

<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						
Client First and Last Name:		Date of Birth:	RIN:	Gender:	Referral Source:	Date First Contact:
Phone Number:	Primary Language:		Interpreter Services: <input type="checkbox"/> None required <input type="checkbox"/> TDD/TYY <input type="checkbox"/> Spoken Language: _____ <input type="checkbox"/> American Sign Language <input type="checkbox"/> Other: _____			
Address:		City:	State:	Zip Code:	County:	
US Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No	Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Hawaiian Native/Other Pacific Islander <input type="checkbox"/> Other: _____ <input type="checkbox"/> Black/African American <input type="checkbox"/> Multi-Race		<input type="checkbox"/> White		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
Insurance Coverage and Company: <input type="checkbox"/> N/A		Household Size:	Household Income:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partnership		
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: _____		Employment Status: <input type="checkbox"/> Self-employed <input type="checkbox"/> Military <input type="checkbox"/> Employed full-time <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Employed part-time <input type="checkbox"/> Homemaker <input type="checkbox"/> Unable to work <input type="checkbox"/> Unemployed				
Living Arrangement: <input type="checkbox"/> Lives alone <input type="checkbox"/> Independent Living <input type="checkbox"/> Lives with parent(s), relative(s), or guardian(s) <input type="checkbox"/> State operated facility (mental health/dev. disability) <input type="checkbox"/> Jail or correctional facility			<input type="checkbox"/> Residential/Institutional Setting (residential, nursing home, shelter) <input type="checkbox"/> Community integrated living arrangement (CILA) <input type="checkbox"/> Foster Care <input type="checkbox"/> Homeless <input type="checkbox"/> Other: _____			
Education Level: (last completed) <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 <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"/> Grade 1 – 3 <input type="checkbox"/> Grade 9 – 12 <input type="checkbox"/> Associate's degree <input type="checkbox"/> Bachelor's degree						
Parent, Guardian, or Significant Other Info.	First and Last Name: _____		Relationship to Client: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <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
						<input type="checkbox"/> Yes <input type="checkbox"/> No
Established 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

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

Addendum 1 – Health Risk Assessment (HRA)

Please note: This assessment must be completed for all individuals once every 12 months.

18. GENERAL INFORMATION (HRA)				
Staff Name:	Individual First and Last Name:	RIN:	Date of Birth:	Gender:
Height: _____ ft. _____ in.	Weight: _____ lbs.	Primary Care Doctor's Name:	Date of Last Physical Exam: _____ <input type="checkbox"/> Visit due	Date of Last Flu Shot: _____

19. MEDICATION(S) List current and previous medications below, including over-the-counter medications. Attach additional pages as needed.					
Is the individual currently taking any psychotropic medications? <input type="checkbox"/> Yes <input type="checkbox"/> No CANS Rating – Medication Compliance: _____					
If yes, does the individual regularly receive lab work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not required <input type="checkbox"/> Unknown					
Medication Name	Prescriber	Dosage	Date Started	Date Ended	Medication Issues

20. HEALTH STATUS		CANS Rating – Medical/Physical: _____
<p>a. Individual's self-report on general physical health: <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor</p> <p>b. How many snack foods or drinks (e.g., chips, cookies, candy, soda) does the individual usually consume in a day? <input type="checkbox"/> 0-1 <input type="checkbox"/> 2-3 <input type="checkbox"/> More than 4</p> <p>c. How many servings of fruits and vegetables does the individual usually eat in a day? <input type="checkbox"/> 0-1 <input type="checkbox"/> 2-3 <input type="checkbox"/> More than 4</p> <p>d. Does the individual engage in physical activity? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how often? _____</p> <p>e. Does the individual use any form of tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>HEALTH CONCERNS: Does the individual have any current health concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe below.</p>	<p>f. Does the individual drink alcohol? If yes, how often and how much? _____</p> <p>g. Has the individual ever fainted or passed out? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: _____</p> <p>h. Does the individual have any allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list: _____</p> <p>i. Has the individual fallen in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: _____</p> <p>j. Does the individual want help to quit smoking? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>GENERAL ILLNESS: Does the individual have a tendency to any illnesses <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe below.</p>	
<p>BREATHING ISSUES: Does the individual have any trouble breathing? <input type="checkbox"/> Yes <input type="checkbox"/> No (if NO, skip to next section)</p> <p>a. What are the breathing issues related to? Check all that apply. <input type="checkbox"/> Physical activity <input type="checkbox"/> Weather extremes <input type="checkbox"/> Other: _____</p> <p>b. Does the individual take medication for breathing issues? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>COGNITIVE ASSESSMENT: (skip if the individual is under age 50)</p> <p>a. Has the individual ever had a significant head injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____</p> <p>b. Does the individual have any difficulty remembering or recalling events? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Can the individual correctly tell you what year, month, and day it is? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>BLOOD SUGAR/DIABETES:</p> <p>a. Does the individual urinate more frequently than appears normal? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Does the individual seem to have an increased thirst, compared to others in the same age range? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Does the individual have any special dietary instructions related to his/her blood sugar? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: _____</p> <p>d. Does the individual take any medication to control his/her blood sugar? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>CHRONIC PAIN: Does the individual experience chronic pain, or complain of pain frequently? <input type="checkbox"/> Yes <input type="checkbox"/> No (if NO, skip to next section)</p> <p>a. Has the individual ever taken or been prescribed medication for pain? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate the type: <input type="checkbox"/> Cannabis <input type="checkbox"/> Opioids <input type="checkbox"/> Other (list): _____</p> <p>b. Describe the location and intensity of the pain. _____</p>	

<p>SEXUAL RISK BEHAVIORS: Is the individual sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No (if NO, skip to next section)</p> <p>a. Does the individual use any protection against sexually transmitted diseases/infections (STDs/STIs) when engaged in sexual activity? <input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No</p> <p>c. When was the individual last tested for STDs/STIs? _____</p> <p>d. Has the individual ever been diagnosed with an STD/STI or HIV? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list the diagnosis and the age of occurrence. _____</p>	<p>FEMALE REPRODUCTIVE HEALTH: (if the individual is a male, or if the female has not had her first period, skip to next section)</p> <p>a. Does the individual see a women's health provider? <input type="checkbox"/> Yes - date of last visit: _____ <input type="checkbox"/> No – referral needed</p> <p>b. Is the individual experiencing any issues related to her menstrual cycle or menopause? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe. _____</p> <p>c. Is the individual currently or has the individual ever been pregnant? <input type="checkbox"/> Yes – currently <input type="checkbox"/> Yes – previously <input type="checkbox"/> No If yes, describe the status or the outcome of the pregnancy.</p>
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21. DEVELOPMENTAL HISTORY	
Complete this section based on the individual's early childhood experiences.	
<p>a. Did the individual's mother receive the appropriate prenatal care? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>b. Were there any complications during the mother's pregnancy? <input type="checkbox"/> Yes (describe below) <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>c. Was the individual's birth normal or premature? <input type="checkbox"/> Normal <input type="checkbox"/> Premature <input type="checkbox"/> Unknown</p> <p>d. Was the individual exposed to the mother's use of tobacco, alcohol, or street/prescription drugs during pregnancy? <input type="checkbox"/> Yes (describe below) <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	<p>e. Were there any unusual issues related to the mother's labor and delivery? <input type="checkbox"/> Yes (describe below) <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>f. What was the individual's birth weight? _____</p> <p>g. When did the individual first crawl? _____ Walk? _____ Talk? _____</p> <p>h. When did the individual begin toilet training? _____</p> <p>i. Does the individual have a biological parent or sibling that has developmental or behavioral problems? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
Supporting Information: Provide additional information on the individual's social/developmental history, including significant events in prenatal/birth/early childhood stages, enduring physical/medical conditions, and pervasive developmental or cognitive difficulties.	

22. MEDICAL HISTORY
<p>How many times has the individual been to the Emergency Room in the past 12 months? <input type="checkbox"/> 0 <input type="checkbox"/> 1 time <input type="checkbox"/> 2 times <input type="checkbox"/> 3 times <input type="checkbox"/> 4+ times</p> <p>What was the reason for the ER visit(s)?</p>

Has the individual ever been psychiatrically hospitalized? <input type="checkbox"/> No <input type="checkbox"/> Yes (if YES , please list below. Attach additional pages as needed.)			
Hospital Name	Location (City, State)	Dates Hospitalized	Reason(s)

List all additional hospitalizations the individual has experienced. Attach additional pages as needed. <input type="checkbox"/> N/A			
Hospital Name	Location (City, State)	Dates Hospitalized	Reason(s)

List the names and specialties of the providers currently providing medical treatment to the individual. Attach additional pages as needed.		
Provider Name	Specialty	Service(s) Provided

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 _____

Instructions: Please rate the degree to which the designated child has Experienced the following problems in the past 30 days.	Not at all	Once or twice	Several Times	Often	Most of the Time	All of the Time
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 _____

Instructions: Please circle the number corresponding to the designated youth's current level of functioning in each area.	Extreme Troubles	Quite a few troubles	Some Troubles	OK	Doing Very Well
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

INSTRUCTIONS FOR PARENTS

To help us improve the quality of the treatment that your child receives, we are asking you to complete the attached rating scale (C.I.S.). This will help us determine the area or areas in which your child needs help and the progress that your child makes in these areas. It also will give us information that will assist us in making changes in his/her treatment plan to better meet his/her needs.

There are thirteen areas of your child's behavior for you to rate from 0 (No problem) to 4 (Very bad problem). Using your best judgement, rate each item by circling the number that best describes at the present time your child's behavior. Since your child's behavior will change over time, only take into consideration recent behavior (within the past week or two). **PLEASE RATE ALL THIRTEEN ITEMS.** Circle the number 5 if you don't know or the question does not apply to your child. If you do not understand an item or items ask your child's therapist to clarify it for you. Your child's therapist will be glad to do so.

When you complete the form please return it as soon as possible to your child's therapist, either in person or by mail.

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

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

01.....2.....3.....45
 No problem Some problem Very bad problem Not applicable/Don't know

In general, how much of a problem do you think [she/he] has with:	
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
How much of a problem would you say [she/he] has:	
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
How much of a problem does [she/he] have:	
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
How much of a problem would you say [she/he] has:	
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