Insight and Empowerment, LLC
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Comprehensive Diagnostic Assessment (Minor)

Name: _____ DOB_____
Email: _____ Phone: _____

Clinician: _____ Date of Assessment: _____

Person providing this information: _____
Relationship to Child: _____

Primary Care Physician: _____
Psychiatrist: _____

Do you give permission for ongoing regular updates to be provided to your primary care physician and/or psychiatrist? Yes No

Please indicate the main reasons for seeking consultation and/or treatment or what are the presenting mental health concerns?

_____
_____
_____
_____
_____
_____

Prior Psychiatrist History/Diagnosis: _____
_____
_____

What are your treatment goals for your child?

_____
_____
_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

( ) Depressed Mood	( ) Fatigue	( ) Excessive Energy
( ) Increased Irritability	( ) Oppositional Behavior	( ) Self-Esteem Issues
( ) Sleep Disturbances	( ) Racing Thoughts	( ) Crying Spells

( ) Loss of Interest
( ) Attention/Concentration
( ) Eating Disturbances
( ) Excessive Guilt/Shame
( ) Suicidal Thoughts
( ) Dissociation
( ) Chronic Pain
( ) Aggressive Behavior
( ) Other _____

( ) Impulsivity
( ) Increase Risky Behavior
( ) Distracted Easily
( ) Recent Changes
( ) Obsessive/Compulsive
( ) Temper/Anger Issues
( ) Flashbacks
( ) Attachment Difficulties

( ) Excessive Worry
( ) Anxiety Attacks
( ) Avoidance
( ) Hallucinations
( ) Suspiciousness
( ) Self-Harm
( ) Hygiene Concerns
( ) Regressive Behavior

Current Family Situation

Place of birth/city/state: _____
Ethnicity: _____ Language: _____

Was your child adopted? _____ Yes _____No Age at adoption _____

Circumstances of Adoption

_____

Parents at the time of birth were: Married Separated Unmarried
If divorced, at what age was child at time of divorce? _____

Current Relationship Status of Mother: _____
_____
Current Relationship Status of Father: _____
_____

Who does child currently reside with? _____

Is there a custody order in place? _____

Are there any current custody concerns/ conflicts?

Father_____
Deceased, year _____
What is her level of education? _____
Occupation? _____

Please describe child's relationship with his/her father:

_____
_____
_____

Mother_____
Deceased, year _____

What is her level of education? _____
Occupation?_____

Please describe child's relationship with his/her mother:

_____
_____
_____

Please describe the current atmosphere of the marriage/ partnership in the home:
Please check all that apply:
____Good, satisfied ____Supportive ____Warm relationship ____Stable
____Bored ____Poor communication ___On the verge of break-up
____Abusive (physical, verbal, sexual)

Does the child witness frequent marital/partner conflicts:

_____

Has the child ever witnessed abuse within the marriage?

_____

Number of Siblings: _____
Full sisters _____Full brothers _____Half-sisters _____Half-brothers ____ Step-sisters
_____Step-brothers _____Deceased, age(s) at death _____

Please list all people in child's immediate family:

Name	Relationship to child	Age	Living in House?

Please list all other non-family members who live in household:

Name	Relationship to child/ family	Age	Length of time living in household

Does your child attend daycare? No_____ Yes _____ Please explain (where, how often) _____

Are there any other adults who have a significant role in raising your child?
No_____ Yes (please indicate name and relationship)

_____

_____

Have there been any significant changes in the home over the last few years? (For example, marriages, births, deaths, money problems, address changes, change religions etc.)

_____

_____

_____

Has your child ever witnessed an immediate family member become incarcerated? (If yes- please Explain- who, when, length of time, offense)
No_____
Yes_____

_____

_____

Are there are any concerns of physical abuse?
No _____ Yes (current) _____ Yes (in the past) _____ Unknown_____
If yes clarify when and by whom:

_____

_____

Are there are any concerns of emotional abuse?
No _____ Yes (current) _____ Yes (in the past) _____ Unknown_____
If yes clarify when and by whom:

_____

_____

Are there are any concerns of sexual abuse/ molestation/ and/ or sexual assault?
No _____ Yes (current) _____ Yes (in the past) _____ Unknown_____
If yes clarify when and by whom:

_____

_____

Are there are any concerns of neglect or the child's needs not being met?
No _____ Yes (current) _____ Yes (in the past) _____ Unknown_____
If yes clarify when and by whom:

_____

_____

Please explain your family's cultural and/or spiritual or religious background/ current practice:

_____

_____

How is your child disciplined in the home?

How does the family express and manage emotions in the home?

What resources and supports do you and your family have?

What strengths does your child demonstrate in the family setting?

What are your child's hobbies, talents, or activities he/she most enjoys?

Family Psychiatric History

Please include any mental health and/or substance use problems with biological relatives. Consider diagnoses such as depression, anxiety, bipolar disorder, schizophrenia, ADHD, alcohol and/or drug abuse, incarceration, or any suicides.

Mother:

Mother's relatives:

Father:

Father's relatives:

Siblings:

Basic Living Skills History and Functioning

Please indicate your child's habits with the following basic living skills practices:

	Daily	A few times per week	Once per week or less
Bathing			
Brushing teeth			
Dress in clean/appropriate clothes			
Go to bed/wake up at regular times			
Preparing balanced meals			

Housekeeping activities _____ _____

Laundry _____ _____

Does your family regularly perform the following safety practices?

Lock door/secure home ___Yes ___No

Turn off the oven/running water, etc. ___Yes ___No

Is your family receiving personal care services, Meals on Wheels, or any other basic living skills provided? ___No ___Yes

Does your child have reliable transportation, or do you have access to public transportation, etc?
_____Yes
No (please explain)_____

What supports and resources do you have in the community (churches, clubs, extra-curricular activities etc)?

_____

_____

Does your child have a: Social Security card _____Yes _____No
Driver's License _____Yes _____No

Medical History and Functioning:

How would you describe your child's overall health? _____
Medical doctor(s) / Specialists:

_____

_____

Date of Last Physical or Wellness Exam: _____

Mother's age at child's birth: _____ Did mother receive routine pregnancy care?
Yes _____ No _____

Please specify any medications used during mother's pregnancy:

_____

Pregnancy lasted _____ weeks/ months
Child's birth weight _____ pounds _____ounces

Please check the conditions below that describe the health of the child and mother during **Mother's Pregnancy**
No complications _____ Blackouts_____ Falls _____ Physical Injury _____
Excessive Bleeding _____ Hypertension _____ Diabetes _____ Emotional Stress _____ Depression _____ Anxiety _____ Abuse _____
Toxemia _____ Alcohol/ Drug Use _____ Tobacco Use _____

Delivery
Normal _____ Induced Labor _____ Forceps/ Vacuum Delivery _____
C-Section _____ Breech Birth_____ Unusually long labor
_____Premature (# of weeks) _____ Overdue (# of weeks)_____
Other_____

Child's Condition at Birth
Normal/ No complications _____ Lack of Oxygen _____ Breathing Problems
_____Heart problems _____ Birth injury/ defect _____ Jaundice
_____Newborn ICU (Length of stay) _____

Parent's Postpartum Period
Did mother experience postpartum depression after the birth?
No_____ Yes_____
Did mother experience postpartum anxiety after the birth?
No_____ Yes_____
Did father experience postpartum depression after the birth?
No_____ Yes_____
Did father experience postpartum anxiety after the birth?
No_____ Yes_____
Was there any increased marital tension after the birth?
No_____ Yes_____

Please circle any health conditions that apply for the child presently:
Thyroid problem High blood pressure Headaches Heart problems Sleep problems
High Cholesterol Asthma Trouble eating Stomach problems Seizures
Other (please describe):
_____

Has your child had any of the following?

	Yes/No	What	When
Contagious or Infectious Diseases			
Disabilities or Handicaps			
Allergies/Food Allergies			

Has your child had any of the following?

	Yes / No	What	When
Accidents/injuries			
Surgeries			

Major illnesses

_____

Hospitalizations

_____

Loss of consciousness

_____

Medications- Please list all current prescribed or over the counter drugs / medications
_____No medications

Medication_____Dosage_____Doctor_____
Medication_____Dosage_____Doctor_____
Medication_____Dosage_____Doctor_____
Medication_____Dosage_____Doctor_____
Medication_____Dosage_____Doctor_____

****Please list additional medications on back of this page**

Can your child self-administer medications? _____Yes _____No

Medication Compliance:
____Regularly taken as prescribed
____Occasionally miss a dose
____Miss doses regularly
____Refuse/forgot to take meds most days

Has your child been treated in the past with psychiatric medications such as antidepressants, mood stabilizers, tranquilizers, sleeping aids, stimulants, or others?_____Yes _____No

Have any of your family members had significant illness or medical treatment? If so, please explain:

_____

Substance Use/Abuse
Do you have any concerns of substance use for your child? If yes, what substance and how often are they using?

_____

_____

Nicotine Use/Abuse

_____

Sexual History or Concern
Does your child have any current or past age-inappropriate sexual behaviors? Sexually acting out? Or sexually aggressive behavior? If yes, please explain:

_____

_____

Behavioral Health Treatment History

	Service Provider	When / How often?	Was it helpful? Please explain
Counseling			
In-Patient Psych Center			
Case Management			
Medication Management			
CBRS / PSR			
Addictions Treatment			
Developmental Services			
Occupational Therapy			
Speech Therapy			
Physical Therapy			
Personal Care Services			
Home Health Provider			
Other			

Is there any history of the previous services received by immediate biological family members? If yes, please explain.

_____

_____

_____

Developmental History

For the following developmental milestones please indicate the most appropriate response:

Milestone	Normal Age Range	Delayed but Caught Up	Ongoing/Current Concern
Sitting Up			
Crawling			
Walking			

Speaking first words			
Speaking sentences			
Fully Potty trained			
Stayed dry all night			

During your child's first few years of life, were any of the following significantly present?
Difficult to comfort _____Colicky _____Excessive Irritable _____
Diminished sleep _____Difficulty nursing _____
poor eye contact _____ did not respond to their name _____
fascination with certain objects _____constantly head banging_____

Prior to age 6 did your child have more difficulty than other children his/her age, (mark if yes):
Sitting still at mealtime _____paying attention when read to _____
throwing/catching a ball _____ buttoning or zipping _____ holding crayon or pencil _____accidently dropping/knocking thing over _____staying focused on tv, movies etc _____ waiting for turn at play _____ knowing left and right _____ dressing self _____tying shoe laces _____

If yes, please describe:

_____
_____
_____

How often are the following a problem for your child:

Getting ready for school:	Rarely ___	Sometimes _____	Frequently _____
Playing by him/herself:	Rarely ___	Sometimes _____	Frequently _____
With a babysitter/ at daycare:	Rarely ___	Sometimes _____	Frequently _____
In the car:	Rarely ___	Sometimes _____	Frequently _____
At school:	Rarely ___	Sometimes _____	Frequently _____
Playing by him/herself:	Rarely ___	Sometimes _____	Frequently _____

How would you describe your child's personality at home? _____
_____
How would you describe your child's personality at school? _____
_____

Are you interested in discussing parenting ideas/techniques as part of your child's therapy process? If yes, please describe areas of concern? _____
_____
_____
_____

Social History and Functioning

How would you describe your child's friendships – please circle all that apply-
No friends Only acquaintances Acquaintances and Friends

Please describe the following about your child in social settings:
Your child's temperament in social situations? (Shy. Outgoing, leader, follower)

_____
_____

How would you describe their behavior and comfort level when in social settings?

_____
_____

What are their talents and/or social strengths?

_____
_____

Do you have any concerns about your child's peer relationships, choice of friends and/or social functioning? If yes, please described: _____
_____

Does your child have appropriate social skills for their age/functioning? If no, please describe:

_____

Has your child ever complained of being bullied or been accused of bullying? If yes, please describe: _____
_____

Has your child identified a sexual orientation: _____
Gender identity: _____
Expressed any confusion/concern over either? _____

Do you have any concerns that your child is experiencing any difficulties with age, gender, sexual orientation, culture, race, or religion?
No____ Yes

_____
_____

Legal History and Functioning

Does your child have any current or past involvement with the legal system including diversion court, probation, arrest, illegal activity, or incarceration?
_____No _____Yes Please explain

_____
_____
_____
_____
_____

Vocational/Educational History and Functioning

Grade in School: _____ School: _____
Teacher_____
Child's Favorite Subject: _____

Please describe how your child did/does in elementary school:
Academically_____
Behaviorally_____
Socially_____

Please describe how your child did/does in junior high/high school:
Academically_____
Behaviorally_____
Socially_____

Does your child receive any specialized classroom setting or receive special education?
_____Yes_____No
Do they currently or in the past had an Individual Education Plan (IEP) or a 504plan:
_____

Has there ever been any concern expressed by physicians, teachers or other professionals related to your child meeting developmental milestones?
_____

Have there been any behavioral issues or concerns at school/ daycare, if yes, please describe:
_____

Does your child currently have educational goals? _____No _____Yes
_____

Has your child had any vocational training? _____No _____Yes
_____

Employment

Is your child currently employed? If yes please describe where and how long-
No _____ Yes_____

Does your child currently have employment goals? _____No _____Yes
_____

Financial History and Functioning

Are finances adequate to meet the family's needs ____Yes ____No – please explain:
_____
_____
Sources of Income: _____

Is there any parental stress of concern, if yes, please indicate:
_____

Housing History

Current Living arrangement:

___Own home
___Renting
___Living with friends/family
___Other
___Supported housing-explain_____

Does the current housing situation meet your child's needs in the following areas?

Health and safety ___Yes ____No-please explain_____
Access to services ___Yes ____No-please explain_____

Is there any history of homelessness/evictions? ____No ___Yes-please explain_____
Is there any risk of homelessness? ____No ____Yes-please explain_____

Signatures

Responsible party completing this form: _____
Relationship to Client: _____

Signature: _____
Date: _____

* medicaid only

ALERT®

Wellness Assessment - Youth

Completing this brief questionnaire will help us provide services that meet your child's needs. Answer each question as best you can and then review your responses with your child's clinician. Shade circles like this ●

Child's Last Name | First Name | Child's Date of Birth: (mm/dd/yy)

Subscriber ID | Authorization #

Clinician Last Name | First Name | Today's Date: (mm/dd/yy)

Clinician ID/Tax ID | Clinician Phone | State | MRef ○

Visit #: ○ 1 or 2 ○ 3 to 5 ○ Other

Relationship to child: ○ Mother ○ Father ○ Stepparent ○ Other Relative ○ Child/Self ○ Other

For questions 1-21, please think about your experience in the past week.

Fill in the circle that best describes your child:	*Never*	*Sometimes*	*Often*
1. Destroyed property	○	○	○
2. Was unhappy or sad	○	○	○
3. Behavior caused school problems	○	○	○
4. Had temper outbursts	○	○	○
5. Worrying prevented him/her from doing things	○	○	○
6. Felt worthless or inferior	○	○	○
7. Had trouble sleeping	○	○	○
8. Changed moods quickly	○	○	○
9. Used alcohol	○	○	○
10. Was restless, trouble staying seated	○	○	○
11. Engaged in repetitious behavior	○	○	○
12. Used drugs	○	○	○
13. Worried about most everything	○	○	○
14. Needed constant attention	○	○	○

How much have your child's problems caused:	*Not at All*	*A Little*	*Somewhat*	*A Lot*
15. Interruption of personal time?	○	○	○	○
16. Disruption of family routines?	○	○	○	○
17. Any family member to suffer mental or physical problems?	○	○	○	○
18. Less attention paid to any family member?	○	○	○	○
19. Disruption or upset of relationships within the family?	○	○	○	○
20. Disruption or upset of your family's social activities?	○	○	○	○

21. How many days in the past week was your child's usual routine interrupted by their problems? ☐ Days

Answer the following only if this is your first time completing this questionnaire for this child.

22. In general, would you say your child's health is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

23. In the past 6 months, how many times did your child visit a medical doctor? ○ None ○ 1 ○ 2-3 ○ 4-5 ○ 6+

24. In past month, how many days were you unable to work because of your child's problems? *(answer only if employed)* ☐☐ Days

25. In the past month, how many days were you able to work but had to cut back on how much you got done because of your child's problems? *(answer only if employed)* ☐☐ Days

59243

Clinician: Please fax to (800) 985-6894

Rev. 2007

Client Information & FAQs About ICANS

What is ICANS?

ICANS is an electronic, internet-based system used to administer and manage the Children and Adolescent Needs and Strengths (CANS) Assessments in Idaho.

Why do I want my child's information available in ICANS?

The Child and Adolescent Needs and Strengths (CANS) is a tool for measuring your child and family's needs and strengths. The CANS is used in Idaho to help determine a child or youth's level of functional impairment and guide treatment planning decisions. In Idaho, the ICANS system uses the information from the CANS Assessment to help clinicians and other providers of children mental health services recommend the appropriate level of care.

To participate in or receive certain state-funded programs, such as the Youth Empowerment Services (YES Program), a child/youth will need to complete a CANS Assessment.

ICANS is the Idaho approved platform to administer and score the CANS. By not allowing your child's information to be available in the ICANS system your child may not be able to access certain state-funded services or programs.

Permitting your child's information to be entered into the ICANS system allows it to be available to authorized providers and staff to make more informed, collaborative decisions regarding your child's mental health services and care.

Why do I need to complete and sign the informed consent?

By completing and signing the informed consent release form, you allow the agency listed to enter your child's information into the ICANS system.

Without the completed and signed informed consent release form, your provider cannot enter your child's information into the ICANS system.

Who may input my child's information into the ICANS system?

The agency that you have named at the top of the informed consent release form has permission to add your child's information to ICANS.

Who will have access to your child's information in ICANS?

Authorized users may have access to your child's information in ICANS.

An authorized user is an individual designated by a provider agency or Idaho Department of Health and Welfare Division of Behavioral Health needing to access ICANS for their job.

Examples of potential authorized users may include, but are not limited to:

- Division of Behavioral Health Children's Mental Health staff.
- Division of Family and Community Services (FACS) staff, including Developmental Disabilities and Child Welfare if your child is involved in their programs.
- Medicaid and/or Optum staff who are responsible for the coordination, payment, and quality management of behavioral health services in Idaho.
- Independent Assessment providers, who are contracted by Medicaid, who will assess children for eligibility for some state-funded children's mental health services.

All ICANS users must also abide by the ICANS policies and procedures which include Health Insurance Portability and Accountability Act of 1996 ("HIPAA") privacy and security standards. Use of the ICANS system for any other reason is strictly prohibited.

What information may be viewable by ICANS authorized users?

Limited information entered into the ICANS system is viewable to all authorized users.

Only the following information in the ICANS system **may be shared** with all authorized users:

- Last Name
- First Name
- Birth Date
- Social Security Number*
- Gender
- Race
- Ethnicity
- Address
- Identifiers (other numbers such as Medicaid ID number)

*The Social Security Number (SSN) is collected for the purpose of identification of the participants, prevention of duplication of benefits and information. The SSN is a fundamental component for case management and care coordination activities.

The Department of Health and Welfare is authorized to collect and use social security numbers (SSN) to determine Medicaid eligibility, verify information, and prevent duplicative participation. Providing your SSN may minimize administrative delays associated with the requested service. The Department will not disclose an individual's SSN without the consent of the individual to anyone outside of the Department except as mandated by law. 31 CFR 1.32; 42 CFR §435.910.

The following information in the ICANS system is **not shared** with authorized users without a specific signed Release of Information:

- Diagnosis(s)
- Any information related to Substance Use.
- Ratings on any of the CANS items.
- Comments entered into ICANS related to the CANS scoring.
- Recommended Level-of-Care outcomes

How do I share my child's information between my child's treatment providers?

A specific completed and signed Release of Information must be completed *in addition* to the ICANS informed consent release form so that your child's provider can access records completed by another provider agency.

What information may be viewable by my child's treatment provider?

Your child's treatment provider can access any ICANS records for your child that have been entered by that specific provider and/or agency.

Please Note: A specific signed Release of Information must be completed *in addition* to the ICANS informed consent release form so that your child's provider can access records completed by another provider agency. The following information is available to your child's provider:

- Last Name
- First Name
- Birth Date
- Social Security Number*
- Gender
- Race
- Ethnicity
- Address
- Identifiers (other numbers such as Medicaid ID number)
- Diagnosis(s)
- Any information related to Substance Use.
- Ratings on any of the CANS items.
- Comments entered into ICANS related to the CANS scoring.
- Recommended Level-of-Care outcomes

Can I revoke the ICANS informed consent release form?

You may revoke the ICANS informed consent release form at any time. This will prevent any future use of ICANS but does not change any action that has already taken place using the informed consent release form.

After the informed consent release form has been revoked, the informed consent release form is no longer valid from that date forward. Copies or exact reproduction of the completed and signed informed consent release form will have the same force and effect as the original.

How is my child's privacy protected?

Information shared through ICANS is protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"); federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 C.F.R. Part 2; 45 C.F.R. Parts 160 & 164; and the Medicaid Act, 42 C.F.R. Part 431, Subpart F.

The ICANS system and participating providers use a combination of safeguards to protect your child's health information.

- Technical safeguards include encryption, password protections, and audit logs that track every participant's use of the system.
- Administrative safeguards include written policies that require limited access to information through ICANS. All participating providers must agree to follow these policies.
- The ICANS Security Safeguards can be found online at: http://icans.dhw.idaho.gov/ResourcesandUserGuide/tabid/4105/Default.aspx

All participating providers are also regulated by HIPAA, and other federal and state privacy laws. Providers must also have their own policies and other safeguards in place, including policies to train their staff and limit access to those who have a need to know.

Have questions not covered by this flyer or have concerns?

Please speak with your local Idaho Department of Health and Welfare Children's Mental Health office.

healthandwelfare.idaho.gov

IDAHO DEPARTMENT OF
HEALTH & WELFARE

ICANS Informed Consent

I, _____ *(parent's name)*, am the parent or legal guardian of

_____ *(minor client's name)*.

I have received a brochure explaining how ICANS is a secure electronic health system used to administer the ICANS assessment, and make the results available to providers who participate in the ICANS system.

I authorize the following Agency _____ (*name of provider/agency/ organization)* to release, use, receive, mutually exchange, communicate with and disclose information to the ICANS system, and with Agencies/Authorized Users with access to ICANS.

WHO MAY DISCLOSE INFORMATION. The agency I have named at the top of this form may disclose protected health information to ICANS.

WHAT MAY BE DISCLOSED. By signing this consent, I specifically understand that protected health information or records will be released, used, disclosed, received, mutually exchanged or communicated to, by, among, or between any person, entity, or agency named in this authorization. I understand this information may include material protected under federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 C.F.R. Part 2; the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 & 164; and the Medicaid Act, 42 CFR Part 431, Subpart F. Federal rules restrict any use of the information to criminally investigate or prosecute and to redisclose records relating to any alcohol or drug abuse patient.

PURPOSES.
I understand this authorization will allow my treatment team to plan and coordinate services I need and allows any person, entity, or agency named in this authorization to be actively involved in my case coordination, evaluation, treatment, planning, or legal proceedings. I hereby request and give my permission for an open exchange of information to, by, among, or between, any person, entity, or agency named in this authorization.

REVOCATION.
I also understand that I may revoke this Informed Consent at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization expires automatically as indicated with each disclosure item identified above. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as this original.

EXPIRATION
This authorization shall expire one (1) year from the date the Minor Client and Parent or Legal Guardian signs below.

CONSENT.
I understand that my information cannot be disclosed without my written consent, except as otherwise provided by law, and that federal and Idaho law will be followed for using and disclosing my ICANS information.

By signing this form, I am authorizing providers assessing or treating my child/ward to provide my child/ward's information to ICANS. I understand that failure to sign this authorization may limit determine of eligibility, enrollment, or treatment for my child/ward.

I have read this Informed Consent/had this Informed Consent read/explained to me and I acknowledge an understanding of the purpose for the release of information. I am signing this authorization of my own free will.

Full Legal Signature of Minor or Authorized Personal Representative	**Relationship to Client**	**Date**
Full Legal Signature of Parent or Legal Guardian – *Required if Client is under 16 years of age, but only after signed by client.*	**Relationship to Client**	**Date**
Full Legal Signature of Witness (Agency Employee)	**Initiating Agency Name**	**Date**