# INFANCY, CHILDHOOD & RELATIONSHIP ENRICHMENT INITIAL ASSESSMENT (May Be Used for Birth -5 yrs)

(**See Reference Manual)**



Initial Contact Date: _____ Date Form Completed: _____

**ASESSING PRACTITIONER** (Name and Discipline): _____

## I. IDENTIFYING INFORMATION

**Child**

**NAME**: _____ **DOB**: _____ Age: _____

Other Names Used: _____ **GENDER**: ☐ Male ☐ Female

**ETHNICITY**: _____ **PREFERRED LANGUAGE**: _____

Referred by (Name & Number): _____

**BIOLOGICAL PARENTS & CONTACT INFORMATION**

Mother's Name: _____

Marital Status: _____ DOB: _____

Address: _____

Phone: _____ Work: _____

Preferred Language: _____

Interviewed: ☐Yes ☐No Interpreter Used: ☐Yes ☐No

Language Used for Interview: _____

Father's Name: _____

Marital Status: _____ DOB: _____

Address: _____

Phone: _____ Work: _____

Preferred Language: _____

Interviewed: ☐Yes ☐No Interpreter Used: ☐Yes ☐No

Language Used for Interview: _____

**PRIMARY CAREGIVER & CONTACT INFORMATION** (Complete only if Biological Parent is not the Primary Caregiver)

☐ Adoptive ☐ Guardian ☐ Foster ☐ Kinship/Relative ☐ Group Home ☐ Other

Name: _____ Relationship to Child: _____ DOB: _____

Address: _____

Marital Status: _____ Phone: _____ Work: _____

Preferred Language: _____ Language Used for Interview: _____ Interpreter Used: ☐ Yes ☐ No

## II. REASON FOR REFERRAL/CHIEF CONCERN

**WHY REFERRED**? Type of help family is hoping to receive.

**CURRENT PRIMARY SYMPTOMS/BEHAVIORS IMPAIRMENTS IN LIFE FUNCTIONING**

**DESCRIBE ONSET, DURATION & FREQUENCEY**

Describe child & family **STRENGTHS**



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# INFANCY, CHILDHOOD & RELATIONSHIP ENRICHMENT INITIAL ASSESSMENT (Continued)

(**See Reference Manual)**



**HISTORY OF PROBLEM**

(Caregiver perception of cause, attempted solutions, possible triggers to onset, etc.)

**Additional Problem Areas**

(Sleeping, eating, toileting, self-care, social/peer relations, tics, etc., frequency & onset)

**III. Physical Status/MEDICAL HISTORY**

Does this client have an identified pediatrician or health care providers? ☐ Yes ☐ No

SOURCE OF INFORMATION: ☐ PHYSICIAN CONSULTATION ☐ MEDICAL RECORDS ☐ PARENT/CAREGIVER REPORT DATE OF LAST PHYSICAL

**PEDIATRICIAN'S NAME**: **PEDIATRICIAN'S PHONE**:

ACUTE ILLNESS/MEDICAL PROBLEMS: (List)

CURRENT MEDICATIONS:

☐ CHRONIC ILLNESS ☐ FAILURE TO THRIVE ☐ GROWTH DELAY ☐ NUTRITIONAL CONCERNS ☐ ASTHMA ☐ **ALLERGIES**

☐ EAR INFECTIONS: # OF TIMES TREATED WITH ANTIBIOTICS PER YEAR: ☐ IMMUNE-SUPPRESSED

☐ DEAFNESS (Partial / Total) ☐ BLINDNESS (Partial / Total) ☐ LEAD LEVEL TESTED: (Date/Details)

IMMUNIZATIONS up to date: ☐ Yes ☐ No ☐ INJURIES/TRAUMA: (Type)

NEUROLOGICAL: ☐ SEIZURE DISORDER ☐ AUTISM ☐ CEREBRAL PALSY ☐ OTHER:

BRAIN TRAUMA: (Date/Details)

SURGERIES: (Date/Details)

OTHER CHRONIC HEALTH PROBLEMS:

VISIBLE ABNORMALITIES/MALFORMATIONS (Head, Hands, Spine, Extremities, Face, Genitalia, Skin):

DETAILS REGARDING ABOVE:



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**IV. DEVELOPMENTAL HISTORY** (ADD PAGES IF NECESSARY)

**PRENATAL/PERINATAL INFORMATION**

PRENATAL CARE: ☐ NONE ☐ INTERMITTENT ☐ REGULAR ☐ OTHER: _____

PRENATAL COMPLICATIONS/CONCERNS: Illnesses, accidents, stresses during pregnancy. Maternal use of alcohol, drugs, cigarettes (specify?) _____

POSTPARTUM PSYCHIATRIC PROBLEMS: ☐ NO ☐ YES (Onset & Duration) _____

**Birth History**

TERM (mos.): _____ BIRTH WEIGHT (LB/oz): _____ BIRTH LENGTH (inches): _____ MOM's AGE: _____

LABOR DURATION: _____ CHILD DAYS in HOSPITAL: _____ PLACE OF DELIVERY: _____ DAD's AGE: _____

TYPE OF BIRTH: ☐ NATURAL ☐ INDUCED ☐ C-SECTION ☐ FORCEPS ☐ VACUUM TYPE ANESTHESIA USED: _____

BIRTH COMPLICATIONS: _____

**Mother/Caregiver Perceptions of Pregnancy & Birth** (Planned or surprise? Your/father's reaction? Support?)

**Feeding**

Breast-fed/Bottle-fed combination? Duration and age weaned?

Age of taking cereal, solids. Types?

Feeding difficulties? Frequency & onset? Spitting up, sucking problems, refusal to eat, over-eating, fussy eater?

Frequency of eating? Signals of hunger/satiation? Self-regulation?



**Name:** _____ **MIS #:** _____

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| | |
|---|---|
| Good sleeper? How did s/he sleep in past week? Last night? Is this typical?<br><br>Length and frequency of naps, nighttime sleep?<br><br>Difficulty falling asleep, waking? Frequency & onset | **Sleeping Patterns** |
| Describe your child's personality: over-active/highly reactive or under-reactive/slow to respond, easy-going, anxious?<br><br>Is your baby colicky, fussy, cries a lot? How often & how long does your baby cry?<br><br>Is it easy to read your baby's signals and moods?<br><br>How responsive is your baby to you? Easy or difficult to soothe? What soothing strategies do you see? | **Temperament** |



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**INFANCY, CHILDHOOD &**
**RELATIONSHIP ENRICHMENT INITIAL ASSESSMENT** (Continued)
(**See Reference Manual)**



**IV. DEVELOPMENTAL HISTORY** (Continued)

| **DEVELOPMENTAL MILESTONS**<br>(Describe if not within normal limits)<br>**See Reference Manual.**<br>Address domains: sensory, motor, socio-emotional, language, cognitive and adaptive / self help | | **ENVIRONMENTAL STRESSORS**<br>**See Reference Manual.** Moves; schools; separation; losses of family/friends, changes in family composition, SES, lifestyle; exposure to family conflict/violence; major illnesses; abuse; placements, etc. |
|---|---|---|
| Infancy: 0-6 mos.<br>Smiles back<br>Rolls over<br>Turns to sound<br>Babbles<br>Plays with objects | | Infancy: 0-6 mos. |
| 6-12 mos.<br>Stranger anxiety<br>Sits upright/walks<br>Responds to name<br>Object constancy<br>Says 1-2 words | | 6-12 mos. |
| 12-18 mos.<br>Reciprocal play<br>Eats with spoon<br>Tolerates noises<br>Jumps with 2 feet<br>Says 4-6 words | | 12-18 mos. |
| 18-24 mos.<br>Words for feeling<br>Balance on 1 foot<br>Brushes teeth/hair<br>2-3 word sentence<br>Pretend play | | 18-24 mos. |
| 24-36 mos.<br>Toilet trained?<br>Throws ball<br>Uses "I"<br>2-step request<br>Uses "big/little" | | 24-36 mos. |
| 36-60 mos.<br>Uses scissors<br>Climbs a ladder<br>Uses sentences<br>Draws a line<br>Symbolic play | | 36-60 mos. |

**Development Assessment Tools & Results**
*(list questionnaires or formal testing)*



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**V. CURRENT FAMILY SYSTEMS REVIEW**

**Family Members Living in Child's Current Home**

*(Identify relation & age)*

| | |
|---|---|
| Who else lives in your home? Apt/house? Enough space? Always lived here?<br><br>**FAMILY RELATIONS**<br>Get along with each other?<br>Extended family?<br>Friends?<br>**SOCIALS/ OTHER SUPPORTS?**<br>DCFS support?<br><br>**FAMILY HISTORY**:<br>Medical<br>Psychiatric<br>Legal/Criminal<br>Alcohol/Drug<br><br>Family cultural identity? Immigration history? Religion? Spiritual practice?<br><br>**FAMILY STRENGTHS?** | |
| **DCFS/ABUSE/ PLACEMENT HISTORY & PLANS** | |



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**V. RELEVANT PAST FAMILY SYSTEMS REVIEW (Complete only if client has had more than one Relevant Family System)**

**Family Members Not Currently Living in Child's Home**

*(Identify relation & age)*

| | |
|---|---|
| Who else lived in your home?<br>Apt/house?<br>Enough space?<br>Always lived there?<br><br>**FAMILY RELATIONS**<br>Get along with each other?<br>Extended family?<br>Friends?<br>**SOCIAL/OTHER SUPPORTS?**<br>DCFS support?<br><br>**FAMILY HISTORY**:<br>Medical<br>Psychiatric<br>Legal/Criminal<br>Alcohol/Drug<br><br>Family cultural identity?<br>Immigration history?<br>Religion? Spiritual practice?<br><br>**FAMILY STRENGTHS?** | |
| Family Visitation & Involvement Plan<br>Visitation schedule<br>Engagement in child's assessment | |



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**VI. Child Care / Early Intervention / Preschool Services**

CURRENT DAY CARE, CHILD CARE OR PRESCHOOL

☐ DOES NOT ATTEND CHILD CARE ☐ ATTENDS LICENSED DAY CARE ☐ ATTENDS UNLICENSED CHILD CARE

☐ CURRENTLY NOT ENROLLED IN PRESCHOOL ☐ REGULAR PROGRAM ☐ SPECIAL EDUCATION PROGRAM

CHILD CARE/PRESCHOOL NAME: _____
CONTACT PERSON: _____
ADDRESS: _____
PHONE: _____
DAYS/TIMES PER DAY CHILD ATTENDS: _____
PARENT PARTICIPATION: _____
NOTABLE INFO: _____
DATE OF LAST IFSP/IEP: _____
IFSP/IEP ELIGIBILITY: _____

ADDITIONAL CHILD CARE: _____
CONTACT PERSON: _____
ADDRESS: _____
PHONE: _____
DAYS/TIMES PER DAY CHILD ATTENDS: _____
PARENT PARTICIPATION: _____
NOTABLE INFO: _____

EARLY INTERVENTION or REGIONAL CENTER SERVICES

☐ CURRENTLY NOT IN EARLY INTERVENTION PROGRAM
DATE ENROLLED: _____
NAME OF PROGRAM: _____
CONTACT PERSON: _____
ADDRESS: _____
PHONE: _____
DAYS/TIMES PER DAY CHILD ATTENDS: _____
SERVICES RECEIVING: _____
PARENT PARTICIPATION: _____
NOTABLE INFO: _____

☐ HISTORY OF EARLY INTERVENTION PROGRAM
DATE ENROLLED: _____
NAME OF PROGRAM: _____
CONTACT PERSON: _____
ADDRESS: _____
PHONE: _____
DAYS/TIMES PER DAY CHILD ATTENDS: _____
SERVICES RECEIVING: _____
PARENT PARTICIPATION: _____
NOTABLE INFO: _____

HISTORY OF CHILD CARE / EARLY INTERVENTION / PRESCHOOL or SPECIAL SERVICES
(CONSIDER: licensed/unlicensed facility, #children in class, age range of children, nature of relationship with teachers/caregivers, peer relationships, parents' perception of support from teachers/caregivers, history of threatened or actual suspensions or expulsions from day care/pre-K, etc.)



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**VII. MENTAL STATUS / BEHAVIORAL OBSERVATIONS: CHILD**

Include relevant features from below. Be sure to address relevant features from each **bolded** category below.

**Appearance**
Dress, grooming, unusual physical characteristics

**Behavior**
Activity level, mannerisms, eye contact, manner of relating to parent/therapist, motor behavior, aggression, impulsivity

**Socio-Emotional/Mood/Affect**
Shy, fearful, labile, sad, blunt, irritable, aggressive, passive, depressed, anxious, risk to self or others
State regulation

**Cognitive**
Attention span and play are age appropriate, problem-solving ability

**Communication/Language**
Verbal/nonverbal, receptive/expressive, age appropriate

**Sensorimotor**
Visual, auditory, tactile, vestibular, proprioceptive, taste, textures, smells (avoidant, neutral, seeking)

**Gross Motor**
Coordination, motor planning, muscle tone (low, floppy, tense), postural stability

**Fine Motor**
Coordination, tremors, etc.

**Adaptive Functioning**
Age appropriate self-care, feeding, toileting

**Strengths**
Adaptive capacity, strengths & assets, cooperation

Provide a description of this child based on your observations.



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**VIII. Observed Caregiver – Child Interaction**

Be sure to address relevant features from each **bolded** category below.

Provide a description based on your observations of child & caregiver interaction.

**Behavioral Observations**

Eye contact
Behavioral quality of the interaction
Affective tone
Psychological involvement (DC 0-3R, Axis II)

**Capacities for Emotional and Social Functioning**

Attention and regulation
Forming relationships/mutual engagement
Intentional two-way communication
Complex gestures and problem solving
Use of symbols to express thoughts/feelings
Connecting symbols logically/abstract thinking
(DC 0-3R, Axis V)

**Attunement, Balance & Congruence**

Caregiver sensitive to infant cues and responds accordingly.



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## IX. Behavioral Observations & Interview with Caregiver

| Be sure to address relevant features from each **bolded** category below. | Provide a description based on your observations of child & caregiver interaction. |
|---|---|
| **Behavioral Observations**<br>Appearance, manner of relating, expressive style, mood/affect | |
| **Caregiver's Perceptions and Expectations**<br>Of the child/baby<br>Of his/herself and parenting | |
| **Insight/Strengths/Challenges**<br>Adaptive capacity, strengths & assets, cooperation, insight, judgment, motivation for treatment | |

## X. SUMMARY & CLINICAL FORMULATION

(Brief description of child problems/strengths and primary family and environmental issues that support diagnosis. Be sure to include symptoms/impairments in life functioning i.e. school, home, community, living arrangement, etc.)



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## XI. DIAGNOSTIC CLASSIFICATION

***DC: 0 – 3R* Diagnosis:**

**Axis I** (Primary Dx):

**Axis II** : (Relationship Classification)

| Relationship quality | No evidence | Some evidence* | Substantial evidence |
|---|---|---|---|
| Overinvolved | ☐ | ☐ | ☐ |
| Underinvolved | ☐ | ☐ | ☐ |
| Anxious/Tense | ☐ | ☐ | ☐ |
| Angry/Hostile | ☐ | ☐ | ☐ |
| VerballyAbusive | ☐ | ☐ | ☐ |
| PhysicallyAbusive | ☐ | ☐ | ☐ |
| SexuallyAbusive | ☐ | ☐ | ☐ |

*Needs further investigation

**PIR-GAS w/Caregiver I: ☐ (Caregiver: ☐)**
**PIR-GAS w/Caregiver 2: ☐ (Caregiver: ☐)**
**PIR-GAS w/Caregiver 3: ☐ (Caregiver: ☐)**

**Axis III** (Medical & Dev. D/O):

**Axis IV** (Psychosocial Stressors):
Source:

Effects: ☐ Mild ☐ Moderate ☐ Severe
Duration: ☐ Age of onset: ☐
Acute: ☐ Enduring: ☐

**Axis V** (Functional Emotional Developmental Level):

1 = age-appropriate under all conditions and full range of affect
2 = age-appropriate but vulnerable to stress and/or constricted range of affect
3 = has capacity but not at age appropriate level
4 = inconsistent/needs support and structure to function at this capacity
5 = barely evidences capacity even with support
6 = has not reached this level
N/A = not applicable

☐ Attention and regulation (0-3 mos)
☐ Forming relationships/mutual engagement (3-6 mos)
☐ Intentional two-way communication (4-10 mos)
☐ Complex gestures and problem solving (10-18 mos)
☐ Use of symbols to express thoughts and feelings (18-30 mos)
☐ Connecting symbols logically and abstract thinking (30-48 mos)

***ICD 10* DIAGNOSIS CODE: (To be entered in the IS/IBHIS)**

**Primary:** ☐
**Secondary:** ☐
**Other:** ☐
**Other:** ☐
**Other:** ☐
**Other:** ☐
**Other:** ☐



**Name:** ☐ **MIS #:** ☐

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## XII. Medical Necessity Criteria

**SPECIALTY MENTAL HEALTH SERVICES MEDICAL NECESSITY CRITERIA:**

1. Medi-Cal Specialty Mental Health Included Diagnosis ☐ YES ☐ NO
2. Significant impairment in life functioning due to the Included Diagnosis ☐ YES ☐ NO
3. Expectation that proposed interventions can impact the client's condition ☐ YES ☐ NO
4. Mental Health Condition will not be responsive to physical health care based treatment ☐ YES ☐ NO

**For EPSDT clients, if criteria (2)-Impairment and (3)-Intervention above are not met, medical necessity is met when the following exists:**

1. Specialty mental health services are needed to correct or ameliorate a defect, mental illness, or condition ☐ YES ☐ NO

## XII. Disposition/Recommenation/Plan

(Consider collaboration between systems and providers and it's impact on the child and family)

## XIII. Referrals Given

SERVICE: _____

REFERRED TO: _____

DATE: _____ CONTACT NAME: _____ PHONE NUMBER: _____

SERVICE: _____

REFERRED TO: _____

DATE: _____ CONTACT NAME: _____ PHONE NUMBER: _____

SERVICE: _____

REFERRED TO: _____

DATE: _____ CONTACT NAME: _____ PHONE NUMBER: _____

## XIV. SIGNATURES

| ASSESSOR'S SIGNATURE | TITLE | DISCIPLINE | DATE |
|---|---|---|---|
| CO-SIGNATURE | TITLE | DISCIPLINE | DATE |



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