



City and County of San Francisco
Department of Public Health
 COMMUNITY BEHAVIORAL HEALTH SERVICES

INITIAL RISK ASSESSMENT (Face to face)

Name:

BIS # (if any):

RU #:

1. Date of assessment: __ __ / __ __ / __ __

New to this clinic Currently open in CBHS, Where _____ Previously seen CBHS (now closed)

2. Demographics

Client DOB: _____ SSN: _____ Male Female Transgender

Address: _____ City _____ Zip _____ Tel: _____

3. Presenting Problem (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Depression, hopelessness, decreased energy | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Sleep Disturbance | <input type="checkbox"/> Residential instability/Risk of homelessness |
| <input type="checkbox"/> Eating Disturbance | <input type="checkbox"/> Victim of abuse, physical, sexual and/or severe neglect |
| <input type="checkbox"/> Anxiety, fear, panic, agitation | <input type="checkbox"/> Victim of domestic violence |
| <input type="checkbox"/> Mania, elevated mood | <input type="checkbox"/> Oppositional, beyond parental control, runaway |
| <input type="checkbox"/> Psychosis, unreal thoughts or beliefs, auditory and/or visual hallucinations | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Adjustment to trauma/major stressors, separation, loss, death, job, school | <input type="checkbox"/> Physical/Medical |
| <input type="checkbox"/> Anger Control | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Impulse Control | <input type="checkbox"/> Employment/School functioning |
| <input type="checkbox"/> Family relationship problems | <input type="checkbox"/> Other, describe below |

FOR ALL AREAS CHECKED, DESCRIBE ONSET, DURATION, AND SEVERITY OF SYMPTOMS/IMPAIRMENTS, INCLUDING RELEVANT HISTORY AND SIGNIFICANT LIFE EVENTS:

4. Risk Assessment (circle appropriate rating)

Danger to self	None (0)	History but no recent intent, ideation or feasible plan (1)	Recent ideation, intention, plan that is feasible and/or history of a potentially lethal attempt (2)	Current ideation or command hallucinations re self-harm, current intent, plan that is immediately accessible and feasible, and or history of multiple potentially lethal attempts (3)
Danger to others	None (0)	History but no recent gesture or ideation (1)	Recent homicidal ideation, physically harmful aggression or dangerous fire setting, but not in past 24 hours. Has plan to harm others that is feasible (2)	Acute homicidal ideation with an accessible, feasible plan of physically harmful aggression, or command hallucinations involving harm of others. Or intentionally set fire that placed others at significant risk of harm (3)

4A. Other Risk Factors Grave disability No Yes Command hallucinations No Yes

4B. Previous Psychiatric Hospitalization: No Yes – Date/reason of last hosp: _____

4C. Risk Assessment (ELABORATION OF ALL RISK FACTORS, NOTE FRUSTRATION TOLERANCE, HOSTILITY, PARANOIA, AND VIOLENT THINKING)

1. IF CLIENT MEETS TARGET POPULATION, THIS AUTHORIZES THE PRE-AUTH. PERIOD OF 2 MONTHS/15 HOURS FOR ADULTS/OA AND 3 MONTHS/24 HOURS FOR CYF
2. IF CASE IS NOT OPENED, FORM SHOULD BE STORED IN A CONFIDENTIAL LOCKED FILE IN ALPHABETICAL ORDER.
3. THIS IS AN INITIAL RISK ASSESSMENT. FURTHER SESSION(S) MAY BE NECESSARY TO COMPLETE A FULL CLINICAL DATABASE ASSESSMENT.



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5. Current Mental Status

Mood	<input type="checkbox"/> Depressed	<input type="checkbox"/> Anxious	<input type="checkbox"/> Euphoric	<input type="checkbox"/> Other
Affect	<input type="checkbox"/> Appropriate	<input type="checkbox"/> Inappropriate		
Thought process/content	<input type="checkbox"/> Normal	<input type="checkbox"/> Loose/Tangential	<input type="checkbox"/> Grandiose	<input type="checkbox"/> Paranoid
Hallucinations:	<input type="checkbox"/> Auditory	<input type="checkbox"/> Visual	<input type="checkbox"/> Other	
Orientation:	<input type="checkbox"/> Time	<input type="checkbox"/> Person	<input type="checkbox"/> Place	
Cognitive	<input type="checkbox"/> Memory problem	<input type="checkbox"/> Lack of insight	<input type="checkbox"/> Poor judgment	<input type="checkbox"/> Concrete thinking
Comments: _____				

6. Substance Use History: Ever Used? No Yes >>>> Is client In remission Currently intoxicated Relapsed
 Date of last use _____ Longest time sober _____

Indicate substances used, if applicable: Alcohol Marijuana Cocaine/Crack Amphetamines Benzodiazepines
 Opiates Prescription Drugs Caffeine Tobacco/Nicotine Inhalants Other _____

Has client experienced severe withdrawal symptoms in past (hospitalization, DTs, seizures)? No Yes
 Is client currently experiencing severe withdrawal symptoms? No Yes

Substance Abuse Screener For any substance client endorses ever using ask: In the last three months...		
Have you felt you should cut down or stop [drinking/using substance]?	No	Yes
Has anyone annoyed you or gotten on your nerves by telling you to cut down or stop [drinking/using substance]?	No	Yes
Have you felt guilty or bad about how much you [drink /use substance]?	No	Yes
Have you been waking up wanting to [drink /use substance]?	No	Yes

7. Legal Issues	Court Mandated Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes	Probation/Parole: <input type="checkbox"/> No <input type="checkbox"/> Yes	History of arrest: <input type="checkbox"/> No <input type="checkbox"/> Yes
8. Mental Health	Currently linked <input type="checkbox"/> No <input type="checkbox"/> Yes Where?	Conserved <input type="checkbox"/> No <input type="checkbox"/> Yes	History of treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Current psych meds <input type="checkbox"/> No <input type="checkbox"/> Yes
9. Physical Health	Linked to PCP <input type="checkbox"/> No <input type="checkbox"/> Yes Where?		Current non-psych meds <input type="checkbox"/> No <input type="checkbox"/> Yes

10. Medical Necessity/Need for Services in CBHS? No Yes (If no, provide NOA-A for SF MediCal clients) Uninsured SMI? No Yes

11. Provisional DSM IV Diagnosis: Axis I: _____ Axis I: _____

Axis II: _____ Axis III: _____ Axis IV: _____ GAF: _____

12. Disposition:

Medication Evaluation When: _____ Continuing Assessment at this clinic When: _____
 Requires Hospitalization (5150) due to: Danger to Self Danger to Others Grave Disability
 Refer to other Mental Health Clinic – Where: _____ When: _____

Refer to: None Substance Abuse Primary Care Physician Private Provider Network Community Social Services

Comments: _____

Staff Name (print): _____

 Clinician/Staff signature (if not LPHA, must have a LPHA co-signer): _____ Date: _____ LPHA Signature _____ Date: _____

Service Code: _____ FF/TT: _____ LOC Office Field Home