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Comprehensive Diagnostic Assessment (Adult)

Name: _____ DOB: _____
Email: _____ Phone: _____

Clinician: _____ Date of Assessment: _____

Primary Care Physician: _____
Psychiatrist: _____

Do you give permission for ongoing regular updates to be provided to your primary care physician and/or psychiatrist? Yes No

Please indicate the main reasons for seeking consultation and/or treatment or what are the presenting mental health concerns?

_____
_____
_____
_____
_____

Prior Psychiatrist History/Diagnosis: _____
_____
_____

What are your treatment goals?

_____
_____
_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

( ) Depressed Mood	( ) Fatigue	( ) Excessive Energy
( ) Decreased or Increase Libido	( ) Increased Irritability	( ) Chronic Pain
( ) Sleep Disturbances	( ) Racing Thoughts	( ) Crying Spells
( ) Loss of Interest	( ) Impulsivity	( ) Excessive Worry
( ) Attention/Concentration	( ) Increase Risky Behavior	( ) Anxiety Attacks
( ) Eating Disturbances	( ) Self-Harm	( ) Avoidance
( ) Excessive Guilt/Shame	( ) Flashbacks	( ) Hallucinations
( ) Suicidal Thoughts	( ) Obsessive/Compulsive	( ) Suspiciousness
( ) Dissociation	( ) Temper/Anger	( ) Other

Family of Origin

Place of birth/city/state: _____
Ethnicity: _____ Primary Language: _____

Parents at the time of birth were: Married Separated Unmarried
Were you in the same location or home while growing up? _____
Did your family move frequently? _____, if yes, please describe:
_____

Are you aware of any significant history about your mother's pregnancy or birth with you such as substance use, major complications during delivery, or born prematurely?
_____
_____

Are your parents currently: Married Divorced, when _____ Remarried
Were you adopted? _____ Age at the time of adoption: _____
Circumstances:_____

Did you ever witness any abuse within your parents' marriage?_____

Were either of your parents or other close family members imprisoned during your childhood/ youth?
_____
_____

Were you ever physically or sexually abused, assaulted, or molested?
_____No _____Don't know_____Yes – Please specify when and by whom:
_____
_____
_____

Were your physical needs provided for when you are growing up?
_____ No _____Yes _____Other (Explain)
_____
_____
_____

Were your emotional needs provided for growing up?
_____ No _____Yes _____Other (Explain)
_____
_____

Father_____
Deceased, year _____
What was his level of education?_____
Occupation?_____

Please describe the relationship with your father:
_____
_____
_____

Mother_____
Deceased, year _____
What was her level of education? _____
Occupation?_____

Please describe the relationship with your mother:
_____
_____
_____

Number of Siblings: _____

Full sisters _____Full brothers _____Half-sisters _____Half-brothers ____ Step-sisters _____Step-brothers _____Deceased, age(s) at death _____

How was conflict handled in your household growing up?
_____
_____

How were emotions viewed and managed in your household growing up?
_____
_____

Please explain your family's cultural and/or spiritual or religious background:
_____

How important to you is spirituality or religion presently? Is there any aspect of spiritualty/ religion you would like to address in therapy? Do you want your spiritual beliefs integrated into our work as a source of strength for you?
_____
_____

Did you have any other significant adults as you grew up that positively impacted your life?
_____No _____Yes

Please list names and relationship to you:
_____
_____

Family Psychiatric History

Please include any mental health and/or substance use problems with biological relatives. Consider diagnoses such as depression, anxiety, bipolar disorder, schizophrenia, ADHD, alcohol and/or drug abuse, incarceration, or any suicides.

Mother:_____
Mother's relatives:
_____
_____
Father:
_____
Father's relatives:
_____
_____
Siblings:
_____
_____
_____
Children:
_____
_____
_____

Family History and Functioning

Circle Current Status: Single Dating Exclusively Married Remarried Separated Divorced Widowed Living Together

Sexual Orientation: _____
Gender Identity: _____

Marital history: Age Year Duration # Children

1st Marriage:
_____
2nd Marriage:
_____
3rd Marriage:
_____
4th Marriage:
_____

Please check all that apply to your current marriage:
____Good, satisfied ____Supportive ____Warm relationship ____Stable
____Bored ____Poor communication ___On the verge of break-up
____Abusive (physical, verbal, sexual)

Marital/Partner conflicts: _____

Current Household Members:

Name	Age	Relationship

Are there children not living in the home? _____ If so, please list name, age, and relationship

_____

_____

Is there a custody/visitation order? If yes, please explain: _____

_____

What resources and supports do you and your family have?

_____

_____

What are your strengths and role in the family setting?

_____

_____

Basic Living Skills History and Functioning

Please indicate your habits with the following basic living skills practices:

	Daily	A few times per week	Once per week or less
Bathing		_____	_____
Brushing teeth		_____	_____
Dress in clean/appropriate clothes		_____	_____
Go to bed/wake up at regular times		_____	_____
Preparing balanced meals		_____	_____
Housekeeping activities		_____	_____
Laundry		_____	_____

Do you regularly perform the following safety practices?

Lock door/secure home ___Yes ___No

Turn off the oven/running water, etc. ___Yes ___No

Are you receiving personal care services, Meals on Wheels, or any other basic living skills provided? ___No ___Yes

Medical History and Functioning:

How would you describe your overall health? _____

Medical doctor(s) / Specialists:

_____

_____

Date of Last Physical or Wellness Exam: _____

Have any of your family members had significant illness or medical treatment? If so, please explain:

_____

Please circle any health conditions that apply:

Thyroid problem High blood pressure Headaches Heart problems Sleep problems
High Cholesterol Asthma Trouble eating Stomach problems Seizures Diarrhea

Other (please describe):

_____

Have you had any of the following?

	Yes/No	What	When
Contagious or Infectious Diseases			
Disabilities or Handicaps			
Allergies/FoodAllergies			

Have you had any of the following?

	Yes / No	What	When
Accidents/injuries			
Surgeries			
Major illnesses			
Hospitalizations			
Loss of consciousness			

Menstrual and Reproductive History

Number of pregnancies _____ Number of live births _____

Do you have any history of the following?

	Yes / No	What	When
Premenstrual syndrome			
Amenorrhea (absence of periods)			
Irregular periods			

Do you regularly engage in any health promoting activities? Relaxation/ Sleep/ Exercise?

_____

_____

Medications- Please list all current prescribed or over the counter drugs / medications

_____No medications

Medication_____Dosage_____Doctor_____
Medication_____Dosage_____Doctor_____
Medication_____Dosage_____Doctor_____
Medication_____Dosage_____Doctor_____
Medication_____Dosage_____Doctor_____

Supplements _____

****Please list additional medications on back of this page**

Can you self-administer your medications? _____Yes _____No

Medication Compliance:
____Regularly taken as prescribed
____Occasionally miss a dose
____Miss doses regularly
____Refuse/forgot to take meds most days

Have you been treated in the past with psychiatric medications such as antidepressants, mood stabilizers, tranquilizers, sleeping aids, stimulants, or others? _____Yes _____No

Please list medications:

_____

_____

_____

_____

Caffeine: _____

Substance Use/ Abuse

No Use_____

	Age of 1st Use	Frequency	Amount	Last Use
Nicotine:				
Vaping:				
Alcohol:				
Marijuana:				
Amphetamines:				
Hallucinogens:				
Cocaine/Crack:				
Heroin:				
Prescription Meds:				
Other:				

Behavioral Health Treatment History

	Service Provider	When / How often?	Was it helpful? Please explain
Counseling			
In-Patient Psychiatric Center			
Case Management			
Medication Management			
CBRS / PSR			
Addictions Treatment			
Developmental Services			
Occupational Therapy			
Speech Therapy			
Physical Therapy			
Personal Care Services			
Home Health Provider			

If you have been to therapy before what as your experience? What did your therapist do that you wished was on differently? What did your therapist do that was beneficial/ helpful?

_____
_____
_____
_____

Legal History and Functioning

Do you have any current or past involvement with the following?
Diversion Court _____No _____Yes- Please explain
_____
Probation _____No _____Yes- Please explain
_____
Arrest _____No _____Yes- Please explain
_____
Illegal Activity _____No _____Yes- Please explain
_____
Incarceration _____No _____Yes- Please explain
_____

Do you have reliable transportation, or do you have access to public transportation, etc?
_____Yes
No (please explain)_____

What supports and resources do you have in the community (churches, clubs, extra-curricular activities etc)?

_____
_____

Do you have a: Social Security card _____Yes _____No
Driver's License _____Yes _____No

Vocational/Educational History and Functioning

What is your highest level of education? _____
What is your partner's highest level of education? _____
Have you ever completed any vocational training? _____Yes _____No

Please describe how you did in elementary school:
Academically_____
Behaviorally_____
Socially_____

Please describe how you did in junior high/high school:
Academically_____
Behaviorally_____
Socially_____

If you had any difficulty in school please explain:
_____
_____

Were you in a specialized classroom setting or receive special education? _____Yes_____No
Were you ever on an Individual Education Plan (IEP) or a 504plan:
_____

Do you currently have educational goals? _____Yes _____No
_____

Employment
Are you currently employed? _____Yes _____No
Job Title/description_____
How long have you been at this job? _____months/years
Are you satisfied with the job? _____ Yes _____ No
How many hours per week do you work? _____

Work History:
Job Length of time Reason for leaving
_____
_____
_____
_____

Do you currently have employment goals? _____Yes _____No
_____
Military Service: ____No ___Yes–please specify
_____
Were you Honorably discharged? _____Yes ____No–please explain
_____
_____

Social History and Functioning
How would you describe your friendships – please circle all that apply
No friends Only acquaintances Acquaintances and Friends

How would you describe your behavior and comfort level when you are in social settings?
_____
_____

Have you experienced any difficulties with age, gender, sexual orientation, culture, race, or religion? _____No _____Yes – please explain
_____
_____

What do you like to do for fun?

_____

_____

What are your talents and/or social strengths?

_____

_____

Financial History and Functioning

Are finances adequate to meet the family's needs ____Yes ____No – please explain problems

_____

_____

Sources of Income: _____

Any History of Financial difficulty/Credit Concerns:

_____

Housing History

Current Living arrangement:

___Own home
___Renting
___Living with friends/family
___Other
___Supported housing-explain_____

Does the current housing situation meet your needs in the following areas?

Health and safety ___Yes ____No-please explain_____

Access to services ___Yes ____No-please explain_____

Is there any history of homelessness/evictions? ____No ___Yes-please explain_____

Is there any risk of homelessness? ____No ____Yes-please explain_____

Signatures

Responsible party completing this form: _____

Relationship to Client: _____

Signature: _____

Date: _____