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

COMPREHENSIVE DIAGNOSTIC ASSESSMENT – ADULT

PLEASE COMPLETE ALL AREAS OF THIS FORM PRIOR TO APPOINTMENT

(1) IDENTIFYING INFORMATION

Name: _____ DOB: _____

Assessor: _____ Date of Assessment: _____

☐ 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 state the principal reason you are requesting a consultation or treatment: _____

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

Please list recent stressful life events: _____

Client Name:_____

FOR CLINICIAN USE ONLY – Specific Questions Regarding Psychiatric Problems	For Clinician Use Only:
Depression – 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. ☐ No **High Periods or Mania –** 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. ☐ 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. ☐ No **Suicide Attempts –** Have you ever attempted suicide? ☐ 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? ☐ Yes, now. ☐ Yes, in the past. ☐ No **Chronic Tension or Anxiety –** Have you ever 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. ☐ No **Panic Attacks –** 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. ☐ No **Panic Associated Fears –** 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. ☐ No **Obsessive/Compulsive Symptoms –** 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. ☐ No **Social Fears or Phobias –** 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. ☐ No **Phobias –** Have you had significant phobias such as heights, flying, closed spaces, insects, etc. that interfere with your life? ☐ Yes, now. ☐ Yes, in the past. ☐ No	

Client Name:_____

FOR CLINICIAN USE ONLY – Specific Questions Regarding Psychiatric Problems	For Clinician Use Only:
Posttraumatic Symptoms – Have you ever experienced a very traumatic event that has continued to bother you or cause emotional problems later in life, such as nightmares or flashbacks of the event? ☐ Yes, now. ☐ Yes, in the past. ☐ No **Hyperactivity/Inattention –** Were you 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. ☐ No **Psychotic Symptoms –** Have you ever 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. ☐ No **Chronic Physical Symptoms –** 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. ☐ No **Chronic Pain –** Have you had problems with chronic pain such as headaches or stomachaches? If so please specify:_____ ☐ Yes, now. ☐ Yes, in the past. ☐ No **Sleep Problems –** Have you experienced sleep problems such as insomnia, oversleeping, frequent nightmares or sleepwalking? ☐ Yes, now. ☐ Yes, in the past. ☐ No **Anorexia –** Have you ever been anorexic or purposely lost weight to obtain a weight below normal? ☐ Yes, now. ☐ Yes, in the past. ☐ No **Binge Eating or Bulimia –** Have you had eating binges associated with inducing vomiting, using laxatives, or exercising to extreme? ☐ Yes, now. ☐ Yes, in the past. ☐ No **Compulsive Behaviors –** Have you had problems with compulsive behaviors such as gambling, spending, work, sex, pornography, or other problematic compulsions? ☐ Yes, now. ☐ Yes, in the past. ☐ No **Temper/Anger Problems –** Have you had problems with your temper? ☐ Yes, now. ☐ Yes, in the past. ☐ No **Dissociative Symptoms –** 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. ☐ 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			

Have you been admitted to a residential treatment program or psychiatric hospital? ☐ No ☐ Yes – please complete:

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

(4) SUBSTANCE USE/ABUSE

Alcohol Use/Abuse – Do you drink alcohol? ☐ 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 ever abused "street" or prescription drugs? ☐ Yes, now ☐ Yes, in the past ☐ No

If yes, what drug(s) and what ages with each drug? _____

_____

Smoking/Vaping/Other – Do you smoke, use other tobacco products, or vape? ☐ Yes, now ☐ Yes, in the past ☐ No

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

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

Clinician Comments:

Client Name:_____

(5) FAMILY PSYCHIATRIC HISTORY

Please include psychiatric problems in your biological relatives. Consider problems such as depression, bipolar disorder, anxiety disorders (OCD, panic disorder, PTSD), schizophrenia, ADHD, alcohol or drug abuse, anger or criminal problems, suicides, etc.

Relative	Yes	No	?	Type(s) of Problem(s)
Mother				
Mother's Relatives				
Father				
Father's Relatives				
Siblings				
Children				

(6) MEDICAL HISTORY & FUNCTIONING

How is your general health? ☐ Good ☐ Fair ☐ Poor

Medical Doctors/Specialists: _____

_____

History of significant illness or medical treatment in the family: _____

_____

Health Conditions - Check any health conditions that apply:

☐ Thyroid problem	☐ High blood pressure	☐ Headaches
☐ Heart problem	☐ Sleep problems	☐ High cholesterol
☐ Asthma	☐ Trouble eating	☐ Other: _____
☐ Stomach problems	☐ Seizures	☐ Other: _____

Do you have

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

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

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

Client Name:_____

Have you 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 and Reproductive History – Number of pregnancies:_____ Number of live births:_____

Do you have any history of:

premenstrual syndrome? ☐ No ☐ Yes What/When: _____

amenorrhea (absence of periods)? ☐ No ☐ Yes What/When: _____

irregular periods? ☐ 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

Have you been treated in the past with psychiatric medication? ☐ No ☐ Yes – please complete:

Antidepressants		Mood Stabilizers	Tranquilizers	Sleeping Aids	Stimulants	Others
Prozac	Serzone	Lithium	Xanax	Ambien	Ritalin	Rispedal
Zoloft	Wellbutrin	Depakote	Klonopin	Sonata	Dexedrine	Zyprexa
Paxil	Amitriptyline	Tegretol	Ativan	Trazodone	Adderall	Seroquel
Luvox	Nortriptyline	Lamictal	Valium		Clonidine	Haldol
Celexa	Desipramine	Neurontin	Buspar		Concerta	Prolixin
Effexor	Anafranil				Provigil	Thorazine
Remeron					Vyvanse	Trilafon
					Strattera	Antabuse
						Naltrexone

Clinician Comments:

Client Name:_____

(7) FAMILY HISTORY & FUNCTIONING

Current Status – Please indicate your current relationship status:

☐ Single ☐ Married ☐ Re-Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Living Together

Please indicate your sexual orientation: ☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Transgendered

Marital History:	Age	Year	Duration	# Children	Comments
1st Marriage:					
2nd Marriage:					
3rd Marriage:					
4th Marriage:					

Please check all that apply to your current marriage:

☐ 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

Please explain your family's cultural and/or spiritual background: _____

_____

What resources and supports do you and/or your family have? _____

_____

What are your strengths in the family setting? _____

_____

Clinician Comments:

Client Name:_____

Family of Origin - Place of birth: _____ Ages of parents when you were born:_____

Parents at the time of birth were: ☐ Married ☐ Separated ☐ Unmarried

Where did you live while you were growing up? Did the family move frequently?_____

_____

Father: ☐ Living ☐ Deceased, year: _____ Education:_____ Occupation:_____

Mother: ☐ Living ☐ Deceased, year: _____ Education:_____ Occupation:_____

Did your parents divorce? If so, when?_____Remarriages? _____

Were you adopted? ☐ No ☐ Yes – Age at time of adoption: _____ Circumstances:_____

FAMILY HISTORY

Please describe your relationship with your father: _____

Please describe your relationship with your mother: _____

Siblings: _____ Full Sisters _____ Full Brothers _____ ½ Sisters _____ ½ Brothers

_____ Step Sisters _____ Step Brothers _____ Deceased, age(s) at death: _____

Were you ever physically or sexually abused, assaulted or molested? ☐ No ☐ Don't know ☐ Yes – please specify when and by whom: _____

_____

_____

Please explain your family's cultural and/or spiritual background: _____

_____

Clinician Comments:

(8) SOCIAL HISTORY & FUNCTIONING

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

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

_____

Have you experienced any difficulties related to age, gender, sexual orientation, culture, race, or religion? ☐ No ☐ Yes – please explain: _____

What leisure/recreational activities are you involved in? _____

_____

What are your talents and social strengths? _____

Clinician Comments:

Client Name:_____

(9) VOCATIONAL/EDUCATIONAL HISTORY & FUNCTIONING

Education – Highest degree of education: ☐ Grade School ☐ GED ☐ High School ☐ Degree ☐ Advanced Degree

Partner's highest degree of education: ☐ Grade School ☐ GED ☐ High School ☐ Degree ☐ Advanced Degree

Vocational Training: _____

Please describe how you did in grade school:

academically: _____

behaviorally: _____

socially: _____

Please describe how you did in secondary school:

academically: _____

behaviorally: _____

socially: _____

Were you in a specialized classroom setting or did you receive special education? ☐ No ☐ Yes – please explain: _____

_____

Do you have any educational goals at this time? _____

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? _____

_____

Work History:

Job	Length of time	Reason for leaving

Have you ever

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 employment goals? _____

Military Service - ☐ No ☐ Yes – Specify: _____

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

Were you Honorably Discharged? ☐ Yes ☐ No – please explain: _____

Clinician comments:

Client Name:_____

(10) FINANCIAL HISTORY & FUNCTIONING

Please describe your/the family's 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:_____

Do you have a history of financial problems? ☐ No ☐ Yes – please explain: _____

_____

Clinician comments:

(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

Are you receiving personal care services, Meals on wheels, or any other basic living skill providers? ☐ No ☐ Yes –

Specify: _____

Clinician comments:

Client Name:_____

(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: _____

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

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

Clinician comments:

(13) COMMUNITY/LEGAL HISTORY & FUNCTIONING

Do you have any current or past 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

Clinician comments:

(14) SIGNATURES

Name of Person completing this form: _____ Relationship to Client: _____

Signature: _____ Date: _____

Client Name:_____

THIS SECTION IS FOR CLINICIAN USE ONLY. PLEASE DO NOT COMPLETE THIS SECTION.

(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: _____

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

(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

Wellness Assessment

What is the purpose of the Wellness Assessment?
The Wellness Assessment is a set of questions to help your Care Advocate at your insurance company understand how you are doing in treatment. It helps the Care Advocate in working with your therapist so that you receive the services you need. The direction of your therapy is the result of the treatment decisions that you make together with your therapist.

How long will it take me to complete the Wellness Assessment?
Completing the form only takes a few moments of your time. Discuss with your therapist anything on the Wellness Assessment that you find important.

Are my answers confidential?
Yes. Your responses on the Wellness Assessment are considered Protected Health Information and are kept confidential. Your insurance company follows the guidelines of the national Health Insurance Portability and Accountability Act (HIPAA) as set by the United States Department of Health and Human Services.

Will my responses affect my benefits?
No. Your answers on this Wellness Assessment will not affect your insurance coverage or eligibility.

Will all the Wellness Assessments I complete be done at my therapist's office?
No. About four months after the date you start treatment, you will receive a Wellness Assessment in the mail directly from your insurance company. A business reply envelope will be included. Simply complete the Wellness Assessment and return it in the envelope provided.

Visit www.liveandworkwell.com. It contains useful information on a variety of topics to help you take charge of your health and well-being.

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 Name | Date of Birth

Subscriber ID | Authorization #

Clinician Name | Today's Date (mm/dd/yy)

Clinician ID/Tax ID: 800104889 | Clinician Phone: (208) 522-0140 | State: ID | *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

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* ☐☐ 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