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|--|
| <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						
Customer First and Last Name:		Chosen/Preferred Name:		Pronouns:	Date First Contact:	Referral Source:
RIN:	Date of Birth:	Sex at Birth:	Gender Identity:	Phone Number:	Primary Language:	
Address:		City:	State:	Zip Code:	County:	
Interpreter <input type="checkbox"/> None required <input type="checkbox"/> TDD/TYY <input type="checkbox"/> Spoken Language: _____ Services: <input type="checkbox"/> American Sign Language <input type="checkbox"/> Other: _____				Ethnicity: <input type="checkbox"/> Hispanic or Latinx <input type="checkbox"/> Unknown <input type="checkbox"/> Non-Hispanic or Latinx		
Race: <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				Marital Status: <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		
Insurance Coverage:	Household Size:	Household Income:	Guardianship Status: <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: _____			
Living Arrangement: <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: _____				Employment Status: <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		
Education Level: <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						
Does the customer have one or more caregivers? <input type="checkbox"/> Yes (please complete the Caregiver Addendum) <input type="checkbox"/> No						
Caregiver or Significant Other Info.	First and Last Name:		Relationship to Customer: <input type="checkbox"/> Parent <input type="checkbox"/> Legal guardian <input type="checkbox"/> Other caregiver <input type="checkbox"/> Significant Other		Phone Number:	
	Address:		City:	State:	Zip Code:	County:
Emergency Contact Information	First and Last Name:		Relationship to Client:		Phone Number:	
	Address:		City:	State:	Zip Code:	
Members of Family Constellation	Name	Age	Relation to Client	Living in Home		
				<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		
Other Supports	Agency	Contact Name		Phone	Email	
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? YES NO
2. Have you ever been annoyed by criticism of your drinking? YES NO
3. Have you ever had guilty feelings about drinking or drug use? YES NO
4. Have you ever taken a morning eye opener? YES 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:



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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.



Devereux Early Childhood Assessment for Infants Record Form (1 month up to 18 months)

Mary Mackrain, Paul LeBuffe and Gregg Powell

Infant's Name _____ Gender _____ DOB _____ Age _____
 Person Completing this Form _____ Relationship to Infant _____ (In Months)
 Date of Rating _____ Site/Program _____ Room _____

This form describes a number of behaviors seen in some infants. Read the statements that follow the phrase: ***During the past 4 weeks, how often did the infant...*** and place a check mark in the box underneath the word that tells how often you saw the behavior. Answer each question carefully. There are no right or wrong answers. Please answer every item. If you wish to change your answer, put an X through it and fill in your new choice as shown to the right.

Never	Rarely	Occasionally	Frequently	Very Frequently
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Item # During the past 4 weeks, how often did the infant...

		Never	Rarely	Occasionally	Frequently	Very Frequently
1	try to do new things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	respond when spoken to?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	imitate actions of others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	enjoy interacting with others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	keep trying when unsuccessful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	enjoy being cuddled?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	show interest in what others were doing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	show affection for a familiar adult?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	notice changes in surroundings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	seek comfort from familiar adults?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	adjust her/his energy level to the type of play?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	act in a good mood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	act happy when praised?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	make eye contact with others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	explore surroundings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	calm down with help from a familiar adult?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	express her/his dislikes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	smile back at a familiar adult?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19	reach for a familiar adult?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	respond to her/his name?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21	keep trying to obtain a toy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22	react to another child's cry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23	smile at familiar adults?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24	respond positively to adult attention?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25	act happy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26	act in a way that make others smile or show interest?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27	easily go from one activity to another?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28	seek attention when a familiar adult was with another child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29	look to a familiar adult when exploring her/his surroundings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30	enjoy being around other children?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31	show pleasure when interacting with adults?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32	act happy with familiar adults?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33	accept comfort from a familiar adult?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>