Wright Step Counseling and Recovery
1904 Jennie Lee Drive
Idaho Falls, Idaho 83404
(208) 520-7074

Comprehensive Diagnostic Assessment

Name: _____ DOB_____

Clinician: _____ Date of Assessment: _____

___New Counseling Participant – No Medicaid mental health counseling services have been received in the past 12 months.

___Active Counseling Participant – Medicaid mental health counseling services have been received in the past 12 months.

Please indicate the main reasons for seeking consultation and/or treatment:

_____
_____
_____
_____
_____

Please list recent stressful life events within the past 6 months:

_____
_____
_____

Family of Origin

Place of birth: _____

Parents at the time of birth were: Married Separated Unmarried

Were you in the same location or home while growing up? _____

Did your family move frequently? _____

Are your parents currently: Married Divorced, when _____ Remarried

Were you adopted? _____ Age at the time of adoption: _____

Circumstances:_____

Were you ever sexually, physically, or emotionally abused ? _____No _____Yes

Please specify when and by whom:

_____

_____

_____

Father: (Please circle) Living Deceased, year _____

What was his level of education? _____Occupation? _____

Please describe the relationship with your father:

_____

_____

_____

Mother: (Please circle) Living Deceased, year _____

What was her level of education? _____Occupation? _____

Please describe the relationship with your mother:

_____

_____

_____

Number of Siblings: _____Full sisters _____Full brothers _____Half-sisters _____Half-brothers

____ Stepsisters _____Stepbrothers _____Deceased, age(s) at death _____

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

Have any of your family members had significant illness or medical treatment? _____ If so, please explain: _____

_____

_____

_____

Family Psychiatric History

Please include any mental health and/or substance use problems with biological relatives. Consider diagnoses such as depression, anxiety, bipolar disorder, schizophrenia, ADHD, alcohol and/or drug abuse, or any suicides.

Relative: Yes/No Type of problem(s)

Mother:_____

Mother's relatives: _____
_____

Father: _____

Father's relatives: _____
_____

Siblings: _____
_____
_____

Children: _____
_____
_____

Family History and Functioning

Current Status: Single Married Remarried Separated Divorced Widowed Living Together

Sexual Orientation: _____

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 the verge of break-up

____Abusive (physical, verbal, sexual)

Conflicts over-please circle: Finances Sex Children Friends Alcohol/drugs Legal Issues
Mental Health Religion Many minor conflicts

Household Members: Name Age Relationship

Member 1: _____

Member 2:_____

Member 3: _____

Member 4: _____

Member 5: _____

Are there children not living in the home? _____ If so, please list name, age, and relationship

_____

_____

What resources and supports do you and your family have?

_____

_____

What are your strengths and role in the family setting?

_____

_____

Basic Living Skills History and Functioning

Please indicate your habits with the following basic living skills practices:

	Daily	A few times per week	Once per week or less
Bathing	_____	_____	_____
Brushing teeth	_____	_____	_____
Dress in clean/appropriate clothes	_____	_____	_____
Go to bed/wake up at regular times	_____	_____	_____
Preparing balanced meals	_____	_____	_____
Housekeeping activities	_____	_____	_____
Laundry	_____	_____	_____

Do you regularly perform the following safety practices?

Lock door/secure home ___Yes ___No Turn off the oven/running water, etc. ___Yes ___No

Are you receiving personal care services, Meals on Wheels, or any other basic living skills provided?

___No ___Yes

Medical History and Functioning:

How is your overall health? Good Fair Poor

Medical doctor(s) / Specialists: _____

Please circle any health conditions that apply:

Thyroid problem High blood pressure Headaches Heart problems Sleep problems

High Cholesterol Asthma Trouble eating Stomach problems Seizures

Other (please describe): _____

Do you have any of the following? Yes/No What When

Contagious Diseases_____

Disabilities or handicaps _____

Allergies _____

Have you had any of the following? Yes / No What When

Accidents/injuries _____

Surgeries _____

Major illnesses _____

Hospitalizations _____

Loss of consciousness _____

Menstrual and Reproductive History Number of pregnancies _____ Number of live births _____

Do you have any history of the following? Yes / No What When

Premenstrual syndrome _____

Amenorrhea (absence of periods) _____

Irregular periods _____

Medications- 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_____

****Please list additional medications on back of this page**

Can you self-administer your medications? _____Yes _____No

Medication compliance: Please circle all that apply

Regularly taken as prescribed Occasionally miss a dose Miss doses regularly

Refuse/forgot to take meds most days

Have you been treated in the past with psychiatric medications such as antidepressants, mood stabilizers, tranquilizers, sleeping aids, stimulants, or others? No Yes

Please list medications:_____
_____
_____

<u>Substance Use/ Abuse</u>

Alcohol: Do you drink alcohol? Yes, now Yes, in the past No

How often do you drink alcoholic beverages?
_____Monthly _____Weekly _____Daily

Do you or others believe that you may have a drinking problem? _____No _____Yes

Drug Abuse: Have you ever used "street" or prescriptions drugs? _____No _____Yes

Name of drug: Age of Use How often Tolerance/Withdrawal
_____
_____
_____

_____
_____

Are you currently use any "street" or prescription drugs? _____No _____Yes

Name of drug: Age of Use How often Tolerance/Withdrawal

_____
_____
_____
_____
_____

Smoking/Vaping/Other: Have you ever smoked, vaped, or used other tobacco products?
_____No _____Yes, in the past _____Yes, now (How often and for how long?) _____
_____

Caffeine: Do you regularly drink coffee, tea, colas, or other caffeinated beverages? _____No _____Yes
How often? _____

Behavioral Health Treatment History

	Service Provider	When / How often?	Was it helpful? Please explain
Counseling			
Family Therapy			
Case Management			
Medication 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 the following information:

Institution Reason for admission Date Length of stay Was it helpful?

_____
_____
_____

Community / Legal History and 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 have access to 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

Educational and Developmental History

Have you ever experienced difficulties developmentally? _____No _____Yes
If yes, please explain:

_____
_____
_____
_____
_____

What is your highest level of education? _____What is your partner's highest level of education? _____

Have you ever completed any vocational training? _____No _____Yes

Please describe how you did in elementary school:
Academically_____ Behaviorally_____Socially_____

Please describe how you did in junior high/high school:
Academically_____ Behaviorally_____Socially_____

Were you in a specialized classroom setting or receive special education? _____No _____Yes
Please explain: _____

Do you currently have any educational goals? _____No _____Yes (describe)_____
_____

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 _____
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–please specify _____

Were you Honorably discharged? _____Yes ____No–please explain _____
_____

Social History and Functioning

How would you describe your friendships – please circle all that apply

No friends Only acquaintances Acquaintances and Friends

How would you describe your behavior and comfort level when you are in social settings? _____
_____

Have you experienced any difficulties with 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/or social strengths? _____
_____

Financial History and Functioning

Please describe your/the family source(s) of income: _____

Are finances adequate to meet the family's needs ____Yes ____No – please explain problems
_____
_____

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 difficulties? ___No ___Yes -please explain _____
_____

Housing History

Current Living arrangement: ___Own home ___Renting ___Living with friends/family ___Other
___Supported housing-explain_____

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? ____No ___Yes-please explain_____
_____

Is there any risk of homelessness? ____No ____Yes

Signatures

Responsible party completing this form: _____

Relationship to Client: _____

Signature: _____ Date:_____