LIFE DOMAIN FORMAT FOR
PSYCHIATRIC/PSYCHOLOGICAL EVALUATIONS:
INITIAL AND CONTINUED CARE

Note: This format is applicable to both initial and continued care evaluations. However, when writing an evaluation for continued care, it is recommended that Section III, Relevant Information, begin with an additional subheading called Brief Update that identifies and briefly summarizes the key events and changes during the most recent service period. The remainder of Relevant Information then follows the usual format (e.g., Strengths, Concerns, Etc).

I. Identifying Information:

A. Places the child in individual, family, cultural, residential, and educational/vocational contexts (e.g., age, date of birth, gender, race, ethnicity, cultural/religious beliefs, name and grade in school, type of class setting).
B. Identifies family and household members, including each biological parent, stepparents, siblings/half-siblings. Identifies marital status of parents, and nature of child's contact with a non-custodial parent. Identifies employment status of current parental caregivers.
C. Identifies custody of the child, and child's legal status (e.g., adjudicated or not). Identifies other team members, including involved professional agencies/systems (e.g., MH/MR, C&Y, juvenile justice, case management, child psychiatrist, special education, etc.) and community supports.

II. Reason for Referral:

A. Determine medical necessity for initial care or continued care service request.
B. Identify additional purposes, as relevant (e.g., monitor medication, respond to crisis).

III. Relevant Information (begin with Brief Update, if a continued care request):

A. **Strengths:**
   - Child/adolescent strengths, in multiple domains.
   - Special attention to motivation and ability to form relationships and use support.
   - Areas of greatest competence and independence.
   - Family and community strengths.

B. **Concerns:**
   - Clinical basis for current service request and recommended treatment.
   - Nature, frequency, severity, and history of the child's behaviors/symptoms/serious emotional disturbance (SED) of concern.
   - Identification of both externalized behaviors and internalized symptoms, comparing present to past.
   - Other identified needs and concerns.
C. **Family:**
   - Family composition (including relevant extended family), family relationships, strengths/concerns.
   - For child in substitute care, foster family and natural family included.
   - Family cultural and spiritual beliefs and practices, as relevant.
   - Family history of psychiatric disorder, as relevant.

D. **School/Vocational:**
   - The child's academic, social, and behavioral adaptations, including relationships with school peers and with teachers and/or level of functioning in vocational programming.
   - Efforts to date of school to address current problems. Characteristics of current class setting.
   - Current or past use of school-based services, if relevant.
   - Current or past educational testing, CER, and IEF. • Prior school placements.

E. **Community:**
   - Place of residence-family home or apartment, group home, RTF, etc.
   - Community activities and attachments.
   - Use of leisure time.
   - Community employment, current and in past.
   - Degree of church or spiritual involvement.
   - Nature of neighborhood, in terms of resources and culture, safety, specific conditions.
   - Specific stressors, as relevant.

F. **Peer Relationships:**
   - Patterns of peer relationships in the neighborhood and in school, including similarities and differences between the two settings.
   - Predominant age of peers-same-aged, older, or younger-and gender of relationships.
   - Predominant activities with peers, formal and informal. Nature of peer culture.

G. **Drug and Alcohol:**
   - Child's current use/abuse of drugs and alcohol-type, frequency, severity.
   - Child's past history of use.
   - Child's past drug and alcohol treatment, response to treatment, involvement in self-help groups.
   - Family substance abuse history, where relevant, including nature of use, type and effectiveness of treatment.

H. **Medical/Developmental:**
   - Medical illness, acute or chronic infection, physical limitation, brain or other injury, past surgery.
   - Lead or other toxicity.
   - Medication allergies as relevant.
   - Developmental history: pregnancy, delivery, neonatal period, developmental milestones.
• Mental retardation, atypical development, autism/PDD.
• Trauma history: neglect, physical abuse, or sexual abuse.
• Gender preference, when relevant and with consent of the child, and other issues of sexuality. Past pregnancy, when relevant.

I. Legal:
• Custody.
• Adjudication as delinquent or dependent.
• Other delinquent status indicators: probation, placement in juvenile facility, incarceration.
• Outstanding legal issues: pending charges, community service requirement, other.

J. Services:
Service History:
• Services used in past, reason, level of participation, and effectiveness. Include all levels of care, psychotropic medication, out-of-home placements (mental health and other), and services from other systems.

Service Update.
• Current services—including hours and sites—with summary of recent service history.
• Impact of services:
  - Role of service providers and of family.
  - Progress/degree of attainment of treatment goals and objectives. Identify effective and ineffective interventions.
  - Receptivity of the child and family to services, and level of participation.
• Nature of planned modifications of goals and services.
• Specific indications for, and use of, psychotropic medication. Include names and dosages and, where applicable, blood levels. Indicate medication adherence and effectiveness of medication, when in use.
• Nature of regular clinical updates to prescriber by involved mental health staff, during most recent service period.

K. Other:
• Other domains as relevant, or added to earlier information.

IV. Interview:
A. Identification of participants.
B. The child/adolescent's appearance, hygiene, self-care.
C. The child/adolescent's manner of relating to the interviewer and other identified adults present. Emphasis on level of engagement, cooperation, openness to input.
D. The child/adolescent's formal mental status. Include verbalized goals, needs, requests, response and commitment to treatment, degree of understanding and insight, other individualized ideas of the child/adolescent, and ability to contract for safety, when relevant. Compare with previous contacts, if applicable.
E. Key issues/themes addressed, and areas of agreement/consensus.
V. Discussion:
   A. Overview/summary.
   B. Hypothesis/formulation.
   C. Diagnostic considerations.
   D. Rationale for recommended services.
   E. Nature of consensus and agreements with the child/adolescent, family if present, and others.
   F. Prognosis.

VI. Diagnosis: 5-Axis diagnosis.

VII. Recommendations:
   A. Identification of each specific behavioral health service recommended, listing the amount, duration, and scope of each.
   B. Other treatment recommendations, both global and specific (e.g., other needed services and interventions for the team to consider; psychotropic medication referral or recommendation; additional recommended assessment(s); community referral(s) and natural supports; education and/or vocational recommendations; consultation with primary care physician; other)
   C. For continued care requests, criteria for service tapering or modification of level of care, and recommendations to increase natural supports.