Cornerstone Behavioral Healthcare
Initial Co-Occurring Assessment

Client #
Provider

Client Name:	A.K.A.	Pronouns:	
DOB:	Date of Service:	Start Time:	End Time:

☐ Telehealth ☐ Telephonic

At time of Assessment, was the client located in Maine? ☐Yes ☐No

Type of Service

1. Therapy Individual/Group ☐
2. Substance Use ☐
3. Medication Management Adult/Child ☐
4. Case Management ☐
5. Medication Assisted Treatment (MAT) ☐
6. Opioid Health Home (OHH) ☐

Participants

Identifying Information

1. Gender: ☐Female ☐Male ☐Transgender ☐Non-binary ☐Other:
2. Living Arrangements (Live Alone, Live with Others, etc.):
3. Housing Adequate (Please explain housing situation & history):
4. What financial resources does the client utilize: ☐Disability ☐Food Stamps ☐HEAP ☐Housing ☐ Mainecare ☐Social Security
   Narrative:

Presenting Problem (*In client's own words*):

Family/Guardian Perception of Client Needs/History of Presenting Problem:

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Vocational History

1. Is the client regularly employed? ☐No ☐N/A ☐N/A Minor ☐Yes

Employment Narrative (F/T, P/T, Current Employer if applicable):

Employment History (Are they retired, Past employers if applicable):

Leisure Activities

Educational History

1. Is the client currently attending or enrolled in an educational program? ☐No ☐Yes
   Narrative:
2. Does the client have any learning disabilities or special education? ☐No ☐Yes
3. Highest Grade or Certification completed:

Spiritual/Cultural/Ethnic History

1. Clients spiritual/cultural/ethnic history:
2. Family spiritual/cultural/ethnic history:

Legal History

1. Any past legal issues? ☐ No ☐ Yes (describe):
2. Any current legal issues? ☐ No ☐ Yes (describe):

Military Service History

1. Current or past history? ☐ No ☐ Yes (describe):

Mental Health History

1. Has the client had the following?
   a. Therapy ☐ No ☐ Yes (describe):
   b. Medication Management ☐ No ☐ Yes (describe):
   c. Suicide Ideation/Behavior/Attempts ☐ No ☐ Yes (describe):

d. Self-Harm ☐ No ☐ Yes (describe):

e. Assault/Fighting/Bullying ☐ No ☐ Yes (describe):

f. Homicidal Ideation ☐ No ☐ Yes (describe):

2. Psychiatric Hospitalization? ☐ No ☐ Yes *(if yes, answer the sub-questions)*
   Please check either voluntary or involuntary: ☐Voluntary ☐Involuntary
   When & Where:

3. IOP/Day Programs? ☐ No ☐ Yes (describe):

4. Residential Treatment? ☐ No ☐ Yes (describe):

Physical Health History

1. Allergies? ☐ No ☐ Yes (describe & state reaction):

2. Any medical/ physical problems/disabilities? ☐ No ☐ Yes (describe):

3. Surgical procedures (please describe)? ☐ No ☐ Yes (describe):

4. Current Medications (*Direct-entry providers, enter on "Medical" tab in the note)*:

5. Any dental problems and date of last visit? ☐ No ☐ Yes (describe):

6. Does client have an Advance Directive? ☐ No ☐ Yes (describe):

7. Does client have a Surrogate Decision Maker? ☐ No ☐ Yes (describe):

8. **(*Case Management Only*)** If AMHI Consent Decree, does client have a Psychiatric Advanced Care Plan?

☐Y ☐N *(if no, offer an Advanced Plan)*

History of Substance Use & Other Addictions (*Direct-Enter providers, enter on "Substance Use" tab in the note*)

☐Client denies any substance usage or addiction

Narrative (drug or other addiction/duration/frequency of use/amount used/how it is used/any applicable consequences):

1. Has client ever received substance use treatment? ☐ No ☐ Yes (describe):
    a. For how long, and what are client's reactions or response to the treatment received?
2. **(*If applicable*)** Describe the client's experience with self-help groups (AA, NA, AI-non, etc.):
3. Has the client been affected by the alcohol & drug use of family members & others around client? ☐ No ☐ Yes (describe):

Current Providers

1. PCP Name *(if client does not have a PCP this is an unmet need and should be reflected on the treatment plan/service plan)*:
2. Specialist(s) Name:
3. Therapist Name:
4. Health Home Coordinator/Case Manager Name:
5. Dental Provider Name *(if client has no dental provider this is an unmet need and should be reflected on the treatment plan/service plan)*:

Developmental History

1. Client's place of birth (City/Town/State):
2. The client was raised by:
3. Approximate number of moves in lifetime:
4. Early Childhood Development: ☐Client uncertain ☐Normal developmental milestones from birth to 5yrs ☐Development delays (please explain):
5. Client's Parent(s) (Name, Location):
6. Client's Sibling(s) (Name, Location, Younger/Older): ☐ **N/A Only Child**

7. Relationship with each family member (Close/Conflicted/Contact Frequency) (If Genogram of Family of Origin was created, please scan):

8. Current Marital/Relationship Status & History:

9. If the client has children please list (Names, Ages, etc.):

Family of Origin Medical History (*diabetes, cancer, heart, asthma, thyroid etc*.)

1. Paternal: Identify family member(s) and health issues:

2. Maternal: Identify family member(s) and health issues:

Family of Origin Mental Health History (*bipolar, schizophrenia, etc.)*

1. Paternal: Identify family member(s) and diagnoses:

2. Maternal: Identify family member(s) and diagnoses:

Trauma & Abuse History

1. Sexual abuse (relationship/duration/severity/reported): ☐No ☐Offender ☐Victim ☐Witness ☐Declined to Answer
   Narrative:

2. Physical abuse (relationship/duration/severity/reported): ☐No ☐Offender ☐Victim ☐Witness ☐Declined to Answer
   Narrative:

3. Emotional abuse (relationship/duration/severity/reported): ☐No ☐Offender ☐Victim ☐Witness ☐Declined to Answer
   Narrative:

4. Neglect (relationship/duration/severity/reported): ☐No ☐Offender ☐Victim ☐Witness ☐Declined to Answer
   Narrative:

5. Has the client suffered a significant loss (if yes, please explain): ☐Yes ☐No ☐Declined to Answer
   Narrative:

6. Other trauma (i.e. military, medical, domestic violence, natural disasters, etc.): ☐ Yes ☐No ☐N/A
   Narrative:

Barriers to Treatment

☐None ☐Physical ☐Family Objections ☐Finances ☐Insurance Restrictions
☐Legal Restrictions ☐Transportation ☐Without Social Support ☐Work Schedule
☐Other Barriers:

Mental Health Status

1. Sleep (hours per night, etc.):
2. Appetite/Nutrition/Disordered Eating/Dietary Habits:
3. Energy Level: ☐High ☐Normal ☐Low
4. Suicidal: ☐Client Denies If yes, please explain:
5. Homicidal: ☐Client Denies If yes, please explain:
6. Appearance: ☐Casual Dress ☐Neatly Groomed ☐Appropriate to Season ☐Stated Age ☐Older ☐Younger ☐Disheveled ☐Unkempt ☐Inappropriate (describe if striking):
7. Behavior/Attitude: ☐WNL ☐Pleasant ☐Engaging ☐Cooperative ☐Guarded ☐Suspicious ☐Hostile ☐Hyperactive ☐Tics ☐Agitated ☐Restless ☐Uncooperative ☐Withdrawn ☐Submissive ☐Shy ☐Indifferent ☐Seductive ☐Evasive ☐Other (Please explain):
8. Eye Contact: ☐Good ☐Intermittent ☐Little ☐None
9. Speech: ☐Normal Rate/Volume/Rhythm ☐Loud ☐Soft ☐Halting ☐Pressured ☐Slurred ☐Nonverbal ☐Tics
10. Psycho motor Activity: ☐WNL ☐Slowed ☐Calm ☐Restless ☐Agitated
11. Mood: ☐WNL ☐Angry ☐Anxious ☐Changeable ☐Excited/Euphoric ☐Depressed ☐ Irritable ☐Grieving ☐Euthymic
12. Affect: ☐WNL ☐Reactive & Mood Congruent ☐Labile ☐Tearful ☐Blunted ☐ Flat
13. Psychological/ Perceptual disturbances: ☐None ☐Compulsions ☐Flashbacks ☐Hallucinations (visual, auditory, hypnagogic, hypnopompic) ☐Dissociations (depersonalization, de-realization, dissociative identities) ☐Nightmares ☐Phobias ☐Paranoid Ideation
14. Thought Processes: ☐Goal-directed & logical ☐Disorganized ☐Tangential ☐Looseness of association ☐Circumstantial ☐Other (describe):
15. Content of thought: ☐WNL ☐Helplessness ☐Hopelessness ☐Illogical ☐Poverty of Thoughts ☐Ruminations ☐Grandiose reasoning ☐Delusions (please describe):
16. Information & Intelligence is appropriate for age and education: ☐Yes ☐No
17. Orientation: ☐Person ☐Place ☐Time ☐Situation ☐Disoriented (please explain):
18. Concentration: ☐Able to concentrate & follow instructions (If no, please explain):
19. Memory: ☐WNL ☐Impaired ☐Short-Term ☐Long-Term ☐Other(explain):

20. Coordination: ☐WNL ☐Awkward ☐Clumsy ☐Tremors
21. Judgment and Insight: ☐WNL ☐Age appropriate ☐Limited ☐Impaired ☐Impulsive ☐Other (explain):
22. Reliability (clinician's perception): ☐Fair ☐Good ☐Poor

Crisis & Risk Assessment

1. Client at risk to harm self or others: ☐No ☐Yes
2. Please rate your client's risk from 1-No risk to 10-high risk. **Please explain any rating 2 or above**.
3. Does client need Crisis Intervention Services at this time: ☐No ☐Yes
4. Does the client have, need or require a Crisis Plan at this time: ☐No ☐Yes
5. Was the client given Crisis/Wabanaki Care Line/Warm Line numbers: ☐No ☐Yes

Strengths & Challenges

1. Client's Strengths (e.g. resilience, seeking help when necessary, good sense of humor, strong self-worth):
2. Client's Challenges (e.g. financial, trauma history, housing, low self-esteem, emotional dysregulation):

Support Systems & Resources

1. Family:
2. Friends:
3. Pets:
4. Community (includes professional or spiritual leaders):

Summary (*In provider's own words, include information regarding client's issues, any past services, needs and goals for treatment in therapy*):

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Diagnosis (*Direct-entry providers, use the "Diagnosis" tab*)
Primary:
Secondary & Other Diagnoses:
Does the client need additional assessments *(check all that apply)*: ☐Nutritional ☐Cognitive ☐Neurological ☐N/A ☐Other:
Recommendations & Care Planning *(Treatment Plan progression, etc.)*:

All questions must be answered in some manner. Please leave no blanks.	
Provider Signature	**Date**
Printed Name & Credentials	
Supervisor Signature (if needed)	**Date**