Client Name: RASPBERRY TEST Welligent ID: 5161761 Birth Date: 08-Sep-1980

Appointment Details

Date of Service:	9-Sep-2020
Scheduled/Start Time:	09:34AM
Appointment Duration or Face to Face:	56 (Minutes)
Date Marked as Complete:	10-Sep-2020 11:56AM
Non-Billable Time:	(Minutes)
Provider:	Cardenas, Jennifer
Other Time (Not Face-to-Face):	11 (Minutes)
Travel Time:	0 (Minutes)
Status:	Completed
Primary Action:	Assessment
Reporting Unit:	County Mental Health
Reporting Unit Address:	555 Main Street, Oakland, CA 94619
Reporting Unit ID:	SC
Place of Service:	Office
Other Individuals Present:	Family:0 Non-Family:0
Collateral Visit:	No Specify:
Service Strategy:	00-No Evidence Based Practice/Service Strategy
Evidence Based Practice:	00-No evidence based practice
Appointment Internal ID:	1376630603

Mental Health Notes

Activities/Services

Goals:	The goal for today's session was to continue completion of the assessment in an attempt to identify the client's individual needs, strengths and goals, and to identify areas for ongoing treatment.
Interventions:	This clinician reviewed collateral clinician information, as well as information provided by client, and her father, in order to complete the comprehensive assessment. This documentation includes information on client placement history, strengths, diagnostic information, presenting issues, trauma history, risk behaviors, family and support information, goals, and the beginning of discharge planning. This document is a valuable tool to aid in creating a comprehensive treatment plan for client and to prepare a safety plan taking into consideration client risk factors and vulnerabilities
Response:	Client was referred for a history of depression, suicidal and self injurious behavior, aggression toward others, and running away. Client reports her last substance use being in November of 2011. She has no access to guns but she does have access to her own medication. She denies current suicidal ideation and states that her last ideation was 8 months ago, as was her last attempt at self injury (cutting). She has a history of numerous attempts and frequent ideation. Her history of danger to others was isolated to when she was in residential placement and she became verbally aggressive and threatening toward peers and staff alike. She believes the last time she did this was late 2011. Client has a

	history of depression (hopelessness, sadness, and low self worth). She is hoping to return home to live with her father. Client and her father identified individual strengths as a good sense of humor, optimistic, social, caring and being a good friend. Client reports being very close to her family and they identified family strengths as humor, supportive of one another, and loving. Preliminary Axis I diagnosis is as follows: Major Depressive Disorder, Recurrent, Severe With Psychotic Features - 296.34
Progress:	Assessment documentation completed as of this service.
Plan:	This clinician plans to meet with the family and Child and Family team to create a safety plan and a wrap plan to guide the wrap process. This clinician plans to develop a treatment plan with client and her father.

Signatures

Electronic Signature/Credentials	September 10, 2020 11:56:10 am
Jennifer Cardenas, LCSW	Date of Signature