221 Laurel Road Suite 102
Voorhees, NJ 08043

Phone #: 856-772-5809
Fax #: 856-772-5852

IIC YOUTH INITIAL ASSESSMENT/CYBER TREATMENT PLAN

Revised 10-1-15 (this version must be used for all intakes completed 10-1-15 and after)

SECTION 1: IDENTIFYING INFORMATION

CLIENT NAME: **GENDER:** ☐ M / ☐ F

D.O.B.: **AGE:** **REFERRAL SOURCE:**

DATE OF CURRENT PLAN:

Presenting Problem: [include client's perspective, reason for referral, onset & duration of problem (I.e. when did behaviors start to occur?)] Please explain any boxes that are checked below.

☐ Physical Aggression	☐ Very Unhappy	☐ Drug Use
☐ Verbal Aggression	☐ Irritable	☐ Alcohol Use
☐ Eating Problems/ Disorder	☐ Temper Outbursts/Rages	☐ Trouble with the Law
☐ Self-Injury	☐ Fearful	☐ Running Away
☐ Suicidal behavior	☐ Phobic	☐ Fire Setting
☐ Suicide Talk	☐ Anxious	☐ Sexual Trouble
☐ Paranoid	☐ Low Self-Esteem	☐ Peer Conflict
☐ Hallucinations	☐ Bullying, Threatening, etc.	☐ Family Conflict
☐ Delusions	☐ Mistrust	☐ Lacks Initiative
☐ Impulsive	☐ Obsessions	☐ Repetitive Behaviors
☐ Destructive	☐ Truancy	☐ Cruelty to animals
☐ Short Attention Span	☐ School Performance	☐ Victim bullying/teasing
☐ Learning Disability	☐ Withdrawn	☐ Other:
☐ Distractible	☐ Lying	☐ Other:
☐ Daydreaming	☐ Clumsy	☐ Other:
☐ Disobedient	☐ Shy	☐ Other:
☐ Overactive	☐ Stubborn	☐ Other:

Family History: (Family composition, significant and/or traumatic events in the life of client and family)

DSM DIAGNOSIS: AXIS I:

PARENTS/GUARDIANS:

ADDRESS: **PHONE: H:**

C:

ANY DCP&P INVOLVEMENT? ☐ **Y /** ☐ **N**

IF YES, WHICH COUNTY?

DCP&P WORKER NAME: **PHONE:**

WHO HAS LEGAL CUSTODY?

OTHER AGENCIES INVOLVED/Identify any community resources utilized by client (If none being utilized please indicate in the box):

ANY HISTORY OF ABUSE OR NEGLECT OR DOMESTIC VIOLENCE? ☐ **Y /** ☐ **N**

IF YES PLEASE EXPLAIN:

1. **SOCIAL FUNCTIONING:**

   Any past or current drug/alcohol use? ☐ **Y /** ☐ **N**

   If yes, please describe (including date of first use, amount, and type of drug):

2. **EDUCATION:**

   Name of School: **Grade:** **Special Education?** ☐ **Y /** ☐ **N**

   Any difficulties or concerns in regard to education? Note changes/trends in school performance ☐ **Y /** ☐ **N**

3. **LEGAL HISTORY**

   Any current or past legal involvement (civil or criminal)? ☐ **Y /** ☐ **N**

   If yes, please describe:

4. **MEDICAL/PSYCHIATRIC HISTORY:**

   List any present medical conditions currently being treated:

   Past Psychiatric Treatment: (please list past/current treatment providers):

List all current medications.

DEVELOPMENT: (Evaluation of any language, self care or other areas of functioning related to MH condition; list any other pertinent information (including any delays in meeting developmental milestones):

5. STRENGTHS:

- ☐ Cooperation
- ☐ Motivated for Treatment
- ☐ Verbal
- ☐ Able to Establish Rapport
- ☐ Medication Compliant
- ☐ Has Hobbies/Interests
- ☐ Independent Self-Care Skills
- ☐ Good Hygiene
- ☐ Motivated for School
- ☐ Problem Solving Skills
- ☐ Has Insight into Difficulties
- ☐ Sense of Humor
- ☐ Good Social Skills
- ☐ Intelligent
- ☐ Helpful
- ☐ Follows Rules
- ☐ Flexible
- ☐ Has Academic/Career Goals
- ☐ Agency Support
- ☐ Family Support
- ☐ Other:
- ☐ Other:
- ☐ Other:
- ☐ Other:

ASSESSMENT/MENTAL STATUS EXAM (MSE)

General Appearance

☐ Neatly groomed, appropriate to climate ☐ Poor grooming/hygiene ☐ Other

Motoric Behavior

☐ Normal ☐ Agitation ☐ Retardation ☐ Tics ☐ Tremor/Mov't Disorder ☐ Other:

Mood

☐ Euthymic ☐ Anxious ☐ Depressed ☐ Neutral ☐ Euphoric ☐ Irritable ☐ Other:

Affect

☐ Appropriate ☐ Labile ☐ Blunted ☐ Flat ☐ Constricted ☐ Inappropriate ☐ Expansive ☐ Other:

Speech

☐ Normal ☐ Sparse ☐ Pressured ☐ Slowed ☐ Hyperverbal ☐ Other:

Thought Content

☐ No Evidence of Abnormality ☐ Delusions (specify type) ☐ Phobias (specify type) ☐ Depersonalization/Derealization

☐ Obsessions ☐ Preoccupation ☐ Other:

Thought Process

☐ No Evidence of Abnormality ☐ Tangential ☐ Circumstantial ☐ Flight of Ideas ☐ Loose Associations ☐ Concrete

☐ Other:

Concentration/Attention

☐ Within normal limits ☐ Variable ☐ Distractible ☐ Other:

Perception

☐ No Evidence of Abnormality ☐ Auditory Hallucinations ☐ Visual Hallucinations ☐ Other:

Memory

☐ No Evidence of Abnormality ☐ Fair ☐ Poor Specify:

Judgment

☐ Good ☐ Impaired: Specify:

Insight

☐ Good ☐ (Age appropriate) ☐ Limited: Specify:

Orientation

☐ Person ☐ Place ☐ Time ☐ Situation Specify impairment:

Risk Assessment

☐ Suicidal ☐ Denies ☐ No Evidence If present, describe below OR ☐ Risk Assessment Tool Completed

☐ Homicidal ☐ Denies ☐ No Evidence If present ,describe below OR ☐ Risk Assessment Tool Completed

Insert Treatment plan from Cyber: Note to all therapists, the remainder the plan needs to be typed directly in cyber under "treatment plan tab" and printed and attached to this initial intake.

Client Name:

SIGNATURE SHEET

PRINT NAME	TITLE/AGENCY	SIGNATURE	DATE
	Client		
	Parent/Guardian		
	Parent/Guardian		
	IICS Worker, TFS		
	Supervisor TFS		

By signing this page, I acknowledge that I have read and understand the treatment goals as described in this INDIVIDUALIZED PLAN OF CARE. I also understand my role as an active participant in treatment planning and understand my responsibility to contribute to the plan as outlined in the objective sections of each goal.