Temanos Counseling Center · Ginna Maus, LCSW
Adult Comprehensive Assessment

Client Name: **Date:** **Time:**

Clinician: **CPT Code:**_________ **# Units** _____

IDENTIFYING INFORMATION:

PRESENTING PROBLEM: *referred by – description of symptoms, behavior, feelings, thoughts, sleep, appetite*

A. Reason for seeking services at this time? *(current condition, see attached symptom checklist)*

B. History of present illness?

C. What changes have you tried to make? What was the outcome?

D. What are your goals for therapy?

- What changes would you like to see in yourself?
- What changes would you like to see in your family?

MENTAL STATUS EXAM:

Grooming *Normal ( ) Disheveled ( ) Unusual ( )*
Hygiene *Normal ( ) Body Odor ( ) Bad Breath ( )*
Interpersonal: *Cooperative ( ) Oppositional ( ) Resistant ( ) Defensive ( ) Other ( )*
Speech: *Normal ( ) Pressured ( ) Dysarthric ( ) Slow ( ) Apraxic ( )*
Mood: *Normal ( ) Irritable ( ) Euphoric ( ) Anxious ( ) Elevated ( ) Depressed ( ) Angry ( )*
Affect: *Broad ( ) Restricted ( ) Labile ( ) Flat ( ) Blunted ( ) Inappropriate ( )*
Motor Activity: *Relaxed ( ) Restless ( ) Pacing ( ) Sedate ( )* Mannerisms ( ) *Other ( )*
Estimated IQ: *Above Average ( ) Average ( ) Below Average ( )*
Attention: *Normal ( ) Distractible ( ) Hypervigilant ( )*
Concentration: *Normal ( ) Brief ( ) Insight ( ) Good ( ) Fair ( ) Poor ( )*
Recent Memory *Normal ( ) Abnormal ( )*
Remote Memory *Normal ( ) Abnormal ( )*
Judgment *Good ( ) Fair ( ) Poor ( )*
Hallucination *None ( ) Auditory ( ) Visual ( ) Olfactory ( ) Gustatory ( )*
Thought Process *Normal ( ) Blocking ( ) Loose Associations ( ) Confabulation ( ) Suicidal Ideation ( ) Homicidal Ideation ( ) Delusions ( ) Depersonalization ( ) Grandiosity ( ) Flight of Ideas ( ) Ideas of Reference ( ) Other* ________________________________

Client Name: **Date:**

CLIENT HISTORY:

A. Birth and Developmental history – *milestones, childhood experiences*

B. Past Psychiatric History:

C. Medical History:

D. Current Medications:

CURRENT SOCIAL INFORMATION:

1. Describe the present living arrangements (include with whom you are living with, and a brief description of these relationships):

2. How long have you been married/dating/living together? Describe this relationship (include occupation and age of significant other):

3. How many children do you have? (name, sex, age)

4. Are there any significant problems with any of these children? (describe)

5. Give details of previous relationships/marriages:

6. Any history of abuse (emotional, physical, sexual) in current or previous relationships:

FAMILY HISTORY

1. Describe your childhood and adolescence (include home atmosphere, relationship with parents, siblings):

2. Any history of significant life events such as death, abuse (physical, emotional, sexual) parental divorce, separation, other?

3. List mother and father by age, include occupation:

4. List siblings by age and describe how you relate to them (past and present):

Client Name: **Date:**

5. Have any family members been treated for/have emotional problems or mental illness? Describe:

6. Any other family history that you think I should know?

DRUG AND ALCOHOL ABUSE

1. Any family history of drug and/or alcohol usage? List and describe:

2. Any personal history of drugs/alcohol usage? List and describe

EDUCATIONAL HISTORY

1. Describe all school experiences, high school, college, vocational school. Were there any problems with truancy, suspensions, special education, vocational training, etc.?

EMPLOYMENT HISTORY

1. Present employment status and where (positive and negative aspects of what is going on at work):

2. If on leave of absence or disability, will you return to present job?

SOCIALIZATION SKILLS

1. Do you have friends? Describe

2. List clubs and organizations you belong to:

3. What do you do for pleasure and relaxation?

OTHER POTENTIAL STRESSORS

1. Are there any legal issues pending? (describe)

2. Are you having financial problems at this time?

3. Describe your plans to change your living arrangements, if any.

CLIENT STRENGTHS: *if client can't say, ask them what their family/friends would say?*
A. What are your interests/inner strengths: *sports, art, personal qualities, what resources do they have that may be harnessed to help cope with their psychological problem?*

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ADDITIONAL COMMENTS:

What does this client need?

What are this client's resources?

What are this client's barriers to treatment?

What is this client's readiness & motivation to participate in treatment?

DSM-IV DIAGNOSIS:

Axis I:
Axis II:
Axis III:
Axis IV:
Axis V: GAF

MEDICAL NECESSITY CRITERIA:

___ SED for Children or SMI for Adults
___ Documentation that participant is presently at risk for an out-of-home placement. DOCUMENTATION:
___ Clinical deterioration that would lead to an out-of-home placement. DOCUMENTATION:
___ Further clinical deterioration which would interfere with the participant's ability to maintain current level of functioning (if this is used then a description of the participant's current level of functioning must also be documented). DOCUMENTATION:

TREATMENT RECOMMENDATIONS: *(level of care, intensity of treatment, expected duration of treatment and services)*

__ Individual Psychotherapy ___ times per month.
__ Family Psychotherapy ___ times per month.
__ Other

EXPECTED DURATION OF TREATMENT: __ 6 mos., __ 12 mos., __ other

REFERRALS: