Evergreen Counseling LLC

Comprehensive Diagnostic Assessment

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| **Client Name** | **DOB** | **Medicaid/Insurance#** |
| Address | Phone: |
| Age | Sex | Name of School | Grade |
| Evaluator with Credentials | Date of Assessment |
| Parent/Guardian Name:Address:Phone:Email: |
| **Presenting Problem**(Onset, duration and frequency of symptoms) |

Reason Client/Guardian is seeking services, Describe Client’s current symptoms, Describe recent events

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| --- |
| **Family History** |
| [ ]  Parent/Guardian’s Home [ ]  Own Home [ ] Foster Care Home [ ] Respite Care[ ]  Homeless living with friend [ ]  Homeless in Shelter/No Residence [ ]  Other |
| **Resident Care/Treatment Facility**[ ]  Hospital [ ] Temporary Housing [ ]  Residential Housing [ ]  Supportive Living [ ]  N/AIdentify Facility or Person’s Name: |
| **Primary Language**  [ ]  English [ ]  Spanish [ ]  Other**Interpretive Services Needed** [ ]  Yes [ ]  No [ ]  Services Declined |
| **Primary/Family/Marital/Significant Other Support Systems** |
| **Basic Living Skills** |
| **Developmental Issues** (physical, psychological, social, intellectual and academic) |
| **Abuse Issues/Concerns** (past or present) |
| **Trauma Concerns** (past or present) |
| **Sexual Behavior** |
| **Social Relationship/Support** |
| **Strengths/Capabilities** |
| **Friendship/Social/Peer Support Relationships** |
| **Leisure Activities/Interests/Hobbies** |
| **Community Supports/Self Help Groups** |
| **Religion/Spirituality** |
| **Cultural/Ethnic Issues** |
| **Educational/Vocational** |
| **Education History**[ ]  Enrolled [ ]  Home Schooled | Highest Grade Completed | Post Secondary Completed |
| **Discuss Problems in School if not addressed in presenting problems** |
| **History of Learning Difficulties**[ ] None Reported [ ]  Learning Disability/Type:**[ ]** Mental Retardation [ ]  Special School Accommodations: [ ] IEP [ ]  504 [ ]  Behavior Plan**[ ]** Other |
| **Employment**[ ]  Student [ ]  Disabled [ ]  Other  |
| **Medical Treatment History** |
| **Primary Care Physician** (name, address, phone number, FAX) |
| **Other Physicians** |
| **Current Physical and Date** |
| **Surgeries** |
| **Hospitalizations** |
| **Current Known Medical Issues****[ ]** No Issues [ ]  Asthma [ ]  Seizures [ ] Vision Impairment [ ] Hearing Impairment [ ]  Allergies [ ]  Other  |
| **Current Medication Information** (include medication/dose/Dr.) |
| **Previous Medication Information** (include medication/dose/Dr.) |
| **Current over-the-counter medications and vitamins** |
| **Current Known Contagious Diseases or Illness** **[ ]** Yes [x]  No [ ]  None ReportedIf yes, list: |
| **Pertinent Family Medical History**  |
| **Prenatal/Perinatal** |
| **Mental Health Treatment History****Psychiatric and Behavioral** |
| **Outpatient Mental Health** [ ]  None Reported  |
| **Psychiatric Hospitalizations** [ ]  None Reported |
| **Previous Behavioral Health History** DatesProvidersInterventionsResponses |
| **Age at Onset** |
| **History of Physical/Sexual/Emotional Abuse** [ ]  None[ ]  Yes If yes, explain |
| **Current Medication Information** (include medication/dose/Dr.) |
| History of Symptoms[ ]  Racing or tangential thoughts[ ]  Intrusive or disturbing thoughts[ ]  Paranoia or the sense that others are watching you[ ]  Feelings of unreality or depersonalizations (ex. feeling outside your body)[ ]  Frequent episodes of déjà vu[ ]  Panic attacks[ ]  Uncontrolled anger or violent behavior[ ]  Mood swings[ ]  Depressed mood[ ]  Mania or hypomania (ex. periods of very high energy with prolonged lack of sleep)[ ]  Hallucinations (ex. hearing voices or seeing things that others do not perceive)[ ]  Compulsions (ex. Excessive hand washing; frequently checking locks)[ ]  Eating Disorder [ ]  Anxiety[ ]  Hyperactivity[ ]  Impulsivity |
| **Risk Assessment** Suicidal or Homicidal Plans [ ]  No [ ]  Yes If yes, explainSuicidal or Homicidal Thoughts [ ]  No [ ]  Yes If yes, explainRisk Taking Behaviors [ ]  No [ ]  Yes If yes, explainViolence [ ]  No [ ]  Yes If yes, explainHistory of Suicidal or Homicidal Plans or Thoughts [ ]  No [ ]  Yes If yes, explain |
| **Legal History**(If client is not an adult, discuss family involvement with legal system) |
| **Current Legal Status**[ ]  None Reported [ ]  On Probation [ ]  Detention [ ]  On Parole [ ]  Awaiting Charge[ ]  AoD Related Legal [ ] Court Ordered to Treatment [ ]  Other |
| **Court Involvement** (related to child abuse, neglect or dependency)[ ]  None ReportedCurrent [ ]  No [ ]  Yes ExplainPast [ ]  No [ ]  Yes Explain |
| **Adult/Children’s Protective Services Involvement**[ ]  None [ ]  Yes If yes, explain |
| **Family History of Legal Issues** [ ]  Yes [ ]  No [ ]  Other |
| **Alcohol/Drug/Nicotine History**(If client is not an adult, discuss family history if applies) |
| **Alcohol Use**[ ]  None ReportedAlcohol abuse in the past 12 months? [ ]  No [ ]  YesHistory of alcohol use [ ]  No [ ]  Yes**Drug Use**[ ]  None ReportedIllegal drug use/abuse in the past 12 months? [ ]  No [ ]  YesPrescription drug use/abuse in the past 12 months? [ ]  No [ ]  Yes**Nicotine Use**[ ]  None ReportedNicotine use in the past 12 months? [ ]  No [ ]  YesHistory of nicotine use [ ]  No [ ]  Yes |
| **Alcohol and Other Drugs (AoD) Treatment History**[ ]  None ReportedCurrent [ ]  Outpatient [ ]  IOP [ ]  Residential [ ]  OtherPast [ ]  Outpatient [ ]  IOP [ ]  Residential [ ]  Hospital [ ]  Detox [ ]  Other**Current or past providers****Family History** [ ]  No [ ]  Yes If yes, explain |