

## ADULT DIAGNOSTIC ASSESSMENT

<b>Client Name</b> (First, MI, Last)		<b>Client No.</b>	
<b>Presenting Problem</b>		<b>Date of Admission</b>	
<p>Note Symptoms: behavioral and functioning problems and precipitating factors; indicate referral source and reason for referral; services sought and client expectations.</p>			
<b>Living Situation</b>			
<b>My Home</b>		<b>**Residential Care/Treatment Facility</b>	
<input type="checkbox"/> Rent <input type="checkbox"/> Own		<input type="checkbox"/> Hospital <input type="checkbox"/> Temporary Housing <input type="checkbox"/> Residential Care <input type="checkbox"/> Nursing Home	
<b>**Other</b>			
<input type="checkbox"/> Friend's Home <input type="checkbox"/> Homeless Living with Friend		<input type="checkbox"/> Relative's/Guardian's Home <input type="checkbox"/> Homeless in Shelter/No Residence <input type="checkbox"/> Foster Care Home <input type="checkbox"/> Respite Care <input type="checkbox"/> Jail/Prison <input type="checkbox"/> Other:	
<b>**Identify Facility or Person's Name</b>			
Household Member Names	Relationship to Client	Age	Quality of Relationship
Significant Family Members/ Others Not Listed Above	Relationship to Client	Age	Quality of Relationship

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<b>Social Information</b> (as appropriate, also include information from the Ohio Mental Health Consumer Outcomes Reports)	
<b>Primary/Family/Marital/Significant Other Support Systems</b>	
<b>Pertinent Family History</b> (to include family MH and AoD history)	
<b>Strengths/Capabilities</b>	
<b>Limitations of Activities of Daily Living</b> (include information relating to financial status and ability to manage own finances)	
<b>Friendship/Social/Peer Support Relationships</b>	
<b>Meaningful Activities</b> (community involvement, volunteer activities, leisure/recreation, other interests)	
<b>Community Supports/Self Help Groups</b> (AA, NA, NAMIO, etc.)	
<b>Religion/Spirituality</b>	
<b>Cultural/Ethnic Issues/Information/Concerns</b>	
<b>Developmental Issues</b>	
<b>Sexual History/Concerns</b>	

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**Education, Employment, and Military Information**

<b>Education History</b> (check all that apply) <input type="checkbox"/> GED <input type="checkbox"/> HS Grad	Highest Grade Completed	Vocational Year Completed
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<input type="checkbox"/> College    No. of Yrs, Qtrs., or Semesters    Degree/Major	<input type="checkbox"/> Other Degree: _____
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**History of Learning Difficulties** (including performance/behavioral problems due to AoD use)

None Reported     Learning Disability/Type: \_\_\_\_\_  
 Mental Retardation  
 Special School Placement: \_\_\_\_\_  
 Other: \_\_\_\_\_

**Barriers to Learning**

None Reported     Inability to Read or Write     Other: \_\_\_\_\_

**Special Communication Needs**

None Reported     TDD/TTY Device     Sign Language Interpreter     Assistive Listening Device(s)  
 Language Interpreter Services Needed/  
 Other Spoken Language: \_\_\_\_\_  
 Other: \_\_\_\_\_

**Employment** (check all that apply)

Full Time (35 hrs. or more per week)     Part Time (<35 hrs. per week)     Non-Competitive  
 Unemployed/Date Last Worked: \_\_\_\_\_

**Not in Labor Force**

Disabled     Retired     Homemaker     Student     Living in Institution  
 Other: \_\_\_\_\_

**If employed, name of employer.**

<b>Job Performance History</b>	
No. of Jobs in Last 5 Years	Comments (include performance/behavioral problems due to AoD use)

**Attendance**

Above Average     Normal     Tardiness     Absenteeism

**Performance**

Exemplary     Good     Average     Below Average

**Employment Interests/Skills**

Is client satisfied with job?     No     Yes    (If not currently employed) Client wants to work?     No     Yes  
 Is client experiencing financial problems?     No     Yes    Is client concerned that employment will affect benefits?     No     Yes

**Comments on Past or Current Employment/Education Skills/Interests** (include information relating to past or current employment/education skills and interests)

**Military History**

No     Yes    If yes, describe branch of service, any pertinent duties, and any trauma experienced during service as applicable.

Type of Discharge (if other than General/Honorable)	Date of Discharge
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**Alcohol/Drug History**

Illegal drug use/abuse past 12 months? <input type="checkbox"/> No <input type="checkbox"/> Yes	Non-prescription drug abuse past 12 months? <input type="checkbox"/> No <input type="checkbox"/> Yes
Prescription drug abuse past 12 months? <input type="checkbox"/> No <input type="checkbox"/> Yes	Alcohol abuse past 12 months? <input type="checkbox"/> No <input type="checkbox"/> Yes

**Toxicology screen completed?**  
 Not Indicated  No  Yes If yes, results:

**Presenting with detox issues?**  
 No  Yes If yes, symptoms:

**Check All That Apply**  
 IV Drug User  Pregnant  Other Addictive Behaviors:

Drug/Substance/Alcohol/Tobacco	Age of First Use	Date of Last Use	Frequency of Use	Amount	Method

**Alcohol/Drug Treatment History**

**AoD Treatment**  
 None Reported  
 Current:  OP  IOP  Residential  Other:  
 Past:  OP  IOP  Residential  Hospital  Detox  Other:

If current or past complete the following:

Name of Provider Agency	Type of Service	Date of Service

**Other Comments Regarding Substance Abuse/Use and Other Addictive Behaviors** (include AoD use/abuse by other family members/significant others, AoD related legal problems, SAMI stage of treatment for providers using dual disorders integrated treatment approach)

**Legal History**

**Legal Guardian/Custodian** Name and Address of Legal Guardian/Custodian Phone No.  
 None Reported ( )

**Current Legal Status**  
 None Reported  On Probation  Detention  On Parole  Awaiting Charge  
 AoD Related Legal Problems  Conditional Release  Outpatient Commitment  Court Ordered to Treatment  
 Other:

**History of Legal Charges**  
 None Reported  Juvenile:  No  Yes If yes:  Status Offense (e.g., Unruly)  Delinquency  
 Adult:  No  Yes If yes:  Misdemeanor  Felony

**List and Date Most Recent Legal Charges**

**Convictions**  
 None Reported

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**Legal History** (continued)

<b>Incarcerations</b> <input type="checkbox"/> None Reported	<b>Name and Phone No. of Probation/Parole Officer</b> (if applicable)
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<b>Civil Proceedings</b> <input type="checkbox"/> None Reported	<b>Domestic Relations Court Problems</b> (i.e., custody, protective services, restraining order)
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**Juvenile Court Involvement** (related to child abuse, neglect, or dependency)

Current:  No     Yes    Comment: \_\_\_\_\_

Past:     No     Yes    Comment: \_\_\_\_\_

**Child Support Enforcement Orders**

None Reported

**Children's Protective Services Involvement with Family**

None Reported

**Name of Children's Protective Services Caseworker(s) Assigned to Family** (if applicable)

None Reported

**Abuse History** (describe in comments section each element checked)

<input type="checkbox"/> No Self Reported History of Abuse/Violence	<input type="checkbox"/> Physical Abuse	<input type="checkbox"/> Domestic Violence/Abuse	<input type="checkbox"/> Community Violence
<input type="checkbox"/> Physical Neglect	<input type="checkbox"/> Emotional Abuse	<input type="checkbox"/> Elder Abuse	<input type="checkbox"/> Sexual Abuse/Molestation
<input type="checkbox"/> Other: _____			

**Comments** (identify if client was/is a victim of abuse or a perpetrator or both)

  
  
  
  

**Problem Checklist Including Functional Domains**

Check	Check All Current Problem	As Evidenced By
	<b>Nutritional/Eating Pattern Changes/Disorders</b>	
	<b>Pain Management</b>	
	<b>Depressed Mood/Sad</b>	
	<b>Bereavement Issues</b>	
	<b>Anxiety</b>	
	<b>Traumatic Stress</b>	
	<b>Anger/Aggression</b>	

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**Problem Checklist Including Functional Domains (continued)**

Check	Check All Current Problem Areas	As Evidenced By						
	<b>Oppositional Behaviors</b>							
	<b>Inattention</b>							
	<b>Impulsivity</b>							
	<b>Disturbed Reality Contact (psychosis)</b>							
	<b>Mood Swings/Hyperactivity</b>							
	<b>Substance Use/Addiction</b>							
	<b>Other Addictive Behaviors</b>							
	<b>Sleep Problems</b>							
	<b>Psychosocial Stressors</b>							
	<b>Pertinent Health Issues/Medical History</b> (include any allergies and food/drug reactions)							
	<b>Client's Family Needs Education to be Able to</b> (Describe areas of family education needs. Family education must be directed to the exclusive well being of the client.)							
	<b>Client Needs Other Environmental Supports</b> (Describe areas where environmental supports are needed to support the client in community living and possible sources of that support.)							
	<b>Other</b>							
<b>Skills Deficits/Skills Training/Community Support Needs</b> (check all applicable skills deficits, skills training, and/or community support needs identified)	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; padding: 5px;"><input type="checkbox"/> Client needs symptom and disability management skills.</td> <td style="width: 50%; padding: 5px;"><input type="checkbox"/> Client needs restoration or development of social/personal skills.</td> </tr> <tr> <td style="padding: 5px;"><input type="checkbox"/> Client needs residential supports to develop skills necessary for community living.</td> <td style="padding: 5px;"><input type="checkbox"/> Client needs employment related services to develop skills necessary for successful employment.</td> </tr> <tr> <td style="padding: 5px;"><input type="checkbox"/> Client needs education related services to develop skills necessary to enhance academic success.</td> <td style="padding: 5px;"><input type="checkbox"/> Client needs restoration or development of social support skills and networks including recreational activities.</td> </tr> </table>		<input type="checkbox"/> Client needs symptom and disability management skills.	<input type="checkbox"/> Client needs restoration or development of social/personal skills.	<input type="checkbox"/> Client needs residential supports to develop skills necessary for community living.	<input type="checkbox"/> Client needs employment related services to develop skills necessary for successful employment.	<input type="checkbox"/> Client needs education related services to develop skills necessary to enhance academic success.	<input type="checkbox"/> Client needs restoration or development of social support skills and networks including recreational activities.
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<b>As Evidenced By</b> (describe the specific skill deficits or areas where improvement is needed.)								

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**Ohio Mental Health Consumer Outcomes**

**Ohio Mental Health Consumer Outcomes Administered?**  
 Yes    No   If yes, report results for those forms completed.

Quality of Life Score	Symptom Distress Score	Empowerment Score	Functioning Scale Score

**Comment on Consumer Outcomes**

**Other Outcomes Tools Utilized?** If yes, summarize results.  
 Yes    No

**Mental Status Examination OR**  Refer to Attached Mental Status Exam

**Mental Status Examination** (Complete Mental Status Exam form or provide a thorough written narrative below. If AoD client, include ODADAS MSE elements: appearance, attitude, motor activity, affect, mood, speech, and thought content.)

**Past attempts to Harm Self or Others**    None Reported    Self    Others  
 Comment:

**Current Risk of Harm to Self**    None Noted    Low    Moderate    High  
 Comment:

**Current Risk of Harm to Others**    None Noted    Low    Moderate    High  
 Comment:

**Client/Family/Guardian Expression of Service Preferences**

Clinician and client (and/or primary support person) should have a meaningful recovery focused dialogue to engage and allow the client (and/or primary support person) to express their desired treatment preferences and priorities. Identify the indicated needs/preferences of client/family/guardian for the full range of behavioral health clinical and community-based rehabilitative services, and environmental support services available to them.

**1. Behavioral Health Clinical and Rehabilitative Service Preferences**



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<b>Other Information</b>

**Diagnosis:**    DSM-IV Codes (or successor)    ICD-9 CM Codes (or successor)

Check Primary	Axis	Code	Narrative Description
<input type="checkbox"/>	Axis I		
<input type="checkbox"/>			
<input type="checkbox"/>			
<input type="checkbox"/>	Axis II		
<input type="checkbox"/>			
	Axis III		
	Axis IV		
	Axis V	Current GAF:	Highest GAF in Past Year (if known):

<b>Treatment Recommendations/Assessed Needs</b>
1.
2.
3.
4.
5.
6.
7.

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<b>Client/Guardian/Family Participation in Assessment and Response to Recommendations</b>

<b>Further Evaluations Needed</b>
<input type="checkbox"/> None Indicated <input type="checkbox"/> Psychiatric <input type="checkbox"/> Psychological <input type="checkbox"/> Neurological <input type="checkbox"/> Medical <input type="checkbox"/> Educational <input type="checkbox"/> Vocational <input type="checkbox"/> Visual <input type="checkbox"/> Auditory <input type="checkbox"/> Nutritional <input type="checkbox"/> AoD Assessment <input type="checkbox"/> Other:

<b>Level of Care/Indicated Services Recommendation</b>

**Signatures**

<b>Provider Signature/Credentials</b>	<b>Date</b>
<b>Provider Signature/Credentials Rendering Diagnosis, If Different than Above (ODADAS only)</b>	<b>Date</b>
<b>Supervisor Signature/Credentials (if applicable)</b>	<b>Date</b>
<b>Physician Signature/Credentials</b>	<b>Date</b>

Date of Service	Staff ID No.	Loc. Code	Prcdr. Code	Mod 1	Mod 2	Mod 3	Mod 4	Start Time	Stop Time	Total Time	Diagnostic Code

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