Human Dynamics & Diagnostics, LLC
2267 Teton Plaza, Idaho Falls, ID 83404

COMPREHENSIVE DIAGNOSTIC ASSESSMENT – ADULT

ANNUAL UPDATE

(1) IDENTIFYING INFORMATION

Name: _____ DOB: _____

Assessor: _____ Date of Assessment: _____

Date of original CDA and Assessor: _____

Date(s) of CDA Update(s) and Assessor(s): _____

_____

☐ New Clinic Participant – No Medicaid mental health clinic services have been received in the past 12 months

☐ Active Clinic Participant – Medicaid mental health clinic services have been received in the past 12 months

(2) PRESENTING PROBLEM

Please describe the current episode of your problems/illness from the time of your last assessment to the present, including dates and significant events: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please list stressful life events that have occurred since the date of your last assessment: _____

_____

_____

_____

Client Name:_____

Depression – Since the last assessment have you had a period of time during which you felt unhappy, depressed, irritable, and felt no interest in life consistently for at least two to four weeks? ☐ Yes, now. ☐ Yes, in the past year, but not now. ☐ No **High Periods or Mania –** Since the last assessment have you had moods that lasted one week or more in which you had so much energy you did not sleep for several nights, or felt you could accomplish many difficult tasks easily? Were you feeling so good that others commented on your elevated mood? ☐ Yes, now. ☐ Yes, in the past year, but not now. ☐ No **Chronic Feelings of Unhappiness –** Have you felt mildly unhappy or unable to enjoy life for many years, for no apparent reason? ☐ Yes, now. ☐ Yes, in the past year, but not now. ☐ No **Suicide Attempts –** Have you attempted suicide since the last assessment? ☐ Yes, now. ☐ Yes, in the past. ☐ No **Self Harm –** Besides attempting suicide, have you attempted to do physical harm to yourself in other ways, such as cutting or burning yourself since the last assessment? ☐ Yes, now. ☐ Yes, in the past year, but not now. ☐ No **Chronic Tension or Anxiety –** Since the last assessment have you had problems with chronic anxiety, tension, nervousness, or constant worrying? Do you worry about minor concerns? (Not connected to anxiety attacks) ☐ Yes, now. ☐ Yes, in the past year, but not now. ☐ No **Panic Attacks –** Since the last assessment have you had brief anxiety attacks during which you felt like you were going to die, lose control, were very frightened, extremely anxious, or uncomfortable? ☐ Yes, now. ☐ Yes, in the past year, but not now. ☐ No **Panic Associated Fears –** Since the last assessment have you ever been afraid of going out of the house alone, going to the grocery store, driving or using public transportation because of fear of having a panic attack? ☐ Yes, now. ☐ Yes, in the past year, but not now. ☐ No **Obsessive/Compulsive Symptoms –** Since the last assessment have you had compulsions to repeat tasks such as checking things, washing hands, counting, or obsessions (ideas that make no sense but keep repeating in your mind? ☐ Yes, now. ☐ Yes, in the past year, but not now. ☐ No **Social Fears or Phobias –** Since the last assessment have you been fearful in specific social situations, or felt uncomfortable doing things in front of other people? Do you worry excessively about being embarrassed or humiliated in social situations? ☐ Yes, now. ☐ Yes, in the past year, but not now. ☐ No **Phobias –** Since the last assessment have you had significant phobias such as heights, flying, closed spaces, insects, etc. that interfere with your life? ☐ Yes, now. ☐ Yes, in the past year, but not now. ☐ No	**Comments:**

Client Name:_____

Posttraumatic Symptoms – Have you ever experienced a very traumatic event that has continued to bother you or cause emotional problems since the last assessment, such as nightmares or flashbacks of the event? ☐ Yes, now. ☐ Yes, in the past year, but not now. ☐ No **Hyperactivity/Inattention –** Since the last assessment have you been considered hyperactive and/or inattentive, or have you been treated with Ritalin or another stimulant, or been diagnosed with ADHD? ☐ Yes, now. ☐ Yes, in the past year, but not now. ☐ No **Psychotic Symptoms –** Since the last assessment have you had hallucinations, heard voices, felt that you had special powers or were receiving special messages, felt inappropriately suspicious that people were trying to hurt you? ☐ Yes, now. ☐ Yes, in the past year, but not now. ☐ No **Chronic Physical Symptoms –** Since the last assessment have you had a period of time during which you felt physically sick or worried about your health when no physical cause could be found? ☐ Yes, now. ☐ Yes, in the past year, but not now. ☐ No **Chronic Pain –** Since the last assessment have you had problems with chronic pain such as headaches or stomachaches? If so please specify:_____ ☐ Yes, now. ☐ Yes, in the past year, but not now. ☐ No **Sleep Problems –** Since the last assessment have you experienced sleep problems such as insomnia, oversleeping, frequent nightmares or sleepwalking? ☐ Yes, now. ☐ Yes, in the past year, but not now. ☐ No **Anorexia –** Since the last assessment have you been anorexic or purposely lost weight to obtain a weight below normal? ☐ Yes, now. ☐ Yes, in the past year, but not now. ☐ No **Binge Eating or Bulimia –** Since the last assessment have you had eating binges associated with inducing vomiting, using laxatives, or exercising to extreme? ☐ Yes, now. ☐ Yes, in the past year, but not now. ☐ No **Compulsive Behaviors –** Since the last assessment have you had problems with compulsive behaviors such as gambling, spending, work, sex, pornography, or other problematic compulsions? ☐ Yes, now. ☐ Yes, in the past year, but not now. ☐ No **Temper/Anger Problems –** Since the last assessment have you had problems with your temper? ☐ Yes, now. ☐ Yes, in the past year, but not now. ☐ No **Dissociative Symptoms –** Since the last assessment have you had periods of time during which you feel "out of touch", removed from the world around you, or lost large amounts of time that you cannot account for? ☐ Yes, now. ☐ Yes, in the past year, but not now. ☐ No	**Comments:**

Client Name:_____

(3) BEHAVIORAL HEALTH TREATMENT HISTORY

	Who provided the service?	When and how often?	Was it helpful? Please explain.
Counseling			
Medication Management			
Family Therapy			
Case Management			
CBRS/PSR			
Addictions Treatment			
Developmental Services			
Occupational Therapy			
Speech Therapy			
Physical Therapy			
IEP or 504 Plan			
Personal Care Services			
Other			

Have you been admitted to a residential treatment program or psychiatric hospital since the last assessment?

☐ No ☐ Yes – please complete:

Institution	Reason for admission	Date	Length of stay	Did it help?

(4) SUBSTANCE USE/ABUSE

Alcohol Use/Abuse – Have you drunk alcohol since the last assessment? ☐ Yes, now ☐ Yes, in the past ☐ No

☐ I drink occasionally: ___ x per month ☐ I drink most days: ___ x per week ☐ I drink daily: ____ drinks per day

☐ I, or others I associate with, believe I have a drinking problem.

Drug Abuse – Have you abused "street" or prescription drugs since the last assessment? ☐ Yes, now ☐ Yes, in the past

☐ No If yes, what drug(s) and what ages with each drug? _____

_____

Tobacco Products – Do you smoke or use other tobacco products? ☐ Yes, now ☐ Yes, in the past ☐ No

If yes how many packs per day/week and for how long? _____

Caffeine – Do you regularly drink coffee, tea or colas? ☐ No ☐ Yes – How much? _____

Client Name:_____

(5) FAMILY PSYCHIATRIC HISTORY

Have there been any changes in the family's psychiatric history since the last assessment? ☐ No ☐ Yes – Please explain:

_____

_____

_____

(6) MEDICAL HISTORY & FUNCTIONING

How has your general health been since your last assessment? ☐ Good ☐ Fair ☐ Poor

Medical Doctors/Specialists: _____

_____

Health Conditions – Have there been any changes in your health history since the last assessment? ☐ No ☐ Yes

What/When: _____

_____

Since your last assessment have you experienced

any contagious diseases? ☐ No ☐ Yes What/When: _____

any disabilities or handicaps? ☐ No ☐ Yes What/When: _____

any allergies? ☐ No ☐ Yes What/When: _____

Since your last assessment have you experienced any

accidents/injuries? ☐ No ☐ Yes What/When: _____

surgeries? ☐ No ☐ Yes What/When: _____

major illnesses? ☐ No ☐ Yes What/When: _____

hospitalizations? ☐ No ☐ Yes What/When: _____

loss of consciousness? ☐ No ☐ Yes What/When: _____

Menstrual and Reproductive History – Have there been changes in your menstrual/reproductive history since the last assessment? ☐ No ☐ Yes What/When: _____

Medication - 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: _____

Medication: _____ Dosage: _____ Doctor: _____

Can you self-administer your medication? ☐ No ☐ Yes

Medication compliance: ☐ Regularly taken as prescribed ☐ Occasionally miss a dose

☐ Miss doses regularly ☐ Refuse/forget to take meds most days

Client Name:_____

(7) FAMILY HISTORY & FUNCTIONING

Has your marital status or family composition changed since the last assessment? ☐ No ☐ Yes – Please explain: _____

_____

_____

_____

Please check all that apply to your current relationship:

☐ Good, Satisfied ☐ Supportive ☐ Warm relationship ☐ Stable ☐ Bored

☐ Poor communication ☐ On verge of breakup ☐ Abusive (physical, verbal, sexual)

Conflicts over:

☐ Finances ☐ Sex ☐ Children ☐ Friends ☐ Alcohol/Drugs

☐ Legal issues ☐ Mental health ☐ Religion ☐ Many minor conflicts

Household members:	Name	Age	Relationship

Children not in the home:	Name	Age	Relationship

Have your family resources/supports changes since the last assessment? ☐ No ☐ Yes – Please explain: _____

_____

_____

Has there been any instances of abuse since the last assessment? ☐ No ☐ Don't know ☐ Yes – please specify when and by whom: _____

_____

(8) SOCIAL HISTORY & FUNCTIONING

Have there been changes in your social support/relationships since the last assessment? ☐ No ☐ Yes – please explain: ____

_____

_____

Client Name:_____

How would you describe your current behavior/comfort level when you are in social situations? _____

What leisure/recreational activities are you currently involved in? _____

(9) VOCATIONAL/EDUCATIONAL HISTORY & FUNCTIONING

Education – Have there been changes in your educational history since the last assessment? ☐ No ☐ Yes – please explain: _

Employment – Are you currently employed? ☐ No ☐ Yes – job title/description: _____

How long have you been at this job? _____ Months/Years Are you satisfied with the job? ☐ Yes ☐ No – why? _____

Since the last assessment have you

been reprimanded at work? ☐ No ☐ Yes – please explain: _____

been fired from a job? ☐ No ☐ Yes – please explain: _____

participated in a work program? ☐ No ☐ Yes – please explain: _____

What are your current employment goals? _____

Military Service – Have you been involed in the military since the last assessment? ☐ No ☐ Yes – Specify: _____

Rank: _____ Branch: _____ Saw Combat? ☐ No ☐ Yes

(10) FINANCIAL HISTORY & FUNCTIONING

Please describe your/the family's current source(s) of income: _____

Are finances adequate to meet the family's needs? ☐ Yes ☐ No – please explain problems and supports/resources available:

Do you/your family receive

child support? ☐ No ☐ Yes – amount/frequency: _____

SSDI? ☐ No ☐ Yes – amount/frequency: _____

SSI? ☐ No ☐ Yes – amount/frequency: _____

food stamps? ☐ No ☐ Yes – amount/frequency: _____

cash assistance? ☐ No ☐ Yes – amount/frequency: _____

other income? ☐ No ☐ Yes – amount/frequency:_____

Have you experienced any financial problems since the last assessment? ☐ No ☐ Yes – please explain: _____

Client Name:_____

(11) BASIC LIVING SKILLS HISTORY & FUNCTIONING

Please indicate your habits with regard to the following basic living skill practices:

Bathing (using soap, washing hair) ☐ Daily ☐ A few times per week ☐ Once per week or less

Brushing teeth ☐ Daily ☐ A few times per week ☐ Once per week or less

Dress in clean/appropriate clothes ☐ Daily ☐ A few times per week ☐ Once per week or less

Go to bed/wake up at regular times ☐ Always ☐ Most of the time ☐ Rarely

Making/Following a shopping list ☐ Each time I shop ☐ Sometimes ☐ Rarely or never

Preparing balanced meals ☐ Twice per day ☐ Once per day ☐ Few times per week ☐ Rarely/Never

Housekeeping activities ☐ Daily ☐ A few times per week ☐ Once per week ☐ Less than 1x week

Laundry ☐ Weekly or more often ☐ Every couple of weeks ☐ Once per month or less

Do you regularly perform the following safety practices?

Lock doors/secure home ☐ Yes ☐ No

Turn off the stove, running water, etc ☐ Yes ☐ No

Since the last assessment have you received personal care services, Meals on wheels, or any other basic living skill providers? ☐ No ☐ Yes – Specify: _____

_____

(12) HOUSING HISTORY & FUNCTIONING

Current living arrangement: ☐ Own home ☐ Renting ☐ Living with friends/family ☐ Other - _____

☐ Supported Housing – Specify: _____

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: _____

Homelessness since the last assessment? ☐ Yes ☐ No – please explain: _____

Is there any risk of homelessness? ☐ Yes ☐ No – please explain: _____

(13) COMMUNITY/LEGAL HISTORY & FUNCTIONING

Since the last assessment have you had any 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 access public transportation etc? ☐ Yes ☐ No – please explain: _____

_____

What supports and resources do you have in the community (churches, clubs, etc)?_____

Do you have a: Social Security card? ☐ Yes ☐ No Driver's license? ☐ Yes ☐ No

Client Name:_____

(14) MENTAL STATUS EXAM

SUICIDALITY/HOMICIDALITY

☐ Client denies any **current** suicidal or homicidal thoughts, feelings, gestures, intentions or plans.

☐ Client reports **current** suicidal or homicidal feelings.

Specify: _____

☐ Client denies **history** of suicidal or homicidal thoughts, feelings, gestures, intentions or plans.

☐ Client has **history** of suicidal or homicidal thoughts, feelings, gestures, intentions or plans.

Specify: _____

Immediate Therapist intervention needed:_____(☐ None needed)

MENTAL STATUS

General Behavior: cooperative, passive, withdrawn, dramatic, restless, hostile, anxious, other: _____

Attire: appropriate, seductive, untidy, loud, meticulous, other: _____

Gait: normal, erect, stooped, ataxic, rigid, shuffling, manneristic, other: _____

Motor Activity: normal, agitated, retarded, tremor, tic, mannerism, other: _____

Productivity of thought: spontaneous, verbose, pressured speech, unproductive, other: _____

Progression of thought: normal, loose, circumstantial, preservation, halting, blocking, incoherent, fragmented, other: _____

Language: normal, baby-talk, peculiar, expression, stilted, other: _____

Mood: indifferent, fearful, angry, euphoric, labile, shallow, blunted, flat, normal, composed, anxious, sad, tearful, depressed

Affect: appropriate, inappropriate, other: _____

Perception: normal, auditory hallucination, visual hallucination, illusions, depersonalization, hypochondriasis, other: _____

Orientation: normal, disoriented to time, place, person

Memory: normal, defective (remote, recent, immediate), other: _____

General knowledge: consistent with education, inconsistent, able to abstract, concrete, other: _____

Insight: absent, good, fair, minimal

Judgment: good, fair, poor

(15) SIGNATURES (The CDA must be signed and dated by all professionals who contribute to its development – PSR staff, etc)

_____

Therapist's Signature Date

_____

Other Date

BCH 8-14-15

ALERT® Wellness Assessment - Adult

Completing this brief questionnaire will help us provide services that meet your needs. Answer each question as best you can and then review your responses with your clinician. Please shade circles like this ●

Client Last Name , First Name Date of Birth: (mm/dd/yy) / /

Subscriber ID Authorization #

Clinician Last Name , First Name Today's Date: (mm/dd/yy) / /

Clinician ID/Tax ID 134636819 8 Clinician Phone - State MRef ○

Visit #: ○ 1 or 2 ○ 3 to 5 ○ Other

For questions 1-16, please think about your experience in the past week.

How much did the following problems bother you?	*Not at All*	*A Little*	*Somewhat*	*A Lot*
1. Nervousness or shakiness	○	○	○	○
2. Feeling sad or blue	○	○	○	○
3. Feeling hopeless about the future	○	○	○	○
4. Feeling everything is an effort	○	○	○	○
5. Feeling no interest in things	○	○	○	○
6. Your heart pounding or racing	○	○	○	○
7. Trouble sleeping	○	○	○	○
8. Feeling fearful or afraid	○	○	○	○
9. Difficulty at home	○	○	○	○
10. Difficulty socially	○	○	○	○
11. Difficulty at work or school	○	○	○	○

How much do you agree with the following?	*Strongly Agree*	*Agree*	*Disagree*	*Strongly Disagree*
12. I feel good about myself	○	○	○	○
13. I can deal with my problems	○	○	○	○
14. I am able to accomplish the things I want	○	○	○	○
15. I have friends or family that I can count on for help	○	○	○	○

16. In the past week, approximately how many drinks of alcohol did you have? Drinks

Please answer the following questions only if this is your first time completing this questionnaire.

17. In general, would you say your health is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor
18. Please indicate if you have a serious or chronic medical condition:
    ○ Asthma ○ Diabetes ○ Heart Disease ○ Back Pain or Other Chronic Pain ○ Other Condition
19. In the past 6 months, how many times did you visit a medical doctor? ○ None ○ 1 ○ 2-3 ○ 4-5 ○ 6+
20. In the past month, how many days were you unable to work because of your physical or mental health? *(answer only if employed)* Days
21. In the past month, how many days were you able to work but had to cut back on how much you got done because of your physical or mental health? *(answer only if employed)* Days
22. In the past month have you ever felt you ought to cut down on your drinking or drug use? ○ Yes ○ No
23. In the past month have you ever felt annoyed by people criticizing your drinking or drug use? ○ Yes ○ No
24. In the past month have you felt bad or guilty about your drinking or drug use? ○ Yes ○ No