A large number of individuals have collaborated in the development of the CANS-Comprehensive.
Along with the CANS versions for developmental disabilities, juvenile justice, and child welfare, this
information integration tool is designed to support individual case planning and the planning and evaluation
of service systems. The CANS-Comprehensive is an open domain tool for use in service delivery systems
that address the mental health of children, adolescents and their families. The copyright is held by the Buddin
Praed Foundation to ensure that it remains free to use. For specific permission to use please contact Melanie
Lyons of the Foundation. For more information on the CANS-Comprehensive assessment tool contact:

**John S. Lyons, Ph.D.,**
Mental Health Services and Policy Program
Northwestern University
710 N. Lakeshore Drive, Abbott 1206
Chicago, Illinois 60611
(312) 908-8972
Fax (312) 503-0425
JSL329@northwestern.edu

**Melanie Buddin Lyons**
558 Willow Road
Winnetka, Illinois 60093
847-501-5113
Fax (847) 501-5291
Melanie405@sbcglobal.net

Please FAX supporting clinicals to (855) 584 2172
Registration
(* required field)
*Referring Party: ____________________________________
*Geographic Area: ____________________________________
*Is this a SWETP Referral? □ Yes □ No
*Are Supplemental clinicals expected? □ Yes □ No
*Contact Name: ____________________________________ *Phone: ___________________
*SW/Probation/Parole/Public Defender Name: __________________ *Phone: __________________
*Program Supervisor Name: ____________________________ *Phone: __________________
*SW/Probation/Parole/Public Defender Supervisor Name: __________________ *Phone: __________________
*Behavioral Health Program Director Name: __________________ *Phone: __________________
*AD Designee Who Approved Congregate Care request: ____________________________ *Phone: __________________
*Link Person #: ____________________________
*Link Case#: ____________________________
*Client Medicaid ID #: ____________________________
*Case #: ____________________________
*Present Placement: ____________________________ *Court Ordered Placement? □ Yes □ No
*Date of next Hearing: ____________________________

CSSD/Probation Information (0-250 characters)
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Diagnosis:
(Documentation of primary behavioral condition is required. Provisional working condition and diagnosis should be documented if necessary. Documentation of secondary co-occurring behavioral conditions that impact or are a focus of treatment (mental health, substance use, personality, intellectual disability) is strongly recommended to support comprehensive care. Authorization (if applicable) does NOT guarantee payment of benefits for these services. Coverage is subject to all limits and exclusions outlined in the member’s plan and/or summary plan description including covered diagnoses.)

1) *Behavioral Diagnoses (Primary is required)
*Diagnosis Code: _______________ *Description__________________________________________
*Diagnostic Category: _____________________________________________________________________

Diagnosis Code: _______________ Description__________________________________________
Diagnostic Category: _____________________________________________________________________

2) *Primary Medical Diagnoses (Primary is required or indicate “None” or “Unknown”)
*Diagnosis Code: _______________ *Description__________________________________________
*Diagnostic Category: _____________________________________________________________________

Diagnosis Code: _______________ Description__________________________________________
Diagnostic Category: _____________________________________________________________________
*Social Elements Impacting Diagnoses  (Required - Check all that apply)

☐ None ☐ Educational problems ☐ Financial problems ☐ Housing problems (Not Homelessness)
☐ Occupational problems ☐ other psychosocial and environmental problems __________________________
☐ Problems with access to health care services ☐ Homelessness ☐ Problems related to interaction with legal system / crime ☐ Problems with primary support group ☐ Problems related to social environment ☐ Unknown
☐ Medical Disabilities that impact diagnosis or must be accommodated for in treatment

3)  Functional Assessment  (Optional)
☐ CDC- HRQOL ☐ CGAS ☐ FAST ☐ GAF ☐ OMFAQ ☐ SF12 ☐ SF36 ☐ WHO DAS
☐ OTHER ______________________________________ Assessment Score: _______________

Diagnosis By: ___________________________ Date of Diagnosis: _______________

CANS: Member Demographics

*Type of CANS:  ☐ Initial ☐ Reassessment

*CANS Completion Date: ___________________________

*Date of this Assessment: ___________________________

*Clinical Information Contact Name ___________________________________________ Phone: ______________________

*Guardian Ad Litem: __________________________________________

*Child’s Attorney: __________________________________________

*School Nexus: __________________________________________

*Current DCF Status:  ☐ CPS In-home ☐ DCF Committed ☐ Voluntary Service ☐ Voluntary Pending
☐ Family with Service Needs ☐ JJ Committed ☐ Dually Committed (CPS/JJ)
☐ OTC ☐ Delinquency Pending ☐ FWSN Pending ☐ FWSN ☐ Voluntary (age of majority)
☐ Non Committed ☐ Open Investigation ☐ Order of Temporary Custody ☐ Pending 136
☐ Probate ☐ Protective Supervision ☐ Termination of Parental Rights ☐ Unknown
☐ N/A ☐ Voluntary Services ☐ Voluntary Services Pending

*Primary Language Spoken: ___________________________

*Member 12 years or younger?  ☐ Yes ☐ No

If Yes, Case Conference with Central Office Date: ___________________________ or ☐ N/A

If Yes, Case Conference Recommendations (up to 250 characters)
_______________________________________________________________________________________________________________
_______________________________________________________________________________________________________________
_______________________________________________________________________________________________________________
_______________________________________________________________________________________________________________
_______________________________________________________________________________________________________________


Current Living Situation (see below):

- Adult Justice System
- AWOL
- CCP
- CJTS
- Crisis Stab.
- Detention
- Foster Care
- GH
- Independent
- Hospital (Psych)
- OOS
- Parent
- PDC
- RTF (Psych)
- Relative
- RTC
- Riverview
- Shelter
- STAR
- TFH
- TH
- TLAP
- Other _____________________________________

Facility Name, if appropriate: __________________________ Facility Phone #: __________________
Facility Address: __________________________ City __________ State _______ Zip ___________
Admission Date: __________________________

Current Living Situation (see below):

- Adult Justice System
- AWOL
- CCP
- CJTS
- Crisis Stab.
- Detention
- Foster Care
- GH
- Independent
- Hospital (Psych)
- OOS
- Parent
- PDC
- RTF (Psych)
- Relative
- RTC
- Riverview
- Shelter
- STAR
- TFH
- TH
- TLAP
- Other _____________________________________

Facility Name, if appropriate: __________________________ Facility Phone #: __________________
Facility Address: __________________________ City __________ State _______ Zip ___________
Admission Date: __________________________

Current Living Situation:

- Parent: Living with biological or adoptive parent(s)
- Relative: Living with biological relative
- Independent: Independent living
- Shelter: Living in shelter with family
- Crisis Stab: Crisis Stabilization Unit
- FH: Foster Home
- TFH: Therapeutic Foster Home
- TH: Treatment Home
- GH: Group Home (Supervised Apts, Supportive Living – DDD
- SH: Safe Home
- PDC: Permanency Diagnostic Center
- TLAP: Transitional Living Program
- RTC: Residential Treatment Center

CANS: LIFE DOMAIN FUNCTIONING

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</table>

0=no evidence of problems  1=history, mild  2=moderate  3=severe  N=Not Assessed

Please complete notes if “3” is selected

Notes: __________________________________________________________
7) Physical

8) Developmental  (Complete Developmental Needs Module below)

---

**DEVELOPMENTAL NEEDS (DD) MODULE**

This module is intended to describe any needs that might involve services for Developmental Disabilities including services provided through the Department of Developmental Disabilities.

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Specify IQ: ________________  (Check if Unknown)  

Means of assessment: ____________________________________________

Specify Developmental Diagnoses: ___________________________________

Does the child require any special assistive devices?  (Check response)  

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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If YES, please specify: ____________________________________________

Does the child require any special accommodations for home or school?  

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<th>1=history, mild</th>
<th>2=moderate</th>
<th>3=severe</th>
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</table>

If YES, please specify: ____________________________________________

Comments: _______________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________
### HEALTH MODULE

- **Child certified medically complex according to DCF policy?**
  - [ ] Yes
  - [ ] No

- **Child’s Current Health Status is:**
  - [ ] Excellent
  - [ ] Good
  - [ ] Fair
  - [ ] Poor

- **Current Medical Conditions (check all that apply):**
  - [ ] None
  - [ ] Allergies
  - [ ] Asthma
  - [ ] Diabetes
  - [ ] Heart Disease
  - [ ] Physical Injury
  - [ ] Seizure Disorder
  - [ ] Thyroid Disorder
  - [ ] Traumatic Brain Injury
  - [ ] Other

  If other or physical injury, please specify: ________________________________________________

- **Allergies (check all that apply):**
  - [ ] Medication
  - [ ] Food
  - [ ] Bee Stings
  - [ ] Latex
  - [ ] Peanuts
  - [ ] Other
  - [ ] No Known

  Specify details of any allergies: ________________________________________________________

- **Medical Medications:**

  ____________________________________________________________

- **Describe Special Equipment, if any:**

  ____________________________________________________________

- **Describe Special Diet:**

  ____________________________________________________________

- **Indicate Services/Therapies beyond scope of IEP (check all that apply):**
  - [ ] Phys. Therapy
  - [ ] Occ. Therapy
  - [ ] Speech
  - [ ] N/A
  - [ ] Other

  If other, please indicate: ____________________________________________________________

- **Past Medical History**

  ____________________________________________________________

- **Immunizations up to date?**
  - [ ] Yes
  - [ ] No

  **Date of Last TB test:** ____________________________________________

- **Date of Last Phys Exam:** _________ Name of Dr./Facility/phone#: __________________________

- **Date of Last Dental Exam:** _________ Name of Dentist/Facility/phone#: __________________________

- **Child’s Dental Health:**
  - [ ] Excellent
  - [ ] Good
  - [ ] Fair
  - [ ] Poor

  **Describe OTHER medical/dental info:** _____________________________________________

  ____________________________________________________________

  ____________________________________________________________

  ____________________________________________________________

- **Indicate Medical and/or Dental f/u needed:**

  ____________________________________________________________

  ____________________________________________________________

  ____________________________________________________________
## SEXUALITY MODULE

### Sex-Related Problems (see attached coding definitions)

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<tr>
<td>1) Promiscuity</td>
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<tr>
<td>2) Masturbation</td>
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<tr>
<td>3) Reactive Sexual Behavior</td>
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<td>4) Knowledge of Sex</td>
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<td>5) Choice of Relationships</td>
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<td>6) Sexual Identity</td>
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### Paraphilia (see attached coding definitions)

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<tr>
<td>7) Voyeurism</td>
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<td>8) Frotteurism</td>
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<td>9) Exhibitionism</td>
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<td>10) Fetishism</td>
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<tr>
<td>11) Pedophilia</td>
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<td>12) Sexual masochism</td>
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<tr>
<td>13) Sexual sadism</td>
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<tr>
<td>14) Transvestic fetishism</td>
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</table>

Are there any sexually deviant behaviors that are not captured in the above ratings? YES ☐  NO ☐

If yes, describe: ________________________________________________________________

What interventions have been tried that were not successful? ________________________________________________________________

What interventions have been tried that were at least partially successful? ________________________________________________________________
SCHOOL MODULE

Current School Type:
- Regular
- Special Ed
- Home Instruction
- Clinical Day School
- Residential
- Self Contained
- Tech School
- Reg. Ed after Hours
- Higher Education

Name of School: ______________________________________________________

Grade:  
- 1st
- 2nd
- 3rd
- 4th
- 5th
- 6th
- 7th
- 8th
- 9th
- 10th
- 11th
- 12th

Date Enrolled: ____________

Contact Person: ______________________________________________________

Address: __________________________________________ City ________________ State ______ Zip ____________

Phone #: __________________________ Email: ______________________________________________________

History School Type (select all that apply):
- Regular
- Special Ed
- Home Instruction
- Clinical Day School
- Residential
- Self Contained
- Tech School
- Reg. Ed after Hours
- Higher Education

0  1  2  3  N/A *Please rate highest level from past 30 days

*School Challenges:  
-  
-  
-  
-  

Notes: ______________________________________________________________

*School Achievement:  
-  
-  
-  
-  

Notes: ______________________________________________________________

*School Attendance:  
-  
-  
-  
-  

Notes: ______________________________________________________________

*Relation w/ Teachers:  
-  
-  
-  
-  

Notes: ______________________________________________________________

Describe the Child’s School Experiences: __________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

Does child have any of the qualifying conditions? (Select all that apply):
- Autism Spectrum Disorder
- Deaf-Blindness
- Develop. Delay 3-5yr.
- Emotion. Disability
- Hearing Impairment
- Spec. Learning Disability
- Intellectual Disability
- Multiple Disabilities
- Orthopedic Impairment
- Other Health Impairment
- Traumatic Brain Injury
- Visual Impairment
- Speech/Lang Impairment
- HI-ADD/ADHD
- To Be Determined
- None

Does child have a current Individualized Education Plan (IEP) in place?  
- Yes  
- No
### CHILD STRENGTHS

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<td>2) Interpersonal</td>
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<td>3) Resiliency</td>
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<td>4) Educational</td>
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<td>5) Vocational</td>
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<td>6) Talents/Interests</td>
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<td>7) Spiritual/Religious</td>
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<td>8) Community Life</td>
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<td>9) Relationship Permanence</td>
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### ACCULTURATION

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<td>3) Ritual</td>
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### CAREGIVER STRENGTHS

Were other children involved?  □ Yes  □ No  (If No, proceed to CHILD BEHAVIORAL/EMOTIONAL NEEDS section)

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<td>4) Organization</td>
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<td>5) Social Resources</td>
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<td>6) Residential Stability</td>
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**CAREGIVER NEEDS**

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<td>3) Substance Use</td>
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<td>4) Developmental</td>
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Notes: _______________________________________________________________

**CHILD BEHAVIORAL/EMOTIONAL NEEDS**

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<td>3) Depression</td>
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<td>4) Anxiety</td>
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<td>8) Anger Control</td>
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<td>9) Substance Use</td>
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<tr>
<td>10) Adj. to Trauma</td>
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Notes: _______________________________________________________________

(Complete Substance Use Module on page 11)

(Complete Trauma Module on page 12)
**SUBSTANCE USE DISORDER (SUD) MODULE**

1) Severity of Use  0  1  2  3  N/A  2) Duration of Use  0  1  2  3  N/A
3) Stage of Recovery  0  1  2  3  4) Peer Influences  0  1  2  3  5) Parental Influences  6) Environment Influences

Specify Substance-related diagnoses: _______________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

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<th>ROUTE of ADMIN.</th>
<th>Age at 1st Use</th>
<th>Regular Use? (check response)</th>
<th>Past 48 hours? (check response)</th>
<th>Monthly Cost</th>
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</tbody>
</table>

What Substance Abuse Treatment/Services have been tried in the past and have been helpful?
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

What Substance Abuse Treatment/Services have been tried in the past have **NOT** been helpful?
_____________________________________________________________________________________________
_____________________________________________________________________________________________
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Comments: __________________________________________________________________________________
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**TRAUMA MODULE**

**Characteristics of the Traumatic Experience(s):** *(see attached coding definitions)*

<table>
<thead>
<tr>
<th>Experience</th>
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<th>3</th>
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<th>1</th>
<th>2</th>
<th>3</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Sexual Abuse</td>
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<tr>
<td>2) Physical Abuse</td>
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<tr>
<td>3) Emotional Abuse</td>
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<td>4) Medical Trauma</td>
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<td>5) Natural Disaster</td>
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<tr>
<td>6) Witnessed Family Violence</td>
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<td>7) Witness to Community Violence</td>
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<tr>
<td>8) Witness/Victim to Crime</td>
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Other Traumatic Experience(s) (e.g. natural disasters): _______________________________________________________

If Sexual Abuse >0, complete the following: *(see attached coding definitions)*

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<th>3</th>
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<tr>
<td>1) Emotion Closeness to Perpetrator</td>
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<tr>
<td>2) Frequency</td>
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<td>3) Duration</td>
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<tr>
<td>4) Force</td>
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<tr>
<td>5) Reaction to Disclosure</td>
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Adjustment: *(see attached coding definitions)*

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<tbody>
<tr>
<td>1) Affect Regulation</td>
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<td>2) Intrusions</td>
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<tr>
<td>3) Attachment</td>
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<td>4) Dissociation</td>
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<td>5) Time before Treatment</td>
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</table>

What Trauma Treatment/Services have been tried in the past and have been helpful? _______________________________________________________

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

What Trauma Treatment/Services have been tried in the past and **NOT** been helpful? _______________________________________________________

_____________________________________________________________________________________________________

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_____________________________________________________________________________________________________

Recommendations for Treatment Approach (specify): _______________________________________________________

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### CHILD RISK BEHAVIORS

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<td>1) Suicide Risk</td>
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<td>2) Self-Mutilation</td>
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<td>3) Other Self Harm</td>
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<td>5) Judgment</td>
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<td>6) Social Behavior</td>
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<tr>
<td>7) Danger to Others</td>
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<td>(Complete Violence Module below)</td>
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### VIOLENCE MODULE

#### Historical Risk Factors

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<tr>
<td>History of Physical Abuse</td>
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<tr>
<td>Witness to Domestic Violence</td>
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</table>

Please describe important Historical Risk Factors: ______________________________________________________ |
____________________________________________________________________________________________________

#### Emotional/Behavioral Risks

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<th>3</th>
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<th>1</th>
<th>2</th>
<th>3</th>
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<tbody>
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<td>Bullying</td>
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<td>Hostility</td>
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<td>Secondary gains from anger</td>
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Please describe important Emotional/Behavioral Risks: ______________________________________________________ |
____________________________________________________________________________________________________

#### Resiliency Factors

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<td>Awareness of Violence Potential</td>
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<td>Commitment to Self-Control</td>
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Please describe important resiliency factors that help reduce the risk of future violence: ______________________ |
____________________________________________________________________________________________________
CHILD RISK BEHAVIORS (continued)

8) Sexual Aggression

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<tr>
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<th>N/A</th>
<th>(Complete SAB Module below)</th>
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</table>

**SEXUALLY ABUSIVE BEHAVIOR (SAB) MODULE**

Date of most recent sexually abusive behavior: _____/_____/_____

Describe the most recent behavior (include activity, circumstances, reasons and results):

____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

Was sexual act against a family member? Yes ☐ No ☐ Identify ____________________________

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<tr>
<th>Relationship</th>
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<tr>
<td>Planning</td>
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<tr>
<td>Type of Sex Act</td>
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<tr>
<td>Temporal Consistency</td>
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<tr>
<td>Severity of Sexual Abuse</td>
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<table>
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<tr>
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<th>3</th>
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<td>Age Differential</td>
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<tr>
<td>Response to Accusation</td>
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<tr>
<td>History of Sexual Behavior</td>
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<tr>
<td>Prior Treatment</td>
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</table>

Is the youth currently subject to the provisions of Megan’s Law? Yes ☐ NO ☐

What Specialty Sexual Aggression Treatment/Services have been tried in the past and have been helpful?

____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

What Specialty Sexual Aggression Treatment/Services have been tried in the past and **NOT** been helpful?

____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

Recommendations for Treatment Approach: ________________________________________________________________
______________________________________________________________________________________________________
9) Runaway

<table>
<thead>
<tr>
<th>Frequency of Running</th>
<th>Consistency of Destination</th>
<th>Involvement in Illegal Activity</th>
<th>Involvement of Others</th>
<th>Planning</th>
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<tbody>
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<td></td>
<td>0 1 2 3 N/A</td>
<td>0 1 2 3 N/A</td>
<td>0 1 2 3 N/A</td>
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</tbody>
</table>

To what locations has child run in the past?

_____________________________________________________________________________________________________
_____________________________________________________________________________________________________

How do you understand the running behaviors?

_____________________________________________________________________________________________________
_____________________________________________________________________________________________________

What reasons has the youth given for running in the past?

_____________________________________________________________________________________________________
_____________________________________________________________________________________________________

In the past, what does the youth do while on run?

_____________________________________________________________________________________________________
_____________________________________________________________________________________________________

Has any approach been successful in the past in:

_____________________________________________________________________________________________________
_____________________________________________________________________________________________________

0=no evidence  1=History, mild  2=Moderate  3=Severe  N=Not Assessed
### JUVENILE JUSTICE (JJ) MODULE

Date of most recent delinquent behavior: _____/_____/

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<th>Planning</th>
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<th>2</th>
<th>3</th>
<th>N/A</th>
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</thead>
<tbody>
<tr>
<td>History</td>
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<td>Community Safety</td>
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<td>Peer Influences</td>
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<td>Parental Criminal Behavior</td>
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<tr>
<td>Environmental Influences</td>
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<td>Age Engaged in Criminal Beh.</td>
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<tr>
<td>Use of Free Time to Engage</td>
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<td>Aggression/Temper Level</td>
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<tr>
<td>Substance Use/Delinquent Behavior</td>
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<td>Educational Goals/Aspirations</td>
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<td>Parental Supervision</td>
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</table>

During the past year has the youth committed acts of delinquency against property? ☐ YES ☐ NO
If YES, please specify: ____________________________________________________________

During the past year has the youth committed acts of delinquency against people? ☐ YES ☐ NO
If YES, please specify: ____________________________________________________________

Has the youth used a weapon in the commission of an act of delinquency? ☐ YES ☐ NO
If YES, please specify: ____________________________________________________________

Has the youth committed any acts of delinquency involving illegal substances? ☐ YES ☐ NO
If YES, please specify: ____________________________________________________________

Describe any current court orders: ______________________________________________________
____________________________________________________________________________________

Parole Officer: __________________________________ Phone: ____________________________
Probation Officer: ________________________________ Phone: ____________________________

Current Living Situation of Youth: ______________________________________________________

Please list dates Admissions to Detentions and/or Mansion/York, if any: _________________________
____________________________________________________________________________________
____________________________________________________________________________________
FIRE SETTING MODULE

Date of most recent fire-setting behavior _____/_____/______

Describe the incident including circumstances, reasons, frequency and results/damage: _____________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

Was the child alone at the time of the incident? □ Yes □ No
Specify: __________________________________________________________________________________________________
________________________________________________________________________________________________________

Were other children involved? □ Yes □ No
Specify: __________________________________________________________________________________________________
________________________________________________________________________________________________________

Rate the child on the following dimensions based on their most recent fire-setting behavior and any prior history of similar behaviors

<table>
<thead>
<tr>
<th>Dimension</th>
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<tr>
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<td>Intention to Harm</td>
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<td>Response to Accusation</td>
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<td>Likelihood of future fires</td>
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<td>History</td>
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<td>Use of accelerants</td>
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<td>Community Safety</td>
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<tr>
<td>Remorse</td>
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</table>

Highlight/detail any pertinent evaluation and identified risk of future fire-setting: _____________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
Any current or history of psychotropic medication used?  □ YES  □ NO  *(If yes, complete Medication module below)*

**MEDICATION MODULE**

List all current meds – Name, Dosage, Frequency:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

List all past psychotropic meds, Name, Dosage, Frequency:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Describe any Allergies/adverse reactions to psychotropic medications:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Prescribing Psychiatrist: ___________________________ Phone: ___________________
Address: __________________________________________________________________

**CURRENT & HISTORY STATUS/INVOLVEMENT** *(check all that apply):*

*Current or past child welfare involvement?  □ Yes  □ No

*Current or past family with service needs?  □ Yes  □ No

*Current or past JJ Probation?  □ Yes  □ No

*Current or past JJ Parole?  □ Yes  □ No

*Current or past Mental Health Services?  □ Yes  □ No

*DDS (Current):  □ None  □ Pending  □ Accepted/No services  □ Accepted/with Services

For any checked, name facility/agency/provider and date of service (start and end):
________________________________________________________________________
________________________________________________________________________
*DMHAS:  ☐ None ☐ Pending ☐ Accepted/No services ☐ Accepted/with Services

*For any checked, name facility/agency/provider and date of service (start and end):

_______________________________________________________________________________________________________________
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*What Treatment/Interventions/Services have been tried in the past and have been helpful?

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*GENERAL NOTES:

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