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/A  Identify 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  No  None Reported  If 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**  Dates  Providers  Interventions  Responses | | |
| **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, explain  Suicidal or Homicidal Thoughts  No  Yes If yes, explain  Risk Taking Behaviors  No  Yes If yes, explain  Violence  No  Yes If yes, explain  History 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 Reported  Current  No  Yes Explain  Past  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 Reported  Alcohol abuse in the past 12 months?  No  Yes  History of alcohol use  No  Yes  **Drug Use**  None Reported  Illegal drug use/abuse in the past 12 months?  No  Yes  Prescription drug use/abuse in the past 12 months?  No  Yes  **Nicotine Use**  None Reported  Nicotine use in the past 12 months?  No  Yes  History of nicotine use  No  Yes | | |
| **Alcohol and Other Drugs (AoD) Treatment History**  None Reported  Current  Outpatient  IOP  Residential  Other  Past  Outpatient  IOP  Residential  Hospital  Detox  Other  **Current or past providers**  **Family History**  No  Yes If yes, explain | | |