CHILD AND ADOLESCENT NEEDS AND STRENGTHS – EARLY CHILDHOOD (Complete for clients ages 0 to 5) San Diego CANS-Ed				
Client Name:			Client ID Number:	
	OBiological Parent _[1]	OFoster Parent _[2]	Client DOB:	
Caregiver Type:	OAdoptive Parent _[3]	$OOther_{[5]}$	Clinician/Staff ID:	
	OOther Family Membe	er (non-foster status)[4]	SubUnit:	
Date of Assessme	ent:		Current Primary Dx (ICD code):	
Assessment Type	e: OInitial _[1] OReassess	ment _[2] ODischarge _[4]	Current Secondary Dx (ICD code):	

2075171411777241744718/42718/42718		
POTENTIALLY TRAUMATIC/ADVERSE CHILDHOOD E	XPERS.	
NO = no evidence of any trauma of this type		
YES = exposure/experienced a trauma of this type		
	NO _[0]	YES _[1]
1. Sexual Abuse		
2. Physical Abuse		
3. Emotional Abuse		
4. Neglect		
5. Medical Trauma		
6. Witness to Family Violence		
7. Witness to Community/School Violence		
8. Natural or Manmade Disaster		
9. War/Terrorism Affected		
10. Victim/Witness to Criminal Activity		
11. Disruption in Caregiving/Attachment Losses		
12. Parental Criminal Behaviors		
Documentation to support endorsement of "Yes"	is locate	ed in
the Clinical Formulation and the following section,	s of the	e BHA
(select all that apply):		
Presenting Problems/Needs \Box		
Past Psychiatric History		
Family History 🛚		
Pregnancy/Birth History ☐		
Medical Tab □		
Other, please specify		
(e.g., Discharge Summary)		

CHALLENGES						
0 = no evidence	1 = history			•		
2 = interferes with functioning;	3 = disabli	-	_		mediat	e or
action needed	intens		tion ne		2	N1 / A
		0	1	2	3	$N/A_{[6]}$
13. Impulsivity/Hyperactivity		님	님	님	님	
14. Depression		닏	닏		닏	
15. Anxiety		닏	닏	닏	닏	
16. Oppositional		Ш	Ш	Ш	Ш	
17. Attachment Difficulties						
18. Adjustment to Trauma						
19. Regulatory						
20. Atypical Behaviors						
21. Sleep (12 months to 5 yea	rs)					
- N/A if child under 12 mo	nths					
Documentation to support ra	tings of a	'2' c	or '3'	is loc	ated i	n the
Clinical Formulation and the f	ollowing	secti	ion/s	of th	е ВНА	4
(select all that apply):						
Presenting Problems	s/Needs					
Past Psychiatric	History					
History of Self-Injury/	Suicide/					
,	/iolence					
Med	lical Tab					
Mental Status Exam Tab o	ategory					
Other, please	specify					
(e.g., Discharge Su	mmary)	Ш				







FUNCTIONING	
0 = no evidence	1 = history or suspicion; monitor
2 = interferes with functioning;	3 = disabling, dangerous; immediate or
action needed	intensive action needed
	0 1 2 3
22. Family Functioning	
23. Early Education	
24. Social and Emotional Fun	nctioning \square \square \square
25. Developmental/Intellecti	ual 🔲 🖺 🖺
26. Medical/Physical	
Documentation to support ra	atings of a '2' or '3' is located in the
Clinical Formulation and the	following section/s of the BHA
(select all that apply):	
Family I	History 🗌
Medi	cal Tab 🔲
Developmental Mile	estones 🗆
History of Early Interve	entions 🗆
Other, please	specify \square
(e.g., Discharge Sun	nmary)

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RISK BEHAVIORS & FACTORS	DYADIC CONSIDERATIONS
0 = no evidence 1 = history or suspicion; monitor	0 = no evidence 1 = history or suspicion; monitor
2 = interferes with functioning; 3 = disabling, dangerous; immediate or	2 = interferes with functioning; 3 = disabling, dangerous; immediate or
action needed intensive action needed	action needed intensive action needed
$0 1 2 3 N/A_{[6]}$	0 1 2 3
27. Self-Harm (12 months to 5 years)	44. Caregiver Emot. Responsiveness
- N/A if child under 12 months	45. Caregiver Adj. to Traumatic Exper.
28. Exploited	Documentation to support ratings of a '2' or '3' is located in the
29. Prenatal Care	Clinical Formulation and the following section/s of the BHA
30. Exposure	(select all that apply):
31. Labor and Delivery	Presenting Problem □
32. Birth Weight	Family History
33. Failure to Thrive	
Documentation to support ratings of a '2' or '3' is located in the	Other, please specify
	(e.g., Discharge Summary)
Clinical Formulation and the following section/s of the BHA	
(select all that apply):	CAREGIVER RESOURCES AND NEEDS
Presenting Problem	☐ Child has no known caregiver. Skip Caregiver Resources and
Past Psychiatric History	Needs Domain.
Pregnancy/Childbirth History	
	A. Caregiver Name:
Medical Tab	Relationship:
History of Self-Injury/Suicide/ Violence ☐	0 = no evidence; this could be a strength
Other, please specify	1 = history or suspicion; monitor; may be an opportunity to build
(e.g., Discharge Summary)	2 = interferes with functioning; action needed
(c.g., Discharge Summary)	3 = disabling, dangerous; immediate or intensive action needed
CULTURAL FACTORS	
	0 1 2 3
0 = no evidence 1 = history or suspicion; monitor 2 = interferes with functioning; 3 = disabling, dangerous; immediate or	46. Supervision
action needed intensive action needed	47. Involvement with Care
	48. Knowledge
0 1 2 3	49. Social Resources
34. Language	
35. Traditions and Rituals	50. Residential Stability
36. Cultural Stress	51. Medical/Physical
Documentation to support ratings of a '2' or '3' is located in the	52. Mental Health
	53. Substance Use
Clinical Formulation and the following section/s of the BHA	54. Developmental
(select all that apply):	55. Safety
Family History	
Medical Tab □	56. Family Rel. to the System
Protective Factors □	57. Legal Involvement
	58. Organization
Other, please specify	Documentation to support ratings of a '2' or '3' is located in the
(e.g., Discharge Summary)	Clinical Formulation and the following section/s of the BHA
	(select all that apply):
STRENGTHS	
0 = Centerpiece strength 1 = Useful strength	Presenting Problem
2 = Identified strength 3 = No evidence	Family History □
0 1 2 3	History of Early Interventions \Box
37. Family Strengths	Other, please specify
38. Interpersonal	(e.g., Discharge Summary)
·	(c.g., Discharge Sammary)
40. Resiliency (Persist. & Adaptability)	
41. Relationships Permanence	
42. Playfulness	
43. Family Spiritual/Religious	
Documentation to support ratings of a '0' or '1' is located in the	
Clinical Formulation and the following section/s of the BHA	
(select all that apply):	
Family History 🔲	
Protective Factors □	
Other place specify	
(e.g., Discharge Summary)	
(c.g., Discharge Summary)	