Client: _____ Chart #/Member ID: _____

ADULT DIAGNOSTIC ASSESSMENT

Today's date _____ Sources of Information _____

PRESENTING COMPLAINT SECTION

Reason for referral/or treatment _____
Description of presenting problem(s) _____

Briefly describe how the problem(s) noted above cause difficulty for you or your child (work, school, church, relatives) _____

SOCIAL HISTORY SECTION

Born/Raised _____ Religion _____
Siblings # of brothers _____ # of sisters _____
Education History _____
History of truancy/suspension/school expulsion/special education _____
Marriage/Relationships _____
Children _____
Current Living Situation _____
Work History _____
Legal Problems/Current P.O. _____
Financial Stresses _____
Military History/Type of Discharge _____
Support/Social Network _____
Hobbies/Interests _____
Significant Life Events _____
Other _____

Client: _____ Chart #/Member ID: _____

LIFE STRESSORS/PRIORITIES SECTION

In the past 12 months . . .

Primary Stressors _____

Highest priorities in life at this time are _____

MEDICAL HISTORY SECTION

Describe current health concerns/changes_____

_____

Allergies? __No __Yes (specify) _____

_____

Known infections disease(s)? __No __Yes (specify) _____

_____

Current psychiatric medications (include purpose/compliance)_____

_____

Past psychiatric medications (include purpose/compliance) _____

_____

Current non-psychiatric medication _____

_____

Are there known allergies to medications or other substances? __No __Yes If Yes, please document: _____

_____

_____

Does family history include significant physical problems? __No __Yes (specify) _____

_____

_____

Family History of Mental Health/Psychiatric Problems _____

_____

_____

Family History of Substance Abuse _____

_____

_____

FINANCIAL RESOURCES SECTION

Client is able to support self without assistance __No __Yes If no _____

Client currently receives assistance __No __Yes (describe) _____

Client requires referral for financial aid __No __Yes

Client requires referral for credit counseling __No __Yes

Current problem has affected financial situation __No __Yes (how) _____

_____

_____

Client: _____ Chart #/Member ID: _____

PSYCHOTIC DISORDERS SECTION

Psychosis Symptoms (2 or more during 1 month period)

Hallucinations ☐ Not present ☐ Auditory ☐ Visual ☐ Tactile ☐ Olfactory ☐ Gustatory

Delusions ☐ Not present

If present, type of delusion ☐ Special Powers/Grandiose ☐ Persecution ☐ Somatic ☐ Erotomatic
Describe the delusion _____

_____

Disorganized speech (e.g. incoherent or frequent derailment) ☐ Not present ☐ Present

Grossly disorganized behavior or catatonic behavior ☐ Not present ☐ Present

MOOD DISORDERS SECTION

Major Depressive Disorder Symptoms ☐ Not present ☐ Present

☐ Depressed Mood **or** ☐ Diminished interest/pleasure (nearly every day for at least 2 weeks)

And 4 or more of the following nearly everyday:

☐ Decreased/increase appetite ☐ Diminished concentrating or ability to make decisions

☐ Insomnia/hypersomnia ☐ Recurrent thought of death

☐ Psychomotor agitation or retardation ☐ Feelings of worthlessness or excessive/inappropriate guilt

☐ Fatigue or loss of energy

☐ Difficulty Making Decisions

Mania Symptoms ☐ Not present ☐ Present

☐ Distinct period (lasting at least 1 week) of elevated, expansive or irritable mood, **and**
3 or more of the following/4 or more if mood is only irritable:

☐ Inflated self-esteem or grandiosity ☐ Decreased need for sleep ☐ Increase in goal directed activity

☐ More talkative or pressured speech ☐ Flight of ideas or racing thoughts

☐ Excessive involvement in pleasurable activities with high potential for painful consequences

Rapid-cycling ☐ Not present ☐ Present (4 or more mood disturbances in past 12 months that meet criteria for major depressive, manic, mixed or hypomania episode).

Client: _____ Chart #/Member ID: _____

ANXIETY DISORDERS SECTION

Trauma History

☐ Individual reports no trauma experiences

Trauma Categories	* Type I	** Type II	*** Victim Status (**P/S/T**)
☐ Child/adolescent sexual abuse	☐	☐	____
☐ Child/adolescent physical abuse	☐	☐	____
☐ Child/adolescent emotional abuse	☐	☐	____
☐ Criminal/physical violence	☐	☐	____
☐ Sexual/physical assault	☐	☐	____
☐ Armed robbery	☐	☐	____
☐ War/combat	☐	☐	____
☐ Traffic accidents	☐	☐	____
☐ First Responder	☐	☐	____
☐ Work related	☐	☐	____
☐ Natural disaster	☐	☐	____
☐ Other	☐	☐	____

Describe trauma event(s) _____

_____

_____

_____

_____

* Type I: single event, acute life threat, unexpected
** Type II: repeated, prolonged, unpredictable course
*** Victim Status: **P**rimary: direct experience with the trauma event
Secondary: witnesses and helpers of trauma event
Tertiary: indirectly affected by the trauma event

Client: _____ Chart #/Member ID: _____

POST TRAUMATIC STRESS

Post Traumatic Stress Disorder Symptoms ☐ Not present ☐ Present

☐ Fear ☐ Helplessness ☐ Horror

☐ Re-experiencing (1 or more)
distressing recollections, distressing dreams, flashbacks,
psychological or physiological distress to stimuli, **and**

☐ Avoidance (3 or more)
efforts to avoid thoughts, feelings, conversations, activities,
places or people associated with the trauma, inability to recall the trauma,
restricted emotions, diminished interest in activities,
sense of a foreshortened future, feeling estranged from others, **and**

☐ Arousal (2 or more)
Difficulty falling/staying asleep, irritability or outbursts of anger,
Difficulty concentrating, exaggerated startle response, hypervigilance

Panic Disorder Symptoms (4 or more with abrupt onset peaking in about 10 minutes) ☐ Not present ☐ Present

☐ Shortness of Breath ☐ Dizziness/Faintness ☐ Palpitations/Chest Pain ☐ Trembling

☐ Sweating ☐ Choking ☐ Nausea/Abdominal Distress ☐ Numbness/Tingling

☐ Hot/Cold Flashes ☐ Depersonalization ☐ Fear of Dying ☐ Fear of Going Crazy/Out of Control

Describe symptom onset/duration/intensity/frequency_____

_____

_____

Agoraphobia Symptoms ☐ Not present ☐ Present (Fear of Being in Places/Situations/Unable to Escape)

Generalized Anxiety Disorder Symptoms ☐ Not present ☐ Present

☐ Excessive anxiety and worry (apprehensive expectation) pervasive for at least 6 months, **and**

☐ Has difficulty controlling the worry, **and**

The anxiety and worry are associated with (at least 3 pervasively for at least 6 months) the following symptoms:

☐ Restlessness/feeling keyed up ☐ Being easily fatigued ☐ Irritability

☐ Muscle tension ☐ Sleep disturbance ☐ Difficulty concentrating/mind going blank

Describe onset/duration/intensity/frequency_____

_____

_____

_____

_____

Client: _____ Chart #/Member ID: _____

OBSESSIVE COMPULSIVE DISORDERS

Obsessive Compulsive Disorder Symptoms ☐ Not Present ☐ Present

Obsessions
- ☐ Recurrent and persistent thoughts, impulses, or images, **and**
- ☐ Thoughts, impulses, or images which are more than excessive worries about real-life problems, **and**
- ☐ Recognition that the thoughts, impulses, or images are a product of their own mind, **and**
- ☐ Attempts to ignore or suppress thoughts, impulses or images or to neutralize them with some other thought or action, **or**

Compulsions
- ☐ Repetitive behaviors (e.g. hand washing, ordering, checking) or mental acts (counting, praying, repeating words/numbers) compelled to perform in response to an obsession or according to rigidly held rules, **and**
- ☐ The behaviors or mental acts are intended to prevent or reduce distress or preventing some dreaded event or situation

Describe symptom onset/duration/intensity/frequency_____

_____

_____

_____

_____

_____

Other symptoms or features for disorders not previously noted _____

_____

_____

_____

_____

SUBSTANCE ABUSE HISTORY SECTION

Past Alcohol/Drug Use (> 12 months)

Check the following substances(s) of past use	Amount of use	Frequency of use	Time period of your use
__ Alcohol			
__ Marijuana			
__ Cocaine/Crack/Meth.			
__ Inhalants			
__ Stimulants			
__ Hallucinogens			
__ Heroin/Opiates			
__ Prescription Drugs (specify)			
__ Other (specify)			

Client: _____ Chart #/Member ID: _____

DRUG USE QUESTIONNAIRE (DAST-10)

These questions refer to the past 12 months only.
(cannabis, inhalants, meth., hallucinogens, narcotics, tranquilizers)

	YES	NO
1. Have you used drugs other than those required for medical reasons? If yes, specify drug(s) _____ _____		
2. Do you abuse more than one drug at a time?		
3. Are you unable to stop using drugs when you want to?		
4. Have you had "blackouts" or "flashbacks" as a result of drug use?		
5. Do you ever feel bad or guilty about your drug use?		
6. Does your spouse (or parent) ever complain about your involvement with drugs?		
7. Have you neglected your family because of your drug use?		
8. Have you engaged in illegal activities in order to obtain drugs?		
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?		
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?		
Dast Score		

Client: _____ Chart #/Member ID: _____

CURRENT ALCOHOL/DRUG USE (past 12 months)

SHORT ALCOHOL SCREENING TEST

These questions refer to the past 12 months only.	**YES**	**NO**
1. Do you feel that you are a normal drinker? (by normal we mean do you drink less or as much as most other people)		
2. Does your wife, husband, a parent, or other near relative ever worry or complain about your drinking?		
3. Do you ever feel guilty about your drinking?		
4. Do friends or relatives think you are a normal drinker?		
5. Are you able to stop drinking when you want to?		
6. Have you ever attended a meeting of Alcoholics Anonymous (AA)?		
7. Has your drinking ever created problems between you and your wife, husband, a parent, or other near relative?		
8. Have you ever gotten into trouble at work because of your drinking?		
9. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?		
10. Have you ever gone to anyone for help about your drinking?		
11. Have you ever been in a hospital because of your drinking?		
12. Have you ever been arrested for drunken driving, driving while intoxicated, or driving under the influence of alcoholic beverage?		
13. Have you ever been arrested, even for a few hours, because of other drunken behaviors?		
SMAST Score		

Client: _____ Chart #/Member ID: _____

RISK ASSESSMENT SECTION

Homicidal Ideation ☐ Not present ☐ Present ☐ Thought ☐ Plan
Target of homicidal thinking _____

****Suicidal Ideation*** ☐ Not present ☐ Present ☐ Thought ☐ Plan
Details _____

Self-Injurious Behavior (SIB) ☐ Not present ☐ Present
Onset/form of SIB _____

Coping Potential Estimate ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Explain (i.e. impulsive, substance use) _____

**Clinicians may elect to use the FBTA Suicide Risk Assessment instrument for further clinical guidance with the client*

TREATMENT HISTORY SECTION

Substance Abuse Treatment History

	No	Yes	Dates	Provider/Treatment Response
Drug/Alcohol treatment				
Involvement with self-help groups				

Behavioral Health Treatment History

	No	Yes	Dates	Provider/Treatment Response
Counseling/Psychiatric treatment				
Hospitalizations				

Client: _____ Chart #/Member ID: _____

GENOGRAM SECTION (optional)

Client: _____ Chart #/Member ID: _____

MENTAL STATUS EXAM SECTION

APPEARANCE	**n/a - ok**	**slight**	**mod**	**severe**
Unkempt, disheveled	O	O	O	O
Clothing: dirty, atypical	O	O	O	O
Odd phys. characteristics	O	O	O	O
Body odor	O	O	O	O
Appears unhealthy	O	O	O	O
POSTURE				
Slumped	O	O	O	O
Rigid, tense	O	O	O	O
BODY MOVEMENTS				
Accelerated, quick	O	O	O	O
Decreased, slowed	O	O	O	O
Restlessness, fidgety	O	O	O	O
Atypical, unusual	O	O	O	O
SPEECH				
Rapid	O	O	O	O
Slow	O	O	O	O
Loud	O	O	O	O
Soft	O	O	O	O
Mute	O	O	O	O
Atypical (e.g. slurring)	O	O	O	O
ATTITUDE/BEHAVIOR				
Domineering, controlling	O	O	O	O
Submissive, dependent	O	O	O	O
Hostile, challenging	O	O	O	O
Guarded, suspicious	O	O	O	O
Uncooperative	O	O	O	O
Negative	O	O	O	O
Overly dramatic	O	O	O	O
Childlike	O	O	O	O

ORIENTATION __Time __Place
__ Person __ Situation

LEVEL OF INSIGHT
__Complete denial __Slight awareness
__Blames others ___Blames self
__Intellectual insight, but few changes likely
___Emotional insight, understanding, change can occur

AFFECT	**n/a – ok**	**slight**	**mod**	**severe**
Inappropriate to thought	O	O	O	O
Increased lability	O	O	O	O
Blunted, dull, flat	O	O	O	O
Euphoria, elation	O	O	O	O
Anger, hostility	O	O	O	O
Depression, sadness	O	O	O	O
Anxious	O	O	O	O
Irritable	O	O	O	O
PERCEPTION				
Illusions	O	O	O	O
Auditory hallucinations	O	O	O	O
Visual hallucinations	O	O	O	O
Tactile hallucinations	O	O	O	O
COGNITIVE				
Alertness	O	O	O	O
Attn span, distractibility	O	O	O	O
Short-term memory	O	O	O	O
Long-term memory	O	O	O	O
JUDGEMENT				
Decision making	O	O	O	O
Impulsivity	O	O	O	O
THOUGHT CONTENT/FORM				
Obsessions/compulsions	O	O	O	O
Phobic	O	O	O	O
Depersonalization	O	O	O	O
Suicidal ideation	O	O	O	O
Homicidal ideation	O	O	O	O
Delusions	O	O	O	O
Incoherent	O	O	O	O
Blocking	O	O	O	O
Tangential	O	O	O	O
Circumstantial	O	O	O	O
Poverty of thought	O	O	O	O

Client: _____ Chart #/Member ID: _____

DIAGNOSIS SECTION

_____

_____

_____

_____

_____

_____

☐ Problems with primary support group

☐ Economic problems ☐ Health related problems

☐ Housing problems ☐ Problems related to legal/criminal system

☐ Occupational problems ☐ Problems related to social environment/school

☐ Other psychosocial and environmental problems _____

_____

CLINICIAN'S ASSESSMENT AND RECOMMENDATIONS SECTION

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Clinician Name (Print) Clinician Signature Date