Adult Diagnostic Assessment

Client Name: (First MI Last)		Client S.S. #
Address:	**Client Phone Number:**	**Date of Birth:**
Emergency Contact: Name	**Relationship to client:**	**Permission to contact them in emergency:**
Emergency contact phone number:		Yes No

Presenting Problem	Date of Admission:

What are you seeking help with?(Please include any symptoms you have had, any behavior problems, functioning problems, what triggering factors may have started these problems, and what made you see your need to come in.)

Living Situation

Please describe your living situation

My Home: Rent Own

Residential Care/Treatment Facility: Hospital Temporary Housing Residential Care Nursing Home

Other: Friend's Home Relative's/Guardian's Home Foster Care Home Respite Care Jail/Prison

Homeless living with friend Homeless in Shelter/No residence Other:_____

Identify Facility/Person's Name:_____

Marital Status: Married Single Divorced Widowed Separated Other

Please list people living with you:

Household Member's Name	Relationship to Client	Age	Quality of Relationship
Significant Family Members/ Others not listed above	Relationship to Client	Age	Quality of Relationship

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Social Information	Client Name:
Do you have anyone you can talk to/count on n your family? Please list your primary support people?	
Please list pertinent family history information, including family mental health and drug and alcohol issues:	
What would you say are your Strengths or your known skills?	
What are your limitations of Activities of Daily Living?	
Do you have friends, or other relationships you can count on for support	
What meaningful activities are you involved in? (Please include Community Involvements, Church, Volunteer Activities, Leisure/Recreation, Other Interests):	
What Community Supports/Self Help Groups are you involved in? (AA, NA, etc)	
How would you describe your Religion/Spirituality?	
Do you have Cultural/Ethnic Issues/Information/Concerns? If so, what are they?	
Have you had Developmental Issues?	
Do you have any Sexual History/Concerns? If so, what are they?	
Do you have any other comments?	

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Education, Employment, & Military Information | **Client Name:**

Please describe your educational history:

Education History (Check all that Apply): GED HS Grad College- # Years___ Degree/Major:
 Other Degree:

_____Highest Grade Completed
_____Vocational Year Completed

Have you had a History of Learning Difficulties Learning Disability-Type_____
 None Reported Mental Retardation
 Special School Placement
 Other

Have you had any Barriers to Learning? Inability To Read or Write
 None Reported Other:

Do you have a Special Communication Needs? TDD/TTY Device Sign Language Interpreter
 None Reported Assistive Listening Devise(s)
 Language Interpreter Services NEEDED- Other Spoken Language: _____

Employment: (Check all that apply)
I am currently Employed: Full Time (35 hours or more per week)
 Part Time (Less than 35 hours per week)
 Unemployed-Date Last Worked: _____
Not in Labor Force: Disabled Retired Homemaker Student Living in Institution Other:

If Employed, Name of Employer:

Job Performance History
_____Number of Jobs in Last 5 Years-Comments

Attendance: Above Average Normal Tardiness Absenteeism
Performance: Great Good Average Below Average

Employment Interests/Skills:
If employed, are you satisfied with your Job? No Yes
Are you experiencing financial problems? No Yes
(If not currently employed)- Do you want to work? No Yes
Are you concerned that employment will affect benefits? No Yes

Comments on past or current skills/interests:

Military History:
 No Yes If yes, describe branch of service, any pertinent duties and any trauma experienced during service as applicable:

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Type of Discharge if other than General/Honorable:
Date of Discharge:

Mental Health Treatment History	**Name of Client:**

Please list any Outpatient Mental Health/Alcohol or Drug Treatment: ☐ None Reported

Agency:	Current (X)	Past (Date)	Client Name:
	☐		
	☐		
	☐		

Please list any Psychiatric Hospitalizations: ☐ None Reported

Hospital:	Date of Service	Reason (Suicidal, Depressed, Etc.)

Please list any Previous or Current Diagnoses (if known): ☐ Not known

Do you have any comments regarding previous Mental Health Treatment: ☐ No Comments

Please list Current Medication Information(Include Medical, Psychiatric, Herbal) ☐ None Reported

Medication	Rationale	Dosage/Route/Frequency	Compliance			
			Yes	No	Partial	Unkn

Primary Care Physician (Name, Phone Number, Address):	**Other Prescribing Physician(s)**

Past Psychotropic Medications ☐ None Reported

Psychotropic Medications	**Reason for Discontinuation**

Legal History

Legal Guardian/Custodian: ☐ None Reported	Phone:

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Please list Current Legal Status: None Reported On Probation Detention On Parole
 Awaiting Charge AoD Related Legal Problems Conditional Release
Outpatient Commitment Court Ordered to Treatment Other

Please list History of Legal Charges: Juvenile No Yes If yes, ___ Status Offence (e.g., Unruly)
 Delinquency

Adult No Yes If yes, ____Misdemeanor Felony

Date of most recent legal charges:

	Client Name:

Please list any Convictions:
 None Reported

Please list any Incarcerations:
 None Reported
Name of probation/Parole Officer (if applicable):

Have you been involved in any Civil Proceedings?
 None Reported
Domestic Relations Court Problems (i.e., Custody, Protective Services, Restraining Order):

Have you had any Juvenile Court Involvement? (Related to Child Abuse, Neglect or Dependency):
Current: No Yes Comment: _____
Past: No Yes Comment: _____

Have you had Child Support Enforcement Orders?
 None Reported

Have you had Children's Protective Services Involvement with family?
 None Reported

Please name of Children's Protective Serves Caseworker(s) assigned to family (if applicable):
 None Reported

Alcohol/Drug History

Have you used/abused Illegal Drugs in the Past 12 Months? No Yes
Have you abused Prescription Drugs in the Past 12 Months? No Yes
Have you abused Non Prescription Drugs in the Past 12 Months**?** No Yes
Have you abused Alcohol in the Past 12 Months? No Yes

Could you benefit from Detox? No Yes If yes, Symptoms:

Check all that apply: IV Drug User Pregnant
Please describe your drug/alcohol history:

Drug/Substance/Alcohol	Age of 1st Use	Date of Last Use	Frequency	Amount	Method

Alcohol/Drug Treatment History

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Alcohol or Drug Treatment:
☐None Reported
☐Current-List provider and services received:
☐ Past ☐OP ☐ IOP ☐ Residential ☐ Hospital ☐Detox ☐Other:

Agency:	Date of Service:
List any other comments, including alcohol and drug related legal problems:	

Abuse History (Describe in Comment Section Each Element Checked) **Client Name:**

☐ **Check if you have a History of Abuse/Violence.**	☐**Physical Abuse**	☐**Domestic Violence/Abuse**
☐**Community Violence**	☐ **Physical Neglect**	☐ **Emotional Abuse**
☐ **Elder Abuse**	☐ **Sexual Abuse/Molestation**	☐ **Other:**

Comments: (Have you been the victim of abuse, the perpetrator, or both?

Problem Checklist Including Functional Domains

Check All Current Problem Areas:	**As Evidenced By:**
☐	**Nutritional/Eating Pattern Changes/Disorders:**
☐	**Pain Management:**
☐	**Depressed Mood/Sad:**
☐	**Bereavement Issues:**
☐	**Anxiety:**
☐	**Traumatic Stress:**
☐	**Anger/Aggression:**

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☐	**Oppositional Behaviors:**	
☐	**Inattention:**	
☐	**Impulsivity**	
☐	**Disturbed Reality Contact (Psychosis):**	**Client Name:**
☐	**Mood Swings/Hyperactivity:**	
☐	**Substance Use/Addiction:**	
☐	**Other Addictive Behaviors:**	
☐	**Sleep Problems:**	
☐	**Psychosocial Stressors:**	
☐	**Pertinent Health Issues (Include any Allergies):**	
☐	**My family needs education to be able to:**	
☐	**I need other environmental supports (Describe areas where environmental supports are needed to support you in community living and possible sources of that support):**	

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Other: Please feel free to share any other concerns you have:

Have you attempted to kill yourself in the past? No Yes
If so, how many times? _____When was the last attempt?_____
Have you attempted to harm others in the past? No Yes
If so, please explain:

Do you currently want to harm or kill yourself? No Yes
Comment:

CURRENT STATUS: PLEASE ANSWER THE FOLLOWING QUESTIONS SO THAT WE MIGHT HAVE A BETTER IDEA OF HOW YOU ARE DOING (**circle the correct number**);

	Not at all			**Some**			**A lot**
During the past week, how concerned or worried have you been about your health?	1	2	3	4	5	6	7
During the past week, how anxious, nervous, or tense have you been?	1	2	3	4	5	6	7
During the past week, how much have you been bothered by feelings of guilt?	1	2	3	4	5	6	7
During the past week, have you felt super-efficient or like you have unlimited energy, special talents or powers?	1	2	3	4	5	6	7
During the past week, how depressed have you felt?	1	2	3	4	5	6	7
During the past week, how irritable or angry have you been?	1	2	3	4	5	6	7
During the past week, how much distrust of others have you felt (or how much did it seem like others were out to hurt you)?	1	2	3	4	5	6	7
During the past week, did you hear or see things around you that others did not see?	1	2	3	4	5	6	7
During the past week, how much difficulty have you had with your thinking?	1	2	3	4	5	6	7
Sub-total							
Total							

THANK YOU FOR GIVING YOUR TIME AND EFFORT
TO FILL OUT THIS QUESTIONNAIRE!