Client Name: **Insurance ID Number:**

First Choice Community Counseling

Intake- DIAGNOSTIC ASSESSMENT

Date Assessment Completed:
Date of Admission:

Demographic Information:

Name:	**DOB:**	**Age:**	**Cultural Background:**
HMO/MCO:	**Social Security Number:**	**Telephone:**	**Primary Language:**

Address

Gender Identity: □ Female □ Male □ GenderQueer □ Other □ Choose Not to Answer
Gender Expression: □ Feminine □Androgynous □ Masculine □ Other □ Choose Not to Answer
Sexual Orientation: □ Heterosexual □ Homosexual □Bisexual □Other □ Choose Not to Answer

Service(s) requested: Please check any and all that apply

□ ***Intensive Outpatient therapy-Substance Use Adult***
□ ***Intensive Outpatient therapy-Substance Use Child***
□***Outpatient therapy-Adult***

Client Name: **Insurance ID Number:**

□*Outpatient therapy-Child*
□ *PRP-Adult*
□ *PRP-Minor*

Presenting Issue (from perspective of person served):

1.How long have you been experiencing these problems?
❑ **Less than 30 days**
❑ **1-6 months**
❑ **1-5 years**

2. Current level of functioning:

Cognitive:
Emotional:
Behavioral:

SNAP:
Personal strengths:

Individual Needs:

Abilities and/or interests:

Preferences:

Are you currently or in the last 30 days experienced any of the following symptoms? (Highlight all that apply)

Activities of Daily Living	**Aggressive Outbursts**	**Avoidance**	**Budgeting Skills**
Can't Concentrate	**Can't sleep**	**Communication Skills**	**Depression**
Easily Startled	**Fatigue/No Energy**	**Fearful**	**Feeling Nervous**
Food management Concerns	**Guilt**	**Have Special Powers**	**Hearing Things**
Hopelessness	**Housekeeping**	**Hygiene Issues**	**Impulsive**

Client Name: **Insurance ID Number:**

Independent Living Skills	**Interpersonal Relationships**	**Irritable/Angry**	**Lack of Interest**
Legal Involvement	**Medication Non-compliance**	**Money Management**	**Mood disturbance**
No Motivation	**No Need for Sleep**	**Not Hungry**	**Panic Attacks**
People Out to Get Me	**Prefer Being Alone**	**Sadness**	**Seeing Things**
Sleep Too Much	**Suspicious**	**Talk Too Fast**	**Thoughts of Dying**
Trauma	**Want to Harm Others**	**Other-Please explain**	**Other-Choose not to answer**

Marital Status: ____ Single First Marriage ____ 2nd____ Other_____ Years Married: __
Education History __ Less than High School __Some High School ____ High School Graduate or Equivalent __Some College __Associate Degree ___Bachelor's Degree __Post Graduate Degree Literacy Level: Need for assistive technology in the provision of services:
Employment history:
Military history:

Spouse Name:	**Birth Date:**
Spouse's Education:	**Spouse's Occupation**

Living Situation: List name, age, sex, relationship of all significant others or persons in household.

Name	**Age**	**Relationship**	**Gender**

Client Name:		Insurance ID Number:	

Family history: Please describe the following:

Your parent's relationship with each other:
Your relationship with each parent and with any other adults present:
Your parent's physical health problems, drug or alcohol abuse, and mental or emotional difficulties:
Relationships with friends, community members, and other interested parties?:

What is your most difficult relationship right now?
What is your most difficult emotion right now?

Fall Risk Assessment: Do any of these conditions put client at risk for falling? If yes, please explain.

a. a. Does the client have a history of falls? Is the client on medications that cause drowsiness, unbalance, or difficulty standing?
b. b. Does the client have any vision problems?
c. c. Does the client use substances that alter his/her mood?
d. d. Does the client require assistance with ambulation?
Fall Prevention Plan:

Crisis Information:

Are you currently homeless, or facing imminent eviction?:

Need for And Availability of Social Supports:

Urgent Needs:

Medication:

Doctor's name, address, and phone:

Client Name: **Insurance ID Number:**

Current Use Profile:

Are you currently taking any medication **(including psychotropic)?** Y/N

If so, please list the following information: **Name of medication, dosage, prescriber, and efficacy**.

Medication History (previous use):

Medication Allergies/Adverse reactions to medication(s): Please indicate if any

Any problems with: eating ____ sleeping ____ chronic pain____ recent weight change____

Describe any answers checked above:

Have you or any of your family been hospitalized for mental or emotional illness? Y/N
If yes, explain **Who, when, where, why, and how long**:

Emergency Information: If some kind of emergency arises and we cannot reach you directly, or we need to reach someone else close to you, whom should we call?
Name: Phone:

Relationship to Client: Address:

Physical Health Issues:

Health history:

Current health needs:

Current Pregnancy and prenatal care needs (if applicable):

Medical Conditions:

Use of complementary health approaches: please highlight

Natural products	**Dietary supplements**	**acupuncture**
Massage therapy	**meditation**	**Movement therapies**
yoga	**Relaxation techniques**	**Homeopathy**
naturopathy	**Traditional healers**	**other**

Co-occurring disabilities and disorders:

Does the person served have any co-occurring disabilities or disorders Y/N:

Client Name: **Insurance ID Number:**

(This may include primary care issues that may impact the therapeutic relationship with the person served.)

Religious identification:

Religious denomination/affiliation: __ Apostolic __Baptist __ Catholic __ Muslim __Other
Involvement: ___ None __ Some/irregular __ Active
How important are spiritual concerns in your life?
Where do you typically attend worship?

Trauma history: □Experienced □Witnessed □None indicated

Do you see yourself as having been abused in any of the following ways? If so, please indicate the level of severity?

Physical Abuse	Minor	Moderate	Severe
Sexual assault	Minor	Moderate	Severe
Neglect	Minor	Moderate	Severe
Violence	Minor	Moderate	Severe

Have you received prior treatment related to any issues of abuse identified? ____ No __ Yes Do you seek further treatment for abuse related issues? ____ No __ Yes

Use of alcohol, tobacco, and/or other drugs:

Current use:
Historical Use:

Risk factors for: Suicide, Other Self-harming behaviors, and/or Violence towards others: Please highlight

Current psychiatric illness/symptoms	**Serious physical or emotional pain**	**Suicide attempts or completion in close family/support network**	**Relationships that may be supportive/protective or that may pose a threat (abuse/neglect)**
Alcohol and/or other drug use	**Previous self-harm or suicide attempts**	**Age/gender and social situation**	**Lack of adequate coping skills/mechanisms**
Financial difficulties	**Access to lethal methods**	**Cutting**	**Sharing needles**

Client Name: **Insurance ID Number:**

Current Intent and plans:

Wish to be dead	**Feelings of Hopelessness**	**Regret/remorse over current or previous attempt**	**Expectation about outcome of self-harming behavior**
Specific plans	**Lethality and frequency of plans or attempts**	**Other self-harming behavior**	**Current suicide intent/wishes**
Length of time suicidal feelings have been present			

Advanced directives: **Y/N**

Psychiatric History

Psychiatrist Name:	**Telephone Number:**	**Address:**

Psychological and social adjustment to disabilities and/or disorders:

Independent Living Skills: **(please check the boxes of the item(s) that the client doesn't have the experience to perform the task in a proficient manner on a consistent basis)**

☐ Money Management/Consumer Awareness

☐ Food management

☐ Housekeeping

☐ Health/Medication Management

☐ Knowledge of community resources

☐ Personal appearance/hygiene

☐ Housing

☐ Interpersonal skills

☐ Transportation

☐ Emergency and safety skills

Recreation/Hobbies:
Discharge Planning:

Estimated Length of services:

Goals Recommended for Treatment: A preliminary treatment plan will be developed at the time of the assessment.

Assessment Tools: **Please describe additional assessment instruments used (if applicable):**

Client Name: **Insurance ID Number:**

☐ASQ	☐SAFE-T pocket card ☐Other
☐C-SSRS	☐DLA 20

Professional Assessment Summary/Clinical Formulation: (Medical Necessity Criteria and include Assessment Results)

Restrictive protocols or special supervision requirements: (Are any in place that are clearly defined to ensure consistent implementation and are reassessed to determine the need):

Resultant DSM V Diagnosis:

Addendum:
Date amended:

LMHP-R/S Signature: _____ Date: _____

LMHP Signature: _____ Date: _____