

**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: \_\_\_\_\_

\_\_\_\_\_  
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Please list recent stressful life events: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FOR CLINICIAN USE ONLY – Specific Questions Regarding Psychiatric Problems	For Clinician Use Only:
<p><b>Depression</b> – 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?  <input type="checkbox"/> Yes, now.    <input type="checkbox"/> Yes, in the past.    <input type="checkbox"/> No</p> <p><b>High Periods or Mania</b> – 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?  <input type="checkbox"/> Yes, now.    <input type="checkbox"/> Yes, in the past.    <input type="checkbox"/> No</p> <p><b>Chronic Feelings of Unhappiness</b> – Have you felt mildly unhappy or unable to enjoy life for many years, for no apparent reason?  <input type="checkbox"/> Yes, now.    <input type="checkbox"/> Yes, in the past.    <input type="checkbox"/> No</p> <p><b>Suicide Attempts</b> – Have you ever attempted suicide?  <input type="checkbox"/> Yes, now.    <input type="checkbox"/> Yes, in the past.    <input type="checkbox"/> No</p> <p><b>Self Harm</b> – Besides attempting suicide, have you attempted to do physical harm to yourself in other ways, such as cutting or burning yourself?  <input type="checkbox"/> Yes, now.    <input type="checkbox"/> Yes, in the past.    <input type="checkbox"/> No</p> <p><b>Chronic Tension or Anxiety</b> – Have you ever had problems with chronic anxiety, tension, nervousness, or constant worrying? Do you worry about minor concerns? (Not connected to anxiety attacks)  <input type="checkbox"/> Yes, now.    <input type="checkbox"/> Yes, in the past.    <input type="checkbox"/> No</p> <p><b>Panic Attacks</b> – 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?  <input type="checkbox"/> Yes, now.    <input type="checkbox"/> Yes, in the past.    <input type="checkbox"/> No</p> <p><b>Panic Associated Fears</b> – 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?  <input type="checkbox"/> Yes, now.    <input type="checkbox"/> Yes, in the past.    <input type="checkbox"/> No</p> <p><b>Obsessive/Compulsive Symptoms</b> – 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?)  <input type="checkbox"/> Yes, now.    <input type="checkbox"/> Yes, in the past.    <input type="checkbox"/> No</p> <p><b>Social Fears or Phobias</b> – 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?  <input type="checkbox"/> Yes, now.    <input type="checkbox"/> Yes, in the past.    <input type="checkbox"/> No</p> <p><b>Phobias</b> – Have you had significant phobias such as heights, flying, closed spaces, insects, etc. that interfere with your life?  <input type="checkbox"/> Yes, now.    <input type="checkbox"/> Yes, in the past.    <input type="checkbox"/> No</p>	

FOR CLINICIAN USE ONLY – Specific Questions Regarding Psychiatric Problems	For Clinician Use Only:
<p><b>Posttraumatic Symptoms</b> – 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?  <input type="checkbox"/> Yes, now.    <input type="checkbox"/> Yes, in the past.    <input type="checkbox"/> No</p> <p><b>Hyperactivity/Inattention</b> – Were you considered hyperactive and/or inattentive, or have you been treated with Ritalin or another stimulant, or been diagnosed with ADHD?  <input type="checkbox"/> Yes, now.    <input type="checkbox"/> Yes, in the past.    <input type="checkbox"/> No</p> <p><b>Psychotic Symptoms</b> – 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?  <input type="checkbox"/> Yes, now.    <input type="checkbox"/> Yes, in the past.    <input type="checkbox"/> No</p> <p><b>Chronic Physical Symptoms</b> – 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?  <input type="checkbox"/> Yes, now.    <input type="checkbox"/> Yes, in the past.    <input type="checkbox"/> No</p> <p><b>Chronic Pain</b> – Have you had problems with chronic pain such as headaches or stomachaches?                      If so please specify: _____  <input type="checkbox"/> Yes, now.    <input type="checkbox"/> Yes, in the past.    <input type="checkbox"/> No</p> <p><b>Sleep Problems</b> – Have you experienced sleep problems such as insomnia, oversleeping, frequent nightmares or sleepwalking?  <input type="checkbox"/> Yes, now.    <input type="checkbox"/> Yes, in the past.    <input type="checkbox"/> No</p> <p><b>Anorexia</b> – Have you ever been anorexic or purposely lost weight to obtain a weight below normal?  <input type="checkbox"/> Yes, now.    <input type="checkbox"/> Yes, in the past.    <input type="checkbox"/> No</p> <p><b>Binge Eating or Bulimia</b> – Have you had eating binges associated with inducing vomiting, using laxatives, or exercising to extreme?  <input type="checkbox"/> Yes, now.    <input type="checkbox"/> Yes, in the past.    <input type="checkbox"/> No</p> <p><b>Compulsive Behaviors</b> – Have you had problems with compulsive behaviors such as gambling, spending, work, sex, pornography, or other problematic compulsions?  <input type="checkbox"/> Yes, now.    <input type="checkbox"/> Yes, in the past.    <input type="checkbox"/> No</p> <p><b>Temper/Anger Problems</b> – Have you had problems with your temper?  <input type="checkbox"/> Yes, now.    <input type="checkbox"/> Yes, in the past.    <input type="checkbox"/> No</p> <p><b>Dissociative Symptoms</b> – 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?  <input type="checkbox"/> Yes, now.    <input type="checkbox"/> Yes, in the past.    <input type="checkbox"/> No</p>	

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:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Thyroid problem  | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Headaches        |
| <input type="checkbox"/> Heart problem    | <input type="checkbox"/> Sleep problems      | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Trouble eating      | <input type="checkbox"/> Other: _____     |
| <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Seizures            | <input type="checkbox"/> Other: _____     |

Do you have

- |                                |  |                  |
|--------------------------------|--|------------------|
| any contagious diseases?       | <input type="checkbox"/> No <input type="checkbox"/> Yes | What/When: _____ |
| any disabilities or handicaps? | <input type="checkbox"/> No <input type="checkbox"/> Yes | What/When: _____ |
| any allergies?                 | <input type="checkbox"/> No <input type="checkbox"/> 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:

<u>Antidepressants</u>		<u>Mood Stabilizers</u>	<u>Tranquilizers</u>	<u>Sleeping Aids</u>	<u>Stimulants</u>	<u>Others</u>
Prozac	Serzone	Lithium	Xanax	Ambien	Ritalin	Risperdal
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
1 <sup>st</sup> Marriage:	_____	_____	_____	_____	_____
2 <sup>nd</sup> Marriage:	_____	_____	_____	_____	_____
3 <sup>rd</sup> Marriage:	_____	_____	_____	_____	_____
4 <sup>th</sup> 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:**

**(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: \_\_\_\_\_

**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