COMPREHENSIVE ASSESSMENT

ASSESSMENT INFORMATION

Assessment Date: Name:

DOB: Insurance:

Contact #: Contact Type:

Assessment Site:

Referred By:

Comments:

CLIENT ISSUE

Presenting Problem:

Expectations:

Service Preferences or Objections to Treatment Interventions:

Are there any language or Literacy barriers?

List of Persons at interview:

Are you currently on FMLA or Short-Term Disability?

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Are there any other involved service providers i.e., Physicians, therapists etc.?

Provider	Dates	Reason For Treatment	Current?

EDUCATION INFORMATION

Are you currently enrolled in school?

How many months has it been since you last attended?

What is your current grade level / degree level?

What type of school do you attend?

Have you had excused absences?

Have you had tardies?

Have you skipped and if so, how many of the last 90 days have you skipped?

Have you been suspended and if so, why?

Have your grades dropped over the past 12 months?

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Are you involved with any extracurricular activities?

Has your participation in these activities changed over the past 12 months?

How bothered are you by any problems that relate to school or your education?

EMPLOYMENT

Are you currently employed?

What type of employment?

How many of the last 12 months have you been employed?

In the last 12 months, have you used alcohol or substance at work or been in withdrawal at work?

Have you performed badly at work?

Have you skipped or cut work?

Have you fought or gotten into arguments at work?

Have you been hurt or injured at work?

Have you come in late or left early from work?

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Have you been suspended or terminated from a job in the last 12 months?

How bothered are you by any issues or problems that relate to your employment or employment status?

LIVING ENVIRONMENT

What has been your primary type of residence for the past 90 days?

How many years have you lived at your current address?

With whom do you live (names, ages and relationship to client)?

Are you satisfied with your living arrangement?

FAMILY PROFILE

Is there anyone in your life that you feel significantly influences the way you think, feel or behave and if so who are they and what is your relationship with this person? (Please list all with relationship, age, household member etc.)

Does your family help and support one another and if so how?

How much do the members of your household fight or argue?

How much do the members of your family participate in activities together?

Do you have a parent, partner or caregiver that you can confide in?

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SPIRITUALITY

Do you have any specific religious or spiritual beliefs?

Do you spend time practicing your beliefs?

SOCIAL RELATIONSHIPS

How many close friends do you have?

Do your friends use drugs or alcohol?

Are you sexually active?

Do you use protection and if so, what type?

Within the past 12 months have you: (Please get as much detail as possible)

Threatened anyone?

Threatened anyone with a weapon?

Hurt anyone, even if it were by accident?

Within the past 12 months have you: (Please get as much detail as possible)

Been bullied?

Been threatened with harm?

Been threatened with a weapon?

Been injured?

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How bothered have you been by issues relating to your peer group and or social circle?

LEGAL INVOLVEMENT

Are you currently on probation or parole or awaiting charges?

Have you ever been arrested?

Have you been arrested within the past 90 days and if so, how many times and what were the charges?

GENERAL HEALTH

Do you suffer from a chronic or painful medical condition and if so, what is it?

Do you have any difficulty sleeping?

How many hours of sleep do you average?

Do you have any difficulties eating?

How many meals do you eat each day?

Dou you use diuretics or emetics to lose weight?

Have you experienced any significant weight loss or gain over the past 30 days and if so, please describe?

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Have you experienced any head trauma or concussive injuries and if so, when?

Do you have any allergies to medications?

Are you currently taking any medications?

Medication	Dosage	Frequency	Strength	Compliant?

Have you been in a medically controlled environment within the past 12 months?

How many of the past 30 days have you been in a medically controlled environment?

Do you currently receive financial support for a disability?

What is the disability?

Does this disability interfere with you activities of daily living, and if so, how?

HIV/HepC SCREENING QUESTIONS

Have you ever injected drugs?

Have you ever shared injecting equipment?

Have you ever snorted drugs?

Have you shared equipment for snorting?

Do you have any tattoos or piercings?

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Have you had unprotected sex of any kind, (vaginal/ oral/anal penetration) without condoms or latex barrier?

Have you had unprotected sex with someone known to inject drugs?

How bothered are you by any problems you may be experiencing with a physical health problem?

MENTAL HEALTH AND TREATMENT HISTORY

How many times have you been treated in a hospital or residential setting for mental or emotional problems?

Have you been treated for these issues in an outpatient setting?

Facility	Reason for Admit	Diagnosis Applied	Dates of stay	

Have you ever had thoughts of killing yourself?

Have you ever made a plan?

Have you ever attempted, if so, how and when?

Have you ever had thoughts of killing another person?

Have you ever made a plan?

Have you ever attempted, if so, how and when?

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Has anyone close to you committed suicide?

CLINCIAN OBSERVATION

Clinicians Observations of Client Affect	None	Slight	Moderate	Considerable	Extreme
Abnormal Affect					
Abnormal Appearance					
Abnormal Behavior					
Abnormal Speech or Language					
Abnormal thought process or content					
Anxiety					
Delusional Symptomology					
Depressed Mood					
Difficulty with Alertness					
Dissociative Symptomology					
Elevated Mood					
Hallucinations					
Hostility					
Hyperactive / Easily Distracted					
Impaired Insight					
Impaired Judgement					
Interpersonal Isolation					
Impulsiveness					
Intoxicated					
Poor Eye Contact					
Poor Grooming					
Shame or Guilt					
Uncooperativeness					

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Are you now, or have you in the past been dealing with any of the following:

MH Screening

Symptom	Never	Past 30 Days	Past 6 – 12 Months	Lifetime
Unbearable sadness				
Loss of pleasure in activities				
Feeling worthless or overly guilty				
Unable to think, concentrate or make decisions				
Difficulty managing anger				
Excessive energy or racing thoughts				
Talking non stop				
Risky behaviors				
Preoccupied with sex				
Compulsive or OCD behaviors				
Excessive anxiety and worry				
Difficulty managing day to day life				
Believed anything is doable				
Heard voiced no one else hears				
Seen things no one else sees				
Felt people had something against you				
Believed someone was trying to influence your thoughts or behaviors				
Serious thoughts of cutting, carving or burning (self – harm)				
Have you self - harmed				

How bothered have you been by any issues relating to your thoughts or feelings?

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SUBSTANCE USE/ABUSE HISTORY

Have you ever used alcohol or other drugs?

Substance	Route of Administration	Frequency of Use / Amount	Age at First Use	Date Last Used	How Many Years Used Regularly

Have you ever been in treatment?

Facility and Location	Residential or Outpatient	Detox Only	Dates of Treatment	AA/NA

Are you dealing with any of the following as they relate to substance use/withdrawal?

Symptom	Never	Last 30 Days	Last 6 -12 Months
Shakes or Tremors			
Blackouts			
Memory Lapses			
Cravings			
Vomiting			
Nausea			
Profuse Sweating			
Hallucinations (visual, auditory, tactile)			
Seizures			
Delirium Tremens (DT's)			
Anxiety			
Headaches			

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Do you use tobacco products?

What form and how frequently?

In the past 30 days, how much money have you spent on substances including alcohol and tobacco products?

Have you ever been injured or caused injury to another person while you were impaired?

In the last 30 days, how many days have you used nothing at all?

How bothered are you by any issues that relate to using substances?

CLINICAL SUMMARY AND WRAP UP:

Rate the following area's on a scale of 1 – 5, 1 being "not a problem at all" and 5 being "an extreme problem". Then, take any rated 3 or higher and include in the development of your treatment plan.

Summary of Severity Scores	1	2	3	4	5
Education / Employment Severity					
Family / Social Severity					
Legal Status Severity					
Medical Status Severity					
Substance Status Severity					
Mental Health Status Severity					

CLINICIAN'S SUMMARY NARRATIVE WITH DSM V CODES:

COMPREHENSIVE ASSESSMENT

UA DATE AND RESULTS:

RECCOMMENDED LEVEL OF CARE:

Inpatient/ Mental Health	Partial Hospitalization	Intensive Outpatient	Residential Treatment	Individual Therapy

Clinician with credentials:

Date:

Time: