This is only a sample and is not meant to be a template. It should not be used in place of clinical judgement and documentation standards.

Child Assessment

Domain 1: Presenting Problem/Chief Complaint

During the assessment, client presented as: dress being disheveled, grooming unkempt, underweight, affect is flat, mood is sad and depressed, insight is fair. He was oriented to person, place, situation, and time.

Client is seeking care due to his mother observing him "locked up all day long in his bedroom" and crying. Client reported experiencing constant feelings of sadness, feeling "grumpy" which makes him irritable when around peers and family, and difficulty sleeping resulting in tiredness. Client's mother and father reported decreased appetite resulting in weight loss and frequent verbal and physical fights with his siblings. The problem results in distress and/or functional impairments including isolation from family and peers, decreased academic performance and unintentional weight loss, in the following areas: school, social, and biomedical.

Domain 2: Trauma

Client has a history of trauma exposure including being bullied by peers at school at the beginning of last year that included threats and physical violence against him. This bullying is ongoing. He shared this was not reported due to fear of his own safety. Client reported stressors/traumas have resulted in feeling deeply sad, fearful, wanting to stay in his room. He began to withdraw in school and his grades began to decline. His sense of self-worth went down along with his grades and he moved into hopelessness and despair. He shared kids at school continue to call him names that are humiliating to him.

Client denied having ever experienced homelessness, the juvenile justice system, or being involved in child welfare.

Domain 3: Behavioral Health History

Current mental health conditions and current substance use and services

Client reported current mental health conditions to be constant feelings of sadness, feeling "grumpy" which makes him irritable when around peers and family, and difficulty sleeping resulting in tiredness and is not currently receiving services.

Client denied current substance use. Client added he is "not into that kind of stuff".

History of previous mental health conditions and current substance use and services

Client reported a history of mental health conditions which included his grief response to the unexpected passing of his grandfather when he was 8. Client received treatment with a school-based counselor. He shared it "kinda helped me feel better" and lasted for 6 weeks.

Client denied a history of substance use and there is no history of previously diagnosed or suspected conditions.

Domain 4: Medical History and Medications

Description of current Physical Health conditions and current medications

Client's current medical conditions include lactose intolerance, anemia and asthma. Client is taking an iron supplement once a day for anemia and for acute asthma attacks takes Zyrtec 5 mL/day and as needed prednisone and Albuterol.

Client is allergic to dust mites and milk.

Description of previous Physical Health conditions and past medications

Client has a history of medical conditions including acute asthma attacks which is triggered by having respiratory infections and allergies and has accessed the care with his current primary care provider the Small-Town Health Clinic

FOR INDIVIDUALS 21 YEARS OLD OR YOUNGER: Primary caregiver reported information on client's developmental history including: normal pregnancy and postpartum depression.

Client has a history of taking the following medication: Zyrtec 5 mL/day and as needed prednisone and Albuterol since the age of 3 for his acute asthma.

Domain 5: Psychosocial Factors

Client currently lives in a house with both of his biological parents, 15 and 10-year-old brothers. He is the third child of his parents. He has a 17-year-old brother who, due to behavior concerns, was sent to live with extended family. It was further communicated that due to mother and father's full-time work schedule, client and his little brother are cared for by an elderly neighbor until the parents come home from work. Client indicated having social supports/networks such as a close friend at school but that the relationship fell apart. He shared he cannot trust kids his age. He is socially connected via online community and enjoys online gaming.

Client identified as cisgender male and uses the pronouns he/him. He identified his family as Caucasian. Client shared, reluctantly, that he has identified as Bi-sexual since 7th grade and has been harassed and beat up by peers after his friend shared this with others. He expressed fear of his family learning about his identity. Client denied any religious affiliation. His parents identify as Christian and attend church on special holidays.

Client and/or family are not involved in the legal/justice system.

Client will be in the 8th grade at Local City Middle School this upcoming academic year and is enrolled in mainstream classes.

Domain 6: Strengths, Risk, and Protective Factors

Client identified strengths/protective factors including: playing sports, riding his bike, skateboarding, and doing parkour. He appears to have the ability to recognize when he is at his limit and will create a space away from his brothers, who he identifies as triggers for him, by going to his bedroom.

Client reported current risk factors/behaviors such as he has thoughts of suicide. He stated, "I just think everyone would be better off without me". He reported he has thought of several different plans which included hanging himself or shooting himself with one of his father's guns. He denied ever acting on these thoughts and denied any intent of following through with them. There were no reports of

previous suicide attempts. Client's current risk level is low given no intent and his willingness to safety plan with his parents at the time of this assessment.

Client participated in safety planning which outlines the following: he identified fighting, being made fun of, feeling like a failure, and yelling are triggers for his suicidal thoughts. Warning signs included racing heart, rapid thoughts, crying, numbness in his arms and fingers, and inability to fall asleep. Activities he identified he would like to use as coping strategies included listening to music, watching his favorite series, and drawing. His father agreed to remove the firearms from the home. Both parents agreed to lock up all sharps, cleaning chemicals, cords, and ropes to keep client safe. For added support client will reach out to his oldest brother, his online friend, or his father. If in the event he continues to require more support, he agreed to reach out to his therapist, reach out to the Teen Text Line (Text HOME to 741741), Seneca Youth Mobile Crisis at 831-687-4379, 988 SAMHSA Suicide Prevention Line, and MCBH Crisis Team by calling 1-888-285-6029.

Domain 7: Clinical Summary, Treatment Recommendations, Level of Care Determination

In summary, client experiences bouts of tearfulness, increased irritability, hopelessness, depressed mood most days, loss of appetite, unintentional weight loss, inability to sleep, inability to concentrate due to lack of sleep, lethargy, and frequent thoughts of death. He has trouble concentrating as a result of his decreased ability to sleep which has negatively impacted his academic performance. Additionally, client noted he had begun to experience symptoms following a physical attack by peers as a result of his sexual identify being unwilling disclosed. He continues to struggle with his sexual identity and fears rejection from his parents, family, and has pushed away from engaging in relationships with peers significantly impacting his social functioning.

Client meets diagnostic criteria for Major Depressive Disorder, single episode, severe, without psychosis (ICD-9 296.23; ICD-10 F32.2) with a rule out diagnosis of Post-Traumatic Stress Disorder. Client is recommended the following: rehab services to improve social connections, family therapy services to improve communication, individual therapy to reduce depressive symptoms, group therapy to improve social connections, medication management and coordination with primary care physician to support unintentional weight loss and inability to sleep. It is recommended that client be provided with specialty mental health services through Monterey County Behavioral Health aimed at decreasing depressive symptoms, eliminating suicidal ideation, and supporting healthy increased sense of self-worth and within the context of his sexual identity and feelings of belongingness.