OCEANSIDE
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Youth & Adolescent Problematic Sexual Behaviors Clinical Risk Assessment

Date:	Referred by:			DOA:	OCS #:
Name:		D.O.B.:	Age:	Gender: Gender expression:	Grade:
Primary Language Spoken: Interpreter Needed: ☐ Yes ☐ No					
Parent/Guardians name:		Client Address: Guardian Address(if different):			
Primary Language Spoken: Interpreter Needed: ☐ Yes ☐ No					
Client Contact Info: ☐ Home Phone: ☐ Cell: ☐ Email: Check preferred method of contact		☐ **MCILS Funding approved** **Docket #: _____** ☐ **Self-Pay**			
Primary Care Physician ☐ Check if referring person	Name:	Phone: Fax:			
Psychiatrist: ☐ Check if referring person	Name:	Phone: Fax:			
Counselor/ Therapist: ☐ Check if referring person	Name:	Phone: Fax:			
Caseworker/ Case Mgr: ☐ Check if referring person	Name: Agency:	Phone: Fax:			
Other Professional: ☐ Check if referring person	Name: Type:	Phone: Fax:			

School:	Name: ☐ Homeschooled	District:
Current Diagnoses:		**Current Medications:**
Current Services Check all that apply	☐ School IEP/Special Ed ☐ School 504 Accommodations ☐ School Counselor ☐ Tutoring ☐ Occupational Therapy ☐ Speech Therapy ☐ Physical Therapy ☐ Vision Therapy ☐ Naturopathy ☐ HCT ☐ BHP ☐ VRT ☐ MST ☐ Psychotherapy ☐ Behavior Therapy (e.g., ABA) ☐ Group Therapy ☐ Social Skills training ☐ Other- Describe:	
Current Status Check all that apply	☐ DHHS Involvement ☐ Foster Care ☐ Adoption Process ☐ JSOP/Probation Supervision ☐ Incarcerated	
Reason for Referral	Current concerns/ Identified Issues / Duration of problems / Types of potentially inappropriate sexualized behavior (example: sexual harassment, exposing oneself to another, excessive/public masturbation, inappropriate sexualized social media, pornography, inappropriate touching, forced sexual behaviors, dating violence, inappropriate interest towards younger children, etc.)	

History of Sexualized Behaviors **Please describe**	Early Childhood (2-4yrs) ☐ yes ☐ No	Late Childhood (5-7yrs) ☐ Yes ☐ No	Latency (8-12yrs) ☐ Yes ☐ No	Adolescents (13-17yrs) ☐ Yes ☐ No
Cognitive Concerns Check all that apply	☐ General Intellectual Abilities ☐ Academic Skills / Learning disabilities ☐ Language / Communication ☐ Sensory Processing ☐ Auditory / Phonological Processing ☐ Reasoning / Problem solving ☐ Executive Processing (sequencing, shifting between tasks, working memory, processing speed, multi-tasking, etc.)	☐ Attention / Concentration ☐ Memory / Learning ☐ Visual Spatial Processing ☐ Motor Functioning ☐ Social Cognition ☐ Judgment / Decision making ☐ Other cognitive concerns Describe:		
Other Concerns Check all that apply	☐ Traumatic brain injury / concussion ☐ Birth Injury ☐ Anxiety ☐ Depression ☐ Anger ☐ Poor social skills / no friends ☐ Other concerns- Describe:	☐ Substance Abuse in pregnancy ☐ Autism characteristics ☐ Moodiness / Emotional dysregulation ☐ Obsessive or compulsive behaviors ☐ Oppositionality / Defiance ☐ Sexual misbehavior		
Office Use	☐ Approved ☐ Not within guidelines. Reason: Initials: ☐ Insurance Confirmed			