ☐ does not follow instructions ☐ poor follow-through on tasks ☐ forgetful ☐ loses things ☐ avoids/dislikes activities that require focus ☐ symptoms present before age 7 ☐ symptoms present in 2 or more settings ☐ NA
Describe: _____

☐ **Hyperactivity/Impulsivity:** ☐ talks excessively ☐ leaves seat ☐ runs and climbs ☐ always "on the go" ☐ fidgets w/ hands/feet ☐ hard to play quietly ☐ subjective feelings of restlessness (teens/adults) ☐ blurts out answers ☐ interrupts others ☐ difficulty waiting turn ☐ symptoms present before age 7 ☐ symptoms present in 2 or more settings ☐ NA
Describe: _____

☐ **Oppositional/Defiant Behaviors:** ☐ temper ☐ angry ☐ resentful ☐ argumentative ☐ intentionally annoying ☐ easily annoyed ☐ defies rules ☐ spiteful ☐ blames others ☐ aggression toward people/animals ☐ destruction of property ☐ NA
Describe: _____

☐ **Other Mood/Personality Symptoms**: _____

Mental Health/Substance Abuse History/Treatment/Recovery

Substance Abuse History

☐ No alcohol or substance use - past and present (skip this section)

Substances Used (Indicate both past and present use)

	Substance Name	Age first used	Route	Frequency	Last Use	Average/day
1st	_____		☐ oral ☐ smoking ☐ inhale ☐ inject ☐ other	☐ no use past month ☐ 1-3x/past month ☐ 1-2x/week ☐ 3-6x/week ☐ daily		
2nd	_____		☐ oral ☐ smoking ☐ inhale ☐ inject ☐ other	☐ no use past month ☐ 1-3x/past month ☐ 1-2x/week ☐ 3-6x/week ☐ daily		
3rd	_____		☐ oral ☐ smoking ☐ inhale ☐ inject ☐ other	☐ no use past month ☐ 1-3x/past month ☐ 1-2x/week ☐ 3-6x/week ☐ daily		

Name: **Medicaid ID #:** **Chart #:**

4th	_____		☐ oral ☐ smoking ☐ inhale ☐ inject ☐ other	☐ no use past month ☐ 1-3x/past month ☐ 1-2x/week ☐ 3-6x/week ☐ daily		

Abuse / Dependence Checklist (indicate if present)

Present	Indicate #	Abuse Symptoms (1 or more required)	Present	Indicate #	Dependence Symptoms (3 or more required)
☐		Failure to fulfill role obligations	☐		Evidence of Tolerance
☐		Use in physically dangerous situations	☐		Evidence of withdrawal (explain in comments)
☐		Recurrent Legal Problems	☐		Use in larger amounts or over longer period of time than intended
☐		Continued use despite social problems	☐		Unsuccessful efforts to cut down
			☐		Spends large amounts of time to get substance or recover from use
			☐		Social, occupational, recreational activities given up or reduced due to use

Withdrawal Symptoms (List both withdrawal symptoms in history and current withdrawal symptoms e.g. shakes, nausea, vomiting, sensitivity to light, headache, body aches, DTs, seizure activity, etc.)

Comments (may include current/past patterns of use, periods of sobriety etc)

☐ No previous alcohol or substance treatment history (skip this section)

Type of Treatment/Facility	When?	Treated for	Beneficial
	_____		☐ Yes ☐ No
	_____		☐ Yes ☐ No
	_____		☐ Yes ☐ No
	_____		☐ Yes ☐ No

MH/SA Treatment Summary: (include relevant details about treatment history, response to past treatments, factors that have contributed to or inhibited previous recovery efforts Include attitude about recovery over time))

Treatment Team history (Results of most recent Team Meetings? Are the correct people involved? What goals have they been working toward?)

☐ No treatment team history.

Name: **Medicaid ID #:** **Chart #:**

Current Medication Plan:

☐ No current medications (skip this section)

Current medications	Dosage	Regimen	# of months	Compliant?
			_______	☐ Yes ☐ No
			_______	☐ Yes ☐ No
			_______	☐ Yes ☐ No
			_______	☐ Yes ☐ No
			_______	☐ Yes ☐ No
			_______	☐ Yes ☐ No
			_______	☐ Yes ☐ No
			_______	☐ Yes ☐ No
			_______	☐ Yes ☐ No
			_______	☐ Yes ☐ No
			_______	☐ Yes ☐ No
			_______	☐ Yes ☐ No
			_______	☐ Yes ☐ No
			_______	☐ Yes ☐ No
			_______	☐ Yes ☐ No

Medical History:

Medical conditions? (chronological history of health issues, include any disease, major injury, major illness and hospitalizations)

☐ No remarkable health history beyond general illness

Date of Diagnosis/Tx	Medical Issue	Outcome
_______		☐Resolved ☐Unresolved ☐Chronic
_______		☐Resolved ☐Unresolved ☐Chronic
_______		☐Resolved ☐Unresolved ☐Chronic
_______		☐Resolved ☐Unresolved ☐Chronic
_______		☐Resolved ☐Unresolved ☐Chronic
_______		☐Resolved ☐Unresolved ☐Chronic
_______		☐Resolved ☐Unresolved ☐Chronic
_______		☐Resolved ☐Unresolved ☐Chronic
_______		☐Resolved ☐Unresolved ☐Chronic
_______		☐Resolved ☐Unresolved ☐Chronic
_______		☐Resolved ☐Unresolved ☐Chronic

Staff only ____

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