Cornerstone Behavioral Healthcare Acehelosu, a division of Cornerstone

Initial Co-Occurring Assessment

Client #
Provider

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

Type of Service:

1. Medication Assisted Treatment (MAT) ☐
2. Opioid Health Home (OHH) ☐

Participants

☐ Clinician
☐ Client
☐ DHHS Guardian (Identify :_____)
☐ Parent(s) (Identify :_____)
☐ Case manager (Identify :_____)
☐ Other (Please Explain):_____)

For Providers Notation only (just italicized section):

Provider reviewed the following clinical documentation with client and obtained clients signatures as needed.

☐ Consolidated Demo Consent Disclosure Attendance and Rights (Combined with BHHO) (HIPAA Documents, Client's Rights, Confidential Policy, Exception to confidentiality, Consent/Disclosure, and Attendance Policy)
☐ AC-OK/PHQ-9
☐ Release of Information
☐ PCP Release of Information
☐ Local Resources Handout
☐ LOCUS
☐ NFC
☐ ANSA
☐ CANS

Client provided legal documentation? (Custody, Probation, Etc.)
☐ Yes ☐ No ☐ N/A

Is client eligible for Telehealth Services? *☐ Yes ☐ No*
Did they complete the Telehealth Paperwork*? ☐ Yes ☐ No*

Identifying Information

1. Gender: ☐Female ☐Male ☐Transgender ☐Non-binary ☐Other
2. Living Arrangements: ☐Live Alone ☐With Others ☐Other (please explain):

If living with others, who:

3. Housing Adequate: ☐Yes ☐No
   If no, please explain:
4. What social services does the client utilize: ☐Disability ☐Food Stamps ☐HEAP ☐Housing ☐Maine Care ☐N/A ☐Other Services (please explain)

Vocational History

1. Is the client regularly employed? ☐Yes ☐No **☐N/A Minor**
   a. ☐Full-time ☐Part-time
   b. Client's current employer (name and length of employment):
2. Have you ever been employed? ☐ Yes ☐ No

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3. Are you retired? ☐ Yes ☐ No
4. At what age did the client start working?
5. Past employer(s) (Identify and Explain)

Who	How Long	Why did you leave

6. Leisure Activities
   a.
   b.

Educational History

1. Highest grade or degree completed & name of school:
2. Learning disabilities or special education (if yes, please explain) ☐Yes ☐No
3. Additional training/certificates (if applicable):
4. Additional Comments/Issues related to school:

Spiritual/Cultural/Ethnic History

a. Clients current spiritual beliefs:
b. Clients family beliefs:

Legal History ☐ **N/A Minor**

1. Was the client ever arrested/ charged? ☐ No ☐ Yes (describe):
2. Was the client ever convicted? ☐ No ☐ Yes (describe):
3. Current Legal Problems: ☐ No ☐ Yes (describe):
4. Custody, OUI, Name Change, Other: ☐ No ☐ Yes (describe):

Military Service History ☐ Yes ☐ No **(*if no, skip to next section*)** ☐ **N/A Minor**

1. **If yes answer the following:** *(These may be helpful to ask: deployments, war related injuries, impact of military life on the family, etc.)*
   a. What branch? ☐Air Force ☐Army ☐Coast Guard ☐Marine Corps ☐Navy
   b. Is the client on Active Duty? ☐ Yes ☐ No If yes, describe:
   c. Type and date of discharge (if applicable): ☐Honorable ☐General ☐Other Than Honorable ☐Bad Conduct Discharge ☐Dishonorable
   d. Other information:

Mental Health History

1. Has the client had the following? (If yes, please explain your answers)
   a. Therapy ☐Yes ☐No
   b. Medication Management ☐Yes ☐No
   c. Suicide Ideation/Behavior/Attempts ☐Yes ☐No
   d. Self-Harm ☐Yes ☐No
   e. Assault/Fighting/Bullying ☐Yes ☐No
   f. Homicidal Ideation ☐Yes ☐No
   g. Depression/ Anxiety ☐Yes ☐No
2. Was client hospitalized? ☐Yes ☐No
   a. If yes, please explain when and where:
   b. ☐Voluntary ☐Involuntary
   c. ☐IOP ☐Day Programs

Medical or Physical History

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1. Any medical/ physical problems (Le. diabetes, cancer, heart, asthma, **allergies**, thyroid etc.)
2. Surgical procedures (please describe)
3. Tests, Labs, Consultation for medical-substance abuse-mental health (please identify)
4. Any dental problems? ☐Y ☐N (if yes, please explain)
5. Disability? ☐Y ☐N **(If yes, answer sub-questions)**
    a. Identify Type:
    b. Receiving disability compensation? ☐Y ☐N (If yes, describe):
6. Has client been discharged from any inpatient (medical or psychiatric) facility in past 30 days? ☐Y ☐N (If yes, answer sub-questions)
    a. Has medication list been reconciled? ☐Y ☐N
    b. Identify facility:
7. Does client have an Advanced Care Plan or Surrogate Decision Maker (medical power of attorney)? ☐Y ☐N **(If yes, answer sub-questions)**
    a. Who is the Surrogate Decision Maker?
    b. Where is the Advanced Care Plan?
    c. Was Advance Care Planning discussed and documented? ☐ Y ☐ N ☐Client did not wish to or was not able to discuss
8. **(*Case Management Only*)** If AMHI Consent Decree, does client have a Psychiatric Advanced Care Plan? ☐Y ☐N
    a. If yes, was the Advanced Plan discussed and documented in file? ☐Y ☐N (If no, please explain)

Current Medications (*Direct-entry providers, please use medications tab if entering electronically into PIMSY*)

Substance Use History (*Direct-Enter providers, please enter information on the "substance usage" tab in PIMSY*)

☐**Client denies any usage**

Drug	Start Date	End Date	Frequency of use	Amount used	How do they use
Caffeine					
Alcohol					
Marijuana, hashish, cannabis					
Cocaine/Crack					
Hallucinogens (LSD, MDA, Psilocybin, mushrooms, Ecstasy)					
Heroin					
Opioids/Synthetics					
Meth/methamphetamines, amphetamines (ICE, Dexedrine, crank, speed)					
Prescription meds					
Nicotine Products and/or					

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Tobacco					
Non-prescription methadone, PCP (Phencyclidine)					
Benzodiazepine (valium, Librium, tranxene)					
Other tranquilizers (Thora zine, Haldol)					
Barbiturates (Phenobarbital, secobarbital, pentobarbital)					
Other sedatives/hypnotics					
Inhalants (nitrites, Freon, glue, turpentine, paint thinner, vaping)					
Over-the-counter drugs					

Additional Comments:

1. Has client ever received substance use treatment (Clinician: please reference Completion of Treatment Guidelines COTG): ☐Yes ☐ No **(*if yes, answer the following sub-question*)**
    a. For how long, and what are client's reactions or response to the treatment received?
2. If Tobacco Products were used, was a brief (3 minutes or less) tobacco cessation counseling intervention provided? ☐Yes ☐ No
3. **(*If applicable*)** Describe the client's experience with self-help groups (AA, NA, AI-non, etc.)
4. Has the client been affected by the alcohol & drug use of family members & others around client? ☐Yes ☐ No (if yes, please describe)

Current Providers (*these are providers the client is currently seeing*)

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 Name (if applicable):
3. Therapist Name:
4. Health Home Coordinator/Case Manager/Level 1 BHHO/Other Name:
5. Dental Provider Name:
    a. Date of last service:

(if client has no dental provider this is an unmet need and should be reflected on the treatment plan/service plan)

Developmental History

1. Where is the client's place of birth? (City/Town/State)
2. The client was raised by: ☐Adopted Parents (If adopted, at what age?) ☐Biological Parents ☐Extended Family ☐Foster Parents ☐Other (Please explain)
3. Parents married? ☐Yes ☐No
4. Number of moves client made in life time? (if more than 10, please explain)
5. Early Childhood Development: ☐Client uncertain ☐Delivery difficult ☐Development delays ☐Normal

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developmental milestones from birth to 5yrs ☐Term baby ☐Other (please explain)

6. Client's siblings Name(s), Location(s) and Age(s): ☐ **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. What is the client's marital status: ☐ **N/A Minor**
   ☐Single, never married ☐ Widowed ☐Engaged (____) years ☐Married for (_____) years
   ☐Divorce in process (_____) months ☐Separated for (____) years ☐Divorced for (_____) years
   ☐Co-habiting for (____) years
   a. What is the client's marital history **(*if applicable*):** List Prior marriages: (Genogram if applicable and please scan)

9. Does the client have children: (Genogram of Nuclear Family as needed and please include to be scanned) ☐Yes ☐No (if yes: names and ages) ☐ **N/A Minor**

10. Is client currently sexually active: ☐Yes ☐No **(*only answer sub questions if #10 was answered yes*)**
    a. Age of first sexual encounter?
    b. Was it consensual? ☐Yes ☐ No (if no, please explain)
    c. What is client's sexual orientation: ☐Bisexual ☐Heterosexual ☐Homosexual ☐Lesbian ☐ Other
    d. Libido: ☐ High level ☐ Moderate ☐ Low ☐ No desire
    e. Practice safe sex? ☐Yes ☐No

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

1. Paternal: Identify family member(s) and health issues (plus treatment, meds, response, etc.)

2. Maternal: Identify family member(s) and health issues (plus treatment, meds, response, etc.)

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

1. Paternal: Identify family member(s) and diagnoses (treatment, meds, response)

2. Maternal: Identify family member(s) and diagnoses (treatment, meds, response)

Trauma & Abuse History

1. Any sexual abuse (relationship/duration/severity): ☐No ☐Offender ☐Victim ☐Witness ☐Declined to Answer
2. Any physical abuse (relationship/duration/severity): ☐No ☐Offender ☐Victim ☐Witness ☐Declined to Answer
3. Any emotional abuse (relationship/duration/severity): ☐No ☐Offender ☐Victim ☐Witness ☐Declined to Answer
4. Any neglect (relationship/duration/severity): ☐No ☐Offender ☐Victim ☐Witness ☐Declined to Answer
5. Has client ever been in an accident (if yes, please explain): ☐Yes ☐No ☐Declined to Answer
6. Has the client seen someone injured or die (if yes, please explain): ☐Yes ☐No ☐Declined to Answer

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

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

Barriers to Treatment

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

Mental Health Status Questions

1. How many hours per night does the client sleep?
2. Does the client have: ☐Early Insomnia ☐Excessive Sleep ☐Middle Insomnia ☐Normal Sleep Patterns ☐Nightmares ☐Other (please explain):
3. How many times does the client wake up per night?
    a. Is it hard to fall asleep? ☐ Yes ☐No
    b. Is it hard to get back to sleep? ☐ Yes ☐No
4. Appetite, nutrition or dietary habits: (check any that apply)
   ☐Binge Eating ☐Vomiting after eating ☐Eating non-food items ☐Picky eater ☐Excessive caloric counting ☐Extreme fear of weight gain ☐Excessive laxative use ☐Loss of control with eating ☐Excessive exercise ☐Current unplanned weight loss/gain ☐Hiding eating habits ☐Current changes in appetite ☐Other:
    a. Client eats: ☐ One meal daily ☐Two meals daily ☐Three meals daily ☐No meals (please explain):
5. Energy Level: ☐High ☐Normal ☐Low
6. Suicidal/homicidal: ☐Client Denies ☐ Occasional Thoughts ☐Vague Plan ☐Serious Thoughts ☐Prior attempts ☐Ideation ☐Clear Plan ☐Means to Carry it Out ☐Intent ☐Specific Target
7. Appearance: ☐Casual Dress ☐Neatly Groomed ☐Appropriate to Season ☐Stated Age ☐Older ☐Younger ☐Disheveled ☐Unkempt ☐Inappropriate (describe if striking)
8. Behavior: ☐WNL ☐Pleasant ☐Engaging ☐Co-operative ☐Guarded ☐Suspicious ☐Hostile ☐Hyperactive ☐Tremors ☐Tics ☐Agitated ☐Restless ☐Other (please explain)
9. Eye Contact: ☐Good ☐Intermittent ☐Little ☐None ☐Changed during interview (please describe)
10. Speech: ☐Normal Rate/Volume/Rhythm ☐Loud ☐Soft ☐Halting ☐Pressured ☐Slurred ☐Nonverbal
11. Psycho motor Activity: ☐WNL ☐Slowed ☐Calm ☐Restless ☐Agitated
12. Attitude: ☐WNL ☐Cooperative ☐Submissive ☐Shy ☐Indifferent ☐Seductive ☐Guarded ☐Evasive ☐Hostile ☐Uncooperative ☐Agitated ☐Withdrawn
13. Mood, temperament and emotional function: ☐WNL ☐Angry ☐Anxious ☐Changeable ☐Excited/Euphoric ☐Depressed ☐Irritable ☐Grieving ☐Euthymic
14. Affect: ☐WNL ☐Reactive and mood congruent ☐Labile ☐Tearful ☐Blunted ☐ Flat ☐Unconstricted
15. Psychological/ Perceptual disturbances: ☐None ☐Compulsions ☐Flashbacks ☐Hallucinations (visual, auditory, hypnagogic, hypnopompic) ☐Dissociations (depersonalization, de-realization, dissociative identities) ☐Nightmares ☐Phobias ☐Paranoid Ideation
16. Thought processes: ☐WNL ☐Goal-directed and logical ☐Disorganized ☐Tangential ☐Looseness of association ☐Circumstantial ☐Other (describe)

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17. Content of thought: ☐WNL ☐Helplessness ☐Hopelessness ☐Illogical ☐Mood congruent ☐Poverty of Thoughts ☐Ruminations ☐Grandiose reasoning ☐Delusions (please describe)

18. Information and intelligence is appropriate for age and education: ☐Yes ☐No

19. Orientation to: ☐Person ☐Place ☐Time ☐Situation

    a. Able to concentrate and follow instructions: ☐Yes ☐No (If no, please explain)

    b. Disoriented ☐Yes ☐No (If yes, please explain)

20. Memory: (if other, please explain): ☐WNL ☐Impaired ☐Short-Term ☐Long-Term ☐Other

21. Coordination: ☐WNL ☐Fine motor skills ☐Awkward ☐Clumsy ☐Tics ☐Tremors

22. Judgment and Insight: ☐WNL ☐Realistic ☐Age appropriate ☐Limited ☐Impaired ☐Impulsive ☐Other (explain):

23. Reliability (clinician's perception): ☐Fair ☐Good ☐Poor

What brings you here today? (*In client's own words.*)

Crisis & Risk Assessment

1. Is the client at risk to harm self or others? ☐Yes ☐No
2. Please rate your client's risk from 1-No risk to 10-high risk. **Please explain any rating 2 or above**.
3. Is a Crisis Plan deemed necessary at this time ☐Yes ☐No
4. Was the client given Crisis number & warm line? ☐Yes ☐No
5. Is the client required to have a Crisis Plan? ☐Yes ☐No
    a. If yes, is it in the file and up-to-date? ☐Yes ☐No

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

1. Family:
2. Friends:

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3. Community (includes professional or spiritual leaders):
Summary (*In provider's own words, include information regarding client's issues, any past services, recommendations, needs and goals for treatment in therapy.*):
(*Case Management Only*) Second Summary for Level 1 BHHO Required Domains:
Domains include: Housing, Financial, Education, Supports (Family, Cultural, Gender, Recreational, Social, Peer Support), Transportation, Health Care (Dental, Eye Care, Hearing Health, Medical), Vocational, Legal, Living Skills, Substance Abuse
Diagnosis (*Direct-entry providers, please use the Diagnosis tab in PIMSY*)
Primary:
Secondary:
Modality Type ☑ Information Gathering Only and Establishing Rapport
(*Case Management Only*) LOCUS & Level of Care
1. LOCUS Date:
2. Composite Score:
3. Level of Care:
Stages of Change for Primary Diagnosis
☐Not Applicable ☐Pre-contemplation ☐Contemplation ☐Preparation ☐Action ☐Maintenance ☐Termination
All questions must be answered in some manner. Please leave no blanks.

Provider Signature	**Date**
Printed Name & Credentials	
Supervisor Signature (if needed)	**Date**