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? _____________________________

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

Provider	Dates	Reason For Treatment	Current?

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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? ______________________________

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? ____

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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 ? ______________________________________

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 ? ____

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 ? ____

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

Do 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? ____

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 your activities of daily living, and if so, how? ______________

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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 ? ____

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 ? ____

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

Has anyone close to you committed suicide ? ____

CLINICIAN 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 Judgment					
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? ____________

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

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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/withdrawals?

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			

Do you use tobacco products ? ____

What form and how frequently ? ____

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In the past 30 days, how much money have you spent on substances including alcoh
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 areas 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: ________________________________

____

UA DATE AND RESULTS: ____

RECOMMENDED LEVEL OF CARE:

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

Clinician with credentials:______________

Date:_____________________

Time:______________________