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

COMPREHENSIVE DIAGNOSTIC ASSESSMENT – YOUTH

ANNUAL UPDATE

(1) IDENTIFYING INFORMATION

Name: ______________________________ DOB: ____________________

Assessor: ______________________________ Date of Assessment: ____________________

Legal Guardian(s)*: ______________________________

*Can the person(s) identified as the legal guardian legally authorize medical treatment for the client? ☐ Yes ☐ No

*If the guardian is someone other than a parent, has proof of guardianship been provided to this agency? ☐ Yes ☐ No

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 Idaho in the past 12 months

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

(2) PRESENTING PROBLEM

Please describe the current episode of the child's problems/illness from the time of the last assessment to the present, including dates and significant events: ______________________________

____

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

____

Client Name:____________________________________

Depression – Since the last assessment has your child had a period of time in which he/she 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 has your child had moods that lasted one week or more in which he/she had so much energy he/she did not sleep for several nights, or felt he/she could accomplish many difficult tasks easily? Was he/she feeling so good that others commented on his/her elevated mood? ☐ Yes, now. ☐ Yes, in the past year, but not now. ☐ No **Chronic Feelings of Unhappiness** – Has your child 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** – Has your child attempted suicide since the last assessment? ☐ Yes, now. ☐ Yes, in the past year, but not now. ☐ No **Self Harm** – Besides attempting suicide, has your child attempted to do physical harm to him/herself in other ways, such as cutting or burning him/herself since the last assessment? ☐ Yes, now. ☐ Yes, in the past year, but not now. ☐ No **Chronic Tension or Anxiety** – Since the last assessment has your child ever had problems with chronic anxiety, tension, nervousness, or constant worrying? Does he or she 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 has your child had anxiety attacks in which he/she felt like they 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 has your child 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 has your child had compulsions to repeat tasks such as checking things, washing hands, counting, or obsessions (ideas that make no sense but keep repeating in his/her mind?) ☐ Yes, now. ☐ Yes, in the past year, but not now. ☐ No **Social Fears or Phobias** – Since the last assessment has your child been fearful in specific social situations, or felt uncomfortable doing things in front of other people? Does he/she 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 has your child had significant phobias such as heights, flying, closed spaces, insects, etc. that interfere with his/her life? ☐ Yes, now. ☐ Yes, in the past year, but not now. ☐ No	**Comments:**

Client Name:___________________________________

	Comments:
Posttraumatic Symptoms – Has your child ever experienced a very traumatic event that has continued to bother him/her 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 was/is your child considered hyperactive and/or inattentive, 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 has your child had hallucinations, heard voices, felt that he/she had special powers or were receiving special messages, felt inappropriately suspicious that people were trying to hurt him/her? ☐ Yes, now. ☐ Yes, in the past year, but not now. ☐ No **Chronic Physical Symptoms –** Since the last assessment has your child had a period of time in which he/she felt physically sick or worried about his/her health when no physical cause could be found? ☐ Yes, now. ☐ Yes, in the past year, but not now. ☐ No **Chronic Pain –** Has your child had problems with chronic pain such as headaches or stomachaches since the last assessment? If so please specify:______________________________________ ☐ Yes, now. ☐ Yes, in the past year, but not now. ☐ No **Sleep Problems –** Since the last assessment has your child 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 has your child 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 has your child 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 has your child 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 –** Has your child had problems with his/her temper since the last assessment? ☐ Yes, now. ☐ Yes, in the past year, but not now. ☐ No **Oppositional Behaviors –** Since the last assessment does your child argue with adults, defy rules, deliberately annoy others, blame others for his/her misbehavior, or act easily annoyed more that his/her peers? ☐ Yes, now. ☐ Yes, in the past year, but not now. ☐ No **Conduct Disorder Problems –** Since the last assessment has your child repetitively exhibited threatening behavior, cruelty to animals, fire-setting, destruction of property, shoplifting, stealing, lying, running away, running away, truancy, gang activity, etc.? ☐ Yes, now. ☐ Yes, in the past year, but not now. ☐ No	

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			

Has your child 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 – Has your child drunk alcohol since the last assessment? ☐ Yes, now ☐ Yes, in the past ☐ No

☐ He/she drinks occasionally: _____ x per month ☐ He/she drinks most days: ______ x per week

☐ I believe he/she has a drinking problem.

Drug Abuse – Has your child 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 – Does your child 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 – Does your child 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 child's general health been since the last assessment? ☐ Good ☐ Fair ☐ Poor

Medical Doctors/Specialists: ________________________________

____

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

What/When: ________________________________

____

Since the last assessment has your child had

any contagious diseases?	☐ No	☐ Yes	What/When: ____________
any disabilities or handicaps?	☐ No	☐ Yes	What/When: ____________
any allergies?	☐ No	☐ Yes	What/When: ____________

Since the last assessment has your child had 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 History – What was the date of your child's last menstrual period? ____________

Since the last assessment has your daughter had any history of:

premenstrual syndrome?	☐ No	☐ Yes	What/When: ____________
amenorrhea (absence of periods)?	☐ No	☐ Yes	What/When: ____________
irregular periods?	☐ No	☐ Yes	What/When: ____________
pregnancy?	☐ No	☐ Yes	What/When: ____________

Current 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 your child self-administer his/her medication? ☐ No ☐ Yes

Med compliance: ☐ Regular/as prescribed ☐ Occasionally misses ☐ Misses regularly ☐ Refuses/forgets to most days

Client Name:_______________

Developmental History – Since the last assessment has your child spent a significant period of time separated from his/her primary caregiver(s) for any reason? ☐ No ☐ Yes – please explain: _______________

____

Since the last assessment have you or your child's pediatrician expressed concerns about your child's development? ☐ No ☐ Yes – please explain: _______________

____

(7) FAMILY HISTORY & FUNCTIONING

Have there been any changes in the family composition since the last assessment (marriages, divorces, new children, moves, deaths, etc)? ☐ No ☐ Yes – Please explain: _______________

____

____

Household members:	Name	Age	Relationship
	___	___	___
	___	___	___
	___	___	___
	___	___	___
	___	___	___
	___	___	___

Siblings not in household:	Name	Age	Relationship
	___	___	___
	___	___	___
	___	___	___
	___	___	___

Have Child Protective Services or Family and Children's Services been involved with the family since the last assessment? ☐ No ☐ Yes – Please explain: _______________

____

Has the child been placed outside of the home since the last assessment? ☐ No ☐ Yes – please explain: _______________

____

____

Has the child been physically or sexually abused, assaulted or molested since the last assessment? ☐ No ☐ Don't know ☐ Yes – please specify when and by whom: _______________

____

____

Please describe the child's relationship with his/her

Father: _______________

Mother: _______________

Siblings: _______________

Stepparent(s): ____

Please describe the type of structure and discipline used in the home since the last assessment: __________________________

____

____

(8) SOCIAL HISTORY & FUNCTIONING

How would you describe your child's friendships? ☐ No friends ☐ Only acquaintances ☐ Acquaintances & Friends

How would you describe your child's behavior when he/she is in social situations? ______________________________________

____

____

Since the last assessment has your child been sexually active or has he/she demonstrated overly sexualized behavior? ☐ No

☐ Yes – please explain: ____

____

____

What leisure/recreational/extracurricular activities is your child involved in? ____

____

(9) VOCATIONAL/EDUCATIONAL HISTORY & FUNCTIONING

Education - School: ___________________________________ Grade Level: _________

Is your child in a specialized classroom setting or receive special education? ☐ No ☐ Yes – please explain: ______________

____

Since the last assessment has your child

had an IEP or 504 plan? ☐ No ☐ Yes – please explain: ____

been tutored? ☐ No ☐ Yes – please explain: ____

been suspended? ☐ No ☐ Yes – please explain: ____

been expelled? ☐ No ☐ Yes – please explain: ____

Have you been contacted by school personnel because of your child's school performance or behavior since the last assessment? ☐ No ☐Yes – please explain: ____

____

What are the average grades your child received since the last assessment? ____

Employment - Has your child been employed since the last assessment? ☐ No ☐ Yes – please describe job(s) and duration of employment: ____

____

Since the last assessment has your child

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 child's current work skills/interests? ____

Client Name:____________________________________

(10) FINANCIAL HISTORY & FUNCTIONING

Please describe 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: _

____

Does the child/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:______________________________

Please explain any financial responsibilities/obligations your child has and how he/she manages these responsibilities: ______

____

____

(11) BASIC LIVING SKILLS HISTORY & FUNCTIONING

Please indicate your child's 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

Does your child require repeated prompting in order to accomplish any of these hygiene tasks? ☐ No ☐ Yes

Is your child able to perform the following basic safety skills?

- Call 911 in an emergency? ☐ Yes ☐ No
- Refrain from playing with matches or other fire hazards? ☐ Yes ☐ No
- Use adequate caution when crossing the street? ☐ Yes ☐ No
- Use adequate caution when engaging with strangers (is she/he aware of stranger danger?) ☐ Yes ☐ No
- Lock doors and use a key? ☐ Yes ☐ No

Please indicate your child's care of his/her personal possessions: ☐ Good care/age appropriate ☐ Careless ☐ Destructive

Will your child be turning 18 soon and/or preparing to live on his/her own? ☐ No ☐ Yes – if "yes", please indicate your child's ability to do the following:

- Prepare meals ☐ Good ☐ Fair ☐ Poor
- Shop for items ☐ Good ☐ Fair ☐ Poor
- Develop regular schedules/routines ☐ Good ☐ Fair ☐ Poor

(12) HOUSING HISTORY & FUNCTIONING

Does the current housing situation meet the child's needs in the following areas?

- Health and safety? ☐ Yes ☐ No – please explain: ____
- Access to services? ☐ Yes ☐ No – please explain: ____

Client Name:___________________________________

Is there any history of homelessness since the last assessment? ☐ No ☐ Yes – please explain: ______________________

____

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

(13) COMMUNITY/LEGAL HISTORY & FUNCTIONING

Since the last assessment has the child 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: ____

Juvenile detention ☐ No ☐ Yes, please explain: ____

Does your child have transportation to and from school, appointments, etc? ☐ Yes ☐ No – please explain: ____________

____

Does your child have a

Social Security card? ☐ Yes ☐ No Driver's license? ☐ Yes ☐ No

Client Name:____________________________________

(15) 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: ________________________________

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

(16) 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 - Youth**

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

Child's Last Name ______ , First Name ______ Child's Date of Birth: (mm/dd/yy) __ / __ / __

Subscriber ID ______ Authorization # ______

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

Clinician ID/Tax ID 1346368198 Clinician Phone ___ ___ - ____ State __ *MRef* ○

Visit #: ○ 1 or 2 ○ 3 to 5 ○ Other

Relationship to child: ○ Mother ○ Father ○ Stepparent ○ Other Relative ○ Child/Self ○ Other

For questions 1-21, please think about your experience in the past week.

Fill in the circle that best describes your child:	*Never*	*Sometimes*	*Often*
1. Destroyed property	○	○	○
2. Was unhappy or sad	○	○	○
3. Behavior caused school problems	○	○	○
4. Had temper outbursts	○	○	○
5. Worrying prevented him/her from doing things	○	○	○
6. Felt worthless or inferior	○	○	○
7. Had trouble sleeping	○	○	○
8. Changed moods quickly	○	○	○
9. Used alcohol	○	○	○
10. Was restless, trouble staying seated	○	○	○
11. Engaged in repetitious behavior	○	○	○
12. Used drugs	○	○	○
13. Worried about most everything	○	○	○
14. Needed constant attention	○	○	○

How much have your child's problems caused:	*Not at All*	*A Little*	*Somewhat*	*A Lot*
15. Interruption of personal time?	○	○	○	○
16. Disruption of family routines?	○	○	○	○
17. Any family member to suffer mental or physical problems?	○	○	○	○
18. Less attention paid to any family member?	○	○	○	○
19. Disruption or upset of relationships within the family?	○	○	○	○
20. Disruption or upset of your family's social activities?	○	○	○	○

21. How many days in the past week was your child's usual routine interrupted by their problems? ☐ Days

Answer the following only if this is your first time completing this questionnaire for this child.

22. In general, would you say your child's health is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor
23. In the past 6 months, how many times did your child visit a medical doctor? ○ None ○ 1 ○ 2-3 ○ 4-5 ○ 6+
24. In past month, how many days were you unable to work because of your child's problems? *(answer only if employed)* ☐☐ Days
25. 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 child's problems? *(answer only if employed)* ☐☐ Days

59243