KidConnections
Initial Mental Health Assessment-
Assessment for Intervention Report
(Infant Toddler 0-24months)

Child's Name _____ Parent/Caregiver Name:_____
Birthday:_____/_____/_____ Age:_____ Adjusted Age_____
Date of the assessment: _____/_____/_____ Unicare #: _____

Referral source:

☐ Family Court	☐ Family Wellness Court	☐ DDTC	☐ DR ☐Path 1 ☐Path 2	
☐ HRIF	☐ IND	☐ Kidscope	☐SARC	☐Pediatrician
☐Early Start	☐ Head Start	☐ F5 Parent Workshop	☐F5 FRC	☐Head Start Non-PoP

Referring Person:	**Referrer Agency/School:**	**Referrer Phone:**	**Referrer E-Mail:**

Identifying Information and History:
Client description, referral reason, referral source
Family Members, Significant Individuals

Cultural Factors and Linguistic Considerations:
(e.g. ethnicity, immigration, language, religion, sexual orientation, etc.and ways these may influence treatment)

Presenting Concerns: (mental health/ behavioral issues, developmental issues, current symptoms, stressors)
Mental Health History:
(onset, symptoms, previous treatment)
Risk Factors:

Psychosocial History:
Pregnancy history (planned, desired, expectations, believes, habits, complications):
Birth (labor, complications, hospitalization, diagnosis, prognosis, evolution, recovery, medical surveillance, trauma)
APGAR, hearing test, vision
Child Development: (developmental milestones) Exploring/ interest
Abuse History
Parental Substance Abuse History
Previous Placement History (i.e., foster care, hospitals, relatives)
Family History/Caregivers
Educational information

Medical History:
Pediatrician Name: **Phone #:** **Fax #:**
Significant medical problems or concern (by history)
Current medical problems/concerns
Allergies
Dietary Restrictions/Modifications
Medication/hospitalization
Nutritional Needs

Child and Family Strengths:

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Results of Screening Tools:

ASQ: **C**_____/cut off:____ **GM**_____/cut off:____ **FM**_____/cut off:____ **PS**_____/cut off:____ **S**_____/cut off:____.
ASQ-**SE**:_____/cut off:____.
CBCL:

Behavioral Observations

	Okay	Possible Concern	Concern	Comments
Temperament and character				
Physical Regulation (Changes in State, Coloration, Muscle tone, Reflexes, Positioning, Sleeping, Feeding, Digestion, Breathing, Crying, Mouthing, Temperature Regulation)				
Eye gaze				
Exploring/ interest				
Attention and concentration				
Emotional Regulation (Facial expression, Level of arousal, Activity, Alertness)				
Attachment				
Affect, Mood and Preferences: (pleasure, distress, self soothing)				
Engagement Capacities (communication, vocalization, social behavior, play)				
Quality of play (toddlers)				
Thought (toddlers)				
Autonomy and development of self (toddlers)				
Learning rules (toddlers)				
Attunement with primary caregiver				
Parent-child, physical connection and touch				

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Caregiver	
Sense of mastery reading infant cues	
Sense of mastery meeting infant basic needs, confidence in parental role	
Affection/ empathy Facial expressions	
Parent Emotional state Social Support	
Rhythm of Interactions Affective flow	
Parenting style Level of stimulation of child	
Mental Health Comments/Conclusions: (optional)	

Interpretation of Scores/Conclusions:
Date of Screening:
Screening provided in:

☐ English ☐ Interpreter assisted in:
☐ Spanish
☐ Vietnamese
☐ Other:

Screening Tools

☐ Brigance Infant Toddler Screen
☐ Speech/Language Screen
☐ Motor Screen
☐ Sensory Processing Screen
☐ Other: _____

☐ Observation of child
☐ Interview with _____
☐ Chart Review of ASQ and ASQ:SE scores
☐ Edinburgh Depression Scale
☐ Parent Stress Index

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Developmental Screening Results

	Okay	Possible Concern	Concern	Comments
Receptive Language / Communication under 18 months				
Expressive Language / not used under 18 months				
Muscle tone, reflexes,				
Gross motor skills (arm and leg movements)				
Fine motor skills (hand and finger movements)				
Self help skills				
Sensory Processing (self-regulation & response to environment)				

*CNS = Could Not Screen *NS = Not Screened

Comments:

Communication

Motor

Sensory Processing

Oral Peripheral Check:

Observation of oral structures

☐ Tonsils _____
☐ Teeth _____
☐ Tongue _____
☐ Palate _____

Comments:

Integrated Mental Health and Developmental Summary:

Areas of concern emerging from Assessment for Intervention:

☐ Affect	☐ Attention	☐ Anxiety	☐ Attachment
☐ Autism spectrum	☐ Behavior	☐ Cognition and learning	☐ Concentration
☐ Engagement	☐ Family system	☐ Health	☐ Mood
☐ Motor development	☐ Parent / child	☐ Parenting	☐ Self care
☐ Self regulation	interaction	☐ Social skills	☐ Temperament

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☐ Trauma	☐ Speech / language delay ☐ Vision / hearing	☐ No concerns		
☐ Other:				

Recommendations /Strategies for Continued Successful Development and Referrals:

☐ Anticipatory guidance ☐ Hearing ☐ Parent education ☐ SARC ☐ Vision	☐ Dental ☐ Home visitation ☐ PHP ☐ School District: _____	☐ Early Start Program ☐ Targeted Diagnostic Assessment ☐ Preschool ☐ Therapeutic services
☐ Other		

Consultants/Participants:

Date of Report: _____

☐ (MH Clinician)
Title, phone

☐ Rosa Gonzalez
Bilingual Educator
(408) 243-7861 Ext. 246

☐ Rosie MacFarlane B.A. C.C.I. Permit
Bi-Lingual Preschool Resource Teacher
(408) 243-7861 RExt. 222

☐ Desiree Q Luong
Bilingual Educator
(408) 243-7861 Ext. 248

☐ Maggie Newman, MA, OTR/L
Occupational Therapist
(408) 243-7861 Ext.221

☐ Mayra Arango
Bilingual Early Childhood Educator
(408) 243-7861 Ext. 240

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This page is **for internal KidScope documentation purposes only**. PLEASE **do not attach** this page to the preceding report which is an effort to give families and service providers appropriate and user-friendly information

Medical Necessity Criteria

Have at least one of the following impairments as a result of a mental health disorder: A) A significant impairment in an important area of life functioning; B) A reasonable probability of significant deterioration in an important area of life functioning; C) Except as provided in Section 1830.210, a reasonable probability a child will not progress developmentally as individually appropriate. For the purpose of this Section, a child is a person under the age of 21 years.

Check all that apply:

✓	Area	Brief Description of Impairment (if checked)
	Health (e.g., physical condition, activities of daily living	
	Daily Activities (e.g., work, school, leisure)	
	Social Relationships (e.g., significant other, family, friends, support system)	
	Living Arrangement (e.g., homeless, maintaining current housing situation	

DC 0-3 R Diagnosis (when applicable/appropriate)	
Axis I	
Axis II	
Axis III	
Axis IV	
Axis V	Emotional and Social Functioning

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Diagnosis Summary

The name of the disorder according to DSM 5 classification followed by the numerical ICD-10 code and description. Example: (Primary) DSM 5: Major Depressive Disorder, Moderate. ICD-10: F33.1, Major depressive disorder, recurrent, moderate.

Each diagnosis must be stated clearly and legibly, and primary and secondary diagnosis (if applicable) must be identified. Please follow the State guidelines for primary and secondary diagnoses for mental health clients. *(Please note that each diagnosis given and documented in this section must be substantiated and supported by symptoms, behaviors, and functional impairments in the assessment form under the appropriate sections, usually under presenting problems and medical necessity.)*

Person completing Assessment:

_____ _____ _____
Signature Discipline Date

Review/Approval by Licensed Professional of the Healing Arts (if different from above):

_____ _____ _____
Signature Discipline Date