



<input type="checkbox"/> Initial
<input type="checkbox"/> Update
<input type="checkbox"/> Re-assessment

### Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS)

1. GENERAL INFORMATION						
<b>Customer First and Last Name:</b>		<b>Chosen/Preferred Name:</b>		<b>Pronouns:</b>	<b>Date First Contact:</b>	<b>Referral Source:</b>
<b>RIN:</b>	<b>Date of Birth:</b>	<b>Sex at Birth:</b>	<b>Gender Identity:</b>	<b>Phone Number:</b>	<b>Primary Language:</b>	
<b>Address:</b>		<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>	<b>County:</b>	
<b>Interpreter</b> <input type="checkbox"/> None required <input type="checkbox"/> TDD/TYY <input type="checkbox"/> Spoken Language: _____ <b>Services:</b> <input type="checkbox"/> American Sign Language <input type="checkbox"/> Other: _____				<b>Ethnicity:</b> <input type="checkbox"/> Hispanic or Latinx <input type="checkbox"/> Unknown <input type="checkbox"/> Non-Hispanic or Latinx		
<b>Race:</b> <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Other: _____ <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Hawaiian Native/Other Pacific Islander <input type="checkbox"/> Multi-Race				<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Unknown		
<b>Insurance Coverage:</b>	<b>Household Size:</b>	<b>Household Income:</b>	<b>Guardianship Status:</b> <input type="checkbox"/> Own guardian <input type="checkbox"/> Youth in Care <input type="checkbox"/> Biological parent <input type="checkbox"/> Other court appointed <input type="checkbox"/> Adoptive parent <input type="checkbox"/> Other: _____			
<b>Living Arrangement:</b> <input type="checkbox"/> Private residence <input type="checkbox"/> Homeless/shelter <input type="checkbox"/> Jail/correctional facility <input type="checkbox"/> Foster home <input type="checkbox"/> State op. facility (MH/DD) <input type="checkbox"/> Supportive/assisted living <input type="checkbox"/> Residential/institution <input type="checkbox"/> Other: _____				<b>Employment Status:</b> <input type="checkbox"/> Self-employed <input type="checkbox"/> Military <input type="checkbox"/> Employed full-time <input type="checkbox"/> Unemployed <input type="checkbox"/> Homemaker <input type="checkbox"/> Employed part-time <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Unable to work		
<b>Education Level:</b> <input type="checkbox"/> Never attended <input type="checkbox"/> Grade 4-5 <input type="checkbox"/> H.S. diploma/GED <input type="checkbox"/> Trade/technical training <input type="checkbox"/> Master's/Doctoral degree (last completed) <input type="checkbox"/> Pre-K/Kindergarten <input type="checkbox"/> Grade 6-8 <input type="checkbox"/> Some college <input type="checkbox"/> Professional certificate <input type="checkbox"/> Unknown <input type="checkbox"/> Grade 1-3 <input type="checkbox"/> Grade 9-12 <input type="checkbox"/> Associate's degree <input type="checkbox"/> Bachelor's degree						
2. ESTABLISHED SUPPORTS						
<b>Does the customer have one or more caregivers?</b> <input type="checkbox"/> Yes (please complete the Caregiver Addendum) <input type="checkbox"/> No						
<b>Caregiver or Significant Other Info.</b>	<b>First and Last Name:</b>		<b>Relationship to Customer:</b> <input type="checkbox"/> Parent <input type="checkbox"/> Legal guardian <input type="checkbox"/> Other caregiver <input type="checkbox"/> Significant Other		<b>Phone Number:</b>	
	<b>Address:</b>		<b>City:</b>	<b>State:</b> <b>Zip Code:</b>	<b>County:</b>	
<b>Emergency Contact Information</b>	<b>First and Last Name:</b>		<b>Relationship to Client:</b>		<b>Phone Number:</b>	
	<b>Address:</b>		<b>City:</b>	<b>State:</b> <b>Zip Code:</b>		
<b>Members of Family Constellation</b>	<b>Name</b>	<b>Age</b>	<b>Relation to Client</b>	<b>Living in Home</b>		
				<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Other Supports</b>	<b>Agency</b>	<b>Contact Name</b>		<b>Phone</b>	<b>Email</b>	
Physician						
School/Daycare						
Counselor/Therapist						
Child Welfare Worker						
ISC/PAS Agent						
Probation Officer						
Other: _____						
Other: _____						
Other: _____						

**Iroquois Mental Health Center**

Would you like your primary doctor to be contacted about your mental health care?  YES  NO

*Please check your current symptoms:*

- |  |   |
|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Depressed Mood   | <input type="checkbox"/> Y <input type="checkbox"/> N Anxious Mood/Worry                                |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fatigue/ Lack of energy/ Sleeping issues                     | <input type="checkbox"/> Y <input type="checkbox"/> N Nightmares/ Flashbacks/ Intrusive thoughts        |
| <input type="checkbox"/> Y <input type="checkbox"/> N Social withdrawal/ Isolation                                 | <input type="checkbox"/> Y <input type="checkbox"/> N Anger outburst/ Loss of temper                    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diminished interest in activities                            | <input type="checkbox"/> Y <input type="checkbox"/> N Argues, defies rules and/or adult requests        |
| <input type="checkbox"/> Y <input type="checkbox"/> N Feelings of hopelessness/ worthlessness                      | <input type="checkbox"/> Y <input type="checkbox"/> N Blames others for own mistakes                    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Irritability   | <input type="checkbox"/> Y <input type="checkbox"/> N Cruelty to animals and/or destruction of property |
| <input type="checkbox"/> Y <input type="checkbox"/> N Past or Current: Suicidal thoughts and/or attempts           | <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty organizing tasks/ activities           |
| <input type="checkbox"/> Y <input type="checkbox"/> N Self-harm (cutting, burning, scratching, hitting self, etc.) | <input type="checkbox"/> Y <input type="checkbox"/> N Easily distracted/ not paying attention           |
| <input type="checkbox"/> Y <input type="checkbox"/> N Racing thoughts  | <input type="checkbox"/> Y <input type="checkbox"/> N Impulsive Behaviors                               |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hyperactive/ Can't sit still/ Fidgets/ Leaves seat at school | <input type="checkbox"/> Y <input type="checkbox"/> N Paranoid feelings and/or thoughts                 |
| <input type="checkbox"/> Y <input type="checkbox"/> N Forgetful (due to distracted thoughts)                       | <input type="checkbox"/> Y <input type="checkbox"/> N Hallucinations: auditory and/or visual            |

Any additional symptoms or information you wish to share:

---



---



---

**CAGE: Please check YES or NO**

- |   |  |
|---|--|
| 1. Have you ever felt a need to cut down on drinking or drug use? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 2. Have you ever been annoyed by criticism of your drinking?      | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 3. Have you ever had guilty feelings about drinking or drug use?  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 4. Have you ever taken a morning eye opener?                      | <input type="checkbox"/> YES <input type="checkbox"/> NO |

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist Signature/ Credentials

\_\_\_\_\_  
Date



HFS

Illinois Department of Healthcare and Family Services

Initial
Update (recommended annually)

Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS)
Addendum 2 – Health Risk Assessment (HRA)

21. GENERAL INFORMATION (HRA)
First Name: Last Name: Chosen/Preferred Name: Pronouns: RIN:
Date of Birth: Sex at Birth: Gender Identity: Height: Weight: Date of Last Physical Exam:
Visit due

22. MEDICATION(S)
List current and previous medications below, including over-the-counter medications. Attach additional pages as needed.
Is the customer currently taking any psychotropic medications? Yes No
Medication Name Prescriber Dosage Date Started Date Ended Medication Side Effects

23. HEALTH STATUS
a. Does the customer have any allergies? Yes No If yes, list:
b. Does the customer want help to quit smoking? Yes No N/A – does not smoke
c. Has the customer fallen in the past 12 months? Yes No N/A – age under 50

REPRODUCTIVE HEALTH: (skip to next section if the customer does not have periods)
a. Does the customer see a reproductive health provider (i.e. OB/GYN)? Yes - date of last visit: No - referral needed
b. Is the customer experiencing any issues related to their menstrual cycle or menopause? Yes No
If yes, describe.
c. Has the customer ever been pregnant? Yes – currently Yes – previously No
If yes, describe the status or the outcome of the pregnancy.
d. Has the customer ever been diagnosed with an STD/STI? Yes No Unknown
If yes, is a referral for specialized care needed? Yes No Unknown

CHRONIC PAIN: Does the customer experience chronic pain or complain of pain frequently? Yes No (if NO, skip this section)
a. Has the customer ever taken or been prescribed medication for pain? Yes No
If yes, indicate the type: Cannabis Opioids Other (list):
b. Describe the location and intensity of the pain.

BLOOD SUGAR/DIABETES:
a. Does the customer urinate more frequently than appears normal? Yes No
b. Does the customer seem to have an increased thirst compared to others in the same age range? Yes No
c. Is the customer compliant with any dietary restrictions related to their blood sugar? Yes No N/A
If yes, describe:
d. What was the customer's last tested A1C level? N/A A1C level: Date of A1C test:



**HFS**

Illinois Department of  
Healthcare and Family Services

**ADDITIONAL RELEVANT HEALTH INFORMATION:**

**24. DEVELOPMENTAL HISTORY** *(skip to the next section if the customer is 21 years of age or older)*

- a. Was the customer's birth premature?  Yes  No  Unknown
- b. Was the customer exposed to the mother's use of tobacco, alcohol, or street/prescription drugs during pregnancy?  
 Yes (describe below)  No  Unknown
- c. Were there any unusual issues related to the mother's labor and delivery?  
 Yes (describe below)  No  Unknown

**Supporting Information:** Provide additional information on the customer's social/developmental history, including significant events in prenatal/birth/early childhood stages, enduring physical/medical conditions, and pervasive developmental or cognitive difficulties.

**25. MEDICAL HISTORY**

**How many times has the customer been to the Emergency Room in the past 12 months?**

- 0 times  1 time  2 times  3 times  4+ times

What was the reason for the ER visit(s)?

**Has the customer ever been psychiatrically hospitalized?**

- No  Yes *(If YES, please describe below. Attach additional pages as needed.)*

**Has the customer ever been medically hospitalized?**

- No  Yes *(If YES, please describe below. Attach additional pages as needed.)*

**Supporting Information:** Describe any other significant medical problems, treatments, hospitalizations, and outcomes not addressed above.

# Ohio Mental Health Consumer Outcomes System

## Ohio Youth Problem, Functioning and Satisfaction Scales **W**

Child's RIN \_\_\_\_\_ Date \_\_\_\_\_ Clinician \_\_\_\_\_

<b>Instructions: Please rate the degree to which the designated child has Experienced the following problems in the past 30 days.</b>	<b>Not at all</b>	<b>Once or twice</b>	<b>Several Times</b>	<b>Often</b>	<b>Most of the Time</b>	<b>All of the Time</b>
1. Arguing with others	0	1	2	3	4	5
2. Getting into fights	0	1	2	3	4	5
3. Yelling, swearing, or screaming at others	0	1	2	3	4	5
4. Fits of anger	0	1	2	3	4	5
5. Refusing to do things teachers or parents ask	0	1	2	3	4	5
6. Causing trouble for no reason	0	1	2	3	4	5
7. Using drugs or alcohol	0	1	2	3	4	5
8. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9. Skipping school or classes	0	1	2	3	4	5
10. Lying	0	1	2	3	4	5
11. Can't seem to sit still, having too much energy	0	1	2	3	4	5
12. Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13. Talking or thinking about death	0	1	2	3	4	5
14. Feeling worthless or useless	0	1	2	3	4	5
15. Feeling lonely and having no friends	0	1	2	3	4	5
16. Feeling anxious or fearful	0	1	2	3	4	5
17. Worrying that something bad is going to happen	0	1	2	3	4	5
18. Feeling sad or depressed	0	1	2	3	4	5
19. Nightmares	0	1	2	3	4	5
20. Eating problems	0	1	2	3	4	5

**(Add rating together) Total \_\_\_\_\_**

<b>Instructions: Please circle the number corresponding to the designated youth's current level of functioning in each area.</b>	<b>Extreme Troubles</b>	<b>Quite a few troubles</b>	<b>Some Troubles</b>	<b>OK</b>	<b>Doing Very Well</b>
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Dating or developing relationships with boyfriends or girlfriends	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal)	0	1	2	3	4
5. Keeping neat and clean, looking good.	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing Teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble	0	1	2	3	4
8. Being motivated and finishing projects	0	1	2	3	4
9. Participating in hobbies (baseball cards, stamps, art)	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending school and getting passing grades in school.	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4
18. Doing things without supervision or restrictions	0	1	2	3	4
19. Accepting responsibility for actions	0	1	2	3	4
20. Ability to express feelings	0	1	2	3	4

**(Add rating together) Total \_\_\_\_\_**

**THE COLUMBIA IMPAIRMENT SCALE (C. I. S.)-- (Parent Version)**

Please circle the number that you think best describes the child or youth's situation:

0 .....1.....2.....3.....4 .....5  
 No problem                      Some problem                      Very bad problem                      Not applicable/Don't know

<b>In general, how much of a problem do you think [she/he] has with:</b>	
1)...getting into trouble?	0 1 2 3 4 5
2)...getting along with (you/[her/his] mother/mother figure).	0 1 2 3 4 5
3)...getting along with (you/[her/his] father/father figure).	0 1 2 3 4 5
4)...feeling unhappy or sad?	0 1 2 3 4 5
<b>How much of a problem would you say [she/he] has:</b>	
5)...with [her/his] behavior at school? (or at [her/his] job)	0 1 2 3 4 5
6)...with having fun?	0 1 2 3 4 5
7)...getting along with adults other than (you and/or [her/his] mother/father)?	0 1 2 3 4 5
<b>How much of a problem does [she/he] have:</b>	
8)...with feeling nervous or afraid?	0 1 2 3 4 5
9)...getting along with [her/his] [sister(s)/brother(s)]?	0 1 2 3 4 5
10) ...getting along with other kids [her/his] age?	0 1 2 3 4 5
<b>How much of a problem would you say [she/he] has:</b>	
11)...getting involved in activities like sports or hobbies?	0 1 2 3 4 5
12)...with [her/his] school work (doing [her/his] job)?	0 1 2 3 4 5
13)...with [her/his] behavior at home?	0 1 2 3 4 5