

**CAMHS – Part 1 Mental Health Assessment**

CCIS ID		NHS No		Referral No	
First Name		Middle Name		Last Name	
Date of Birth:		Age		Age if Estimated	
Gender			Nationality		
Religion			Ethnicity		
Primary Address					
Post Code		Email Address			
Home Phone		Mobile Phone		Work Phone	
Preferred Language		Preferred Contact Method		Interpreter Required	

Surgery/Practice	GP Name
Surgery/Practice Address	
Surgery/Practice Phone Number	Surgery/Practice Fax Number

Other Professional/Services Involved

Organisation	Contact	Email Address	Contact Number	Address
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Is the child in the care of the Local Authority (Child Looked After)?

- Yes
- No
- Don't Know

If Yes, Legal Status

- Accomodated S20
- Full Care Order
- Interim Care Order

Is the Child:

- On the Child Protection Register
- A Child in Need
- On the Sex Offender's Register

Social Worker

Name	Contact Number
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Are there any special arrangements/issues to be aware of when contacting the carer/young person

- Yes
- No

If yes, please give details

Are there any specific issues with communication/literacy for the parent/carer or young person

Yes

No

If yes, please give details

Does the child have a physical or mental health condition or any other impairment that has lasted, or is likely to last at least 12 months or is of a progressive nature

Yes

No

Declined

If Yes, Please State Below

Physical Impairment

Sensory Impairment

Long Standing Illness/Health Condition

Learning Disability

Learning Difficulties

Mental Health Condition

Other

Prefer not to say

Client Disability/Impairment

Disability or Impairment	Disability	Impairment	Severity
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Is there any mobility issues or conditions that may prevent the child attending any appointments offered?

Please provide details below

**Sexual Orientation**

Bisexual [B]

Gay or Lesbian [G]

Heterosexual [H]

Not known [NA]

Not known [NA]

Not Stated (person asked but declined to provide a response) [Z]

Other [O]

Person asked and does not know or is not sure [U]

**Family Responsibilities**

<p>Does the child look after or give help or support to:</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><input type="checkbox"/> Family Member</p> <p><input type="checkbox"/> Friend</p> <p><input type="checkbox"/> Neighbour</p> <p><input type="checkbox"/> Other</p> </div>	<p>Because Of:</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><input type="checkbox"/> Long Term Physical Health</p> <p><input type="checkbox"/> Mental Ill Health</p> <p><input type="checkbox"/> Disability</p> <p><input type="checkbox"/> Problems Relating to Old Age</p> <p><input type="checkbox"/> Other</p> </div>	<p>If yes, please indicate approximately how many hours per week this entails:</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><input type="checkbox"/> 1-19</p> <p><input type="checkbox"/> 20-29</p> <p><input type="checkbox"/> 30-39hrs</p> <p><input type="checkbox"/> 40+</p> </div>
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<input type="checkbox"/> Prefer Not to Say	<input type="checkbox"/> Prefer Not To Say	
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## Assessment

Assessment Date

DD	MM	YYYY
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Referred by

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### 1. Present at Assessment (Age, Occupation, Names)

Name	Age	Occupation	Relationship

### 2. Presenting Problems: (Frequency, Severity, Family Perception of the Problem)

	Details
Frequency	
Severity	
Family Perception of the Problem	

### 3. History of Presenting Problems

Onset and Progression	Situation in which it occurs	Impact on Life	Predisposing	Precipitating	Additional Information

### 4. Current/Past Interventions (Other involved agencies)

**5. Family, Life and Relationships (Parental responsibility, discord, alliances)**

**6. Family Life Events**

**7. School**

(Name of School, Year, Form Tutor, Head of Year, Academic Achievement, Special Educational Needs, Attendance, Behaviour)

School/College Details

Education Establishment	Establishment Type	Start Date	End Date	Status
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(Year, Form Tutor, Head of Year, Academic Achievement, Special Educational Needs, Attendance, Behaviour)

**8. Peer Relationships**

**9. Developmental History (Pregnancy, Birth, Developmental Milestones, Childhood Illnesses)**

## 10. Physical/Mental Health

	Details
Sleep	
Appetite	
Mood	
Thoughts	
General Behaviour	
Self-Harming behaviour Complete Risk Assessment Form	
Medication	
Temperament/Personality	

## 11. Lifestyle

	Details
Smoking	

Drug Use	
Alcohol	
Sexual Activity	
Police Involvement	
Other	

**12. Interests/Hobbies/Strengths**

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**13. Observations during the assessment**

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**14. Assessors View of Family Presentation (Strengths, Resilience, Protective Factors)**

	Details
Strengths	
Resilience	

Protective Factors	
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Completed Forms

	Date	Signature
WARRN Risk Assessment		
Primary Care Mental Health Assessment		
Consent		

Outcome

Please note i.e. waiting for additional information; taken back to CAMHS Team; requires Specialist CAMHS; requires PMHW; referral onto another service; discharged for CAMHS

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Signed	Date
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Form Data Entry

Lead Assessor	Actual Start Date	Status	Modified On	Modified By	Completion Date	Completed By User
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