

## CHILD/ADOLESCENT DIAGNOSTIC ASSESSMENT

Client Name (First, MI, Last)					Client No.
<b>Presenting Problem</b>					Date of Admission
Referral Source and Reason for Referral					
Client's Description of Problem					
Family/Guardian/Child Perceptions of Problem					
<b>Living Situation</b>					
<b>Parent's Home</b> <input type="checkbox"/> Rent <input type="checkbox"/> Own		<b>**Residential Care/Treatment Facility</b> <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"/> Relative's/Guardian's Home <input type="checkbox"/> Foster Care Home <input type="checkbox"/> Respite Care <input type="checkbox"/> Jail/Prison <input type="checkbox"/> Homeless Living with Friend <input type="checkbox"/> Homeless in Shelter/No Residence <input type="checkbox"/> Other:					
<b>**Identify Facility or Person's Name</b>					
<b>Primary Household</b>					
Household Member Names	Relationship to Client	Age	Occupation/School	Level of Education	Quality of Relationship
<b>Street Address</b> (if different from client's address listed on Demographic Information form)					
<b>Secondary Household</b>					
Does client live in more than one household? <input type="checkbox"/> No   If no, skip to "Additional Family Members" <input type="checkbox"/> Yes   If yes, complete the secondary household information below.					
Household Member Names	Relationship to Client	Age	Occupation/School	Level of Education	Quality of Relationship

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**Secondary Household** (continued)

**Secondary Household Street Address** (if different from client's address listed on Demographic Information form)

**Family Members Who Live in Both Households**  
 Only Client     Client and (list):

**Additional Family Members** (i.e., parents or siblings not living in primary or secondary households)  
 No Parents or Siblings Other Than Those Listed in Primary or Secondary Households

**Custody and Parenting Plan**  
 Lives with Both Parents (biological or adoptive) in Same Household or with Widowed Parent  
 Other (describe):

**Family Environment/Relationships**

**Parent-Child (Client) Relationship(s):**      P = Primary Household      S = Secondary Household      B = Both

Parent-Child Conflict:	__ None-Mild	__ Moderate	__ Severe	
Parent Supervision and Monitoring of Child:	__ Always	__ Usually	__ Inconsistently	__ Rarely
Cooperation Between Parents Regarding Child-Rearing:	__ Always	__ Usually	__ Inconsistently	__ Rarely    __ Not Pertinent
Parent Positive Activities with Child:	__ Frequent	__ Occasional	__ Infrequent	
Parent Satisfaction with Relationship:	__ Satisfied	__ Neutral	__ Dissatisfied	
Child Satisfaction with Relationship:	__ Satisfied	__ Neutral	__ Dissatisfied	

Comment on Parent-Child Relationships (describe further if needed)

**Sibling-Child (Client) Relationship(s)**       No Siblings      P = Primary Household      S = Secondary Household      B = Both

Child-Sibling(s) Conflict:	__ None-Mild	__ Moderate	__ Severe	
Sibling(s) Positive Activities with Child:	__ Frequent	__ Occasional	__ Infrequent	
Sibling(s) Satisfaction with Relationship:	__ Satisfied	__ Neutral	__ Dissatisfied	
Child Satisfaction with Relationship:	__ Satisfied	__ Neutral	__ Dissatisfied	

Comment on Sibling-Child Relationships (describe further if needed)

**Parent Marital or Couples Relationship(s)**       Not Applicable in this Case      P = Primary Household      S = Secondary Household      B = Both

Marital or Couples Conflict:	__ None-Mild	__ Moderate	__ Severe	
Marital or Couples Satisfaction:	__ Satisfied	__ Neutral	__ Dissatisfied	

Comment on Parent Marital or Couples Relationship(s) (describe further if needed)

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<b>Other Family Concerns</b>						
Family Member Alcohol Abuse:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, indicate:	<input type="checkbox"/> Parent	<input type="checkbox"/> Sibling	<input type="checkbox"/> Other
Family Member Substance Abuse:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, indicate:	<input type="checkbox"/> Parent	<input type="checkbox"/> Sibling	<input type="checkbox"/> Other
Family Member Mental Health Problems:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, indicate:	<input type="checkbox"/> Parent	<input type="checkbox"/> Sibling	<input type="checkbox"/> Other
Family Member Health Problems:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, indicate:	<input type="checkbox"/> Parent	<input type="checkbox"/> Sibling	<input type="checkbox"/> Other
Family Member Disability:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, indicate:	<input type="checkbox"/> Parent	<input type="checkbox"/> Sibling	<input type="checkbox"/> Other
Family Member Legal Issues:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, indicate:	<input type="checkbox"/> Parent	<input type="checkbox"/> Sibling	<input type="checkbox"/> Other
Family Financial Concerns:	<input type="checkbox"/> No	<input type="checkbox"/> Yes				

Other (describe)

Comment on Other Family Concerns and Information Relating to Financial Status (specify problems that impact client's needs)

**Social Information**

**Pertinent Family History** (to include family MH and AoD history)

**Strengths/Capabilities**

**Limitations of Activities of Daily Living**

**Friendship/Social Peer Support/Relationships**

**Meaningful Activities** (community involvements, volunteer activities, leisure/recreation, other interests)

**Community Supports/Self Help Groups** (AA, NA, etc.)

**Religion/Spirituality**

**Cultural/Ethnic Issues/Information/Concerns**

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**Pertinent Developmental Issues**

**Mother's Pregnancy History**  
 No Problems Reported

**Infancy (age 0-1)**  
 No Problems Reported

**Preschool (age 2-4)**  
 No Problems Reported or Not Pertinent

**Childhood (age 5-12)**  
 No Problems Reported or Not Pertinent

**Adolescent (age 13-17)**  
 No Problems Reported or Not Pertinent

**Sexual History to Include Pertinent Sexual Issues/Concerns**

**School Functioning**

**Educational Classification**  
 Regular Education Classroom, No Special Services  
 Yes     No    If no, check all that apply.)

<input type="checkbox"/> 01 Multiple Disabilities (not deaf-blind)	<input type="checkbox"/> 06 Orthopedic Impairment	<input type="checkbox"/> 12 Autism
<input type="checkbox"/> 02 Deaf-Blindness	<input type="checkbox"/> 08 Emotional Disturbance (SBH)	<input type="checkbox"/> 13 Traumatic Brain Injury
<input type="checkbox"/> 03 Deafness (hearing impairment)	<input type="checkbox"/> 09 Mental Retardation (DH)	<input type="checkbox"/> 14 Other Health Impaired (major)
<input type="checkbox"/> 04 Visual Impairment	<input type="checkbox"/> 10 Specific Learning Disability	<input type="checkbox"/> 15 Other Health Impaired (minor)
<input type="checkbox"/> 05 Speech or Language Impairment	<input type="checkbox"/> 11 Preschoolers with a Disability	<input type="checkbox"/> Current 504 Plan
<input type="checkbox"/> Other:		

**Comments on Educational Classification/Placement** (please indicate if client is home schooled, in gifted program, etc.)

**Grades**

**School Proficiency/Achievement Exams/Ohio Graduation Tests (OGT)**  
**Most Recent Exams:**    Grade Level Taken: \_\_\_\_\_     OGT (reading and math only)     Has Not Taken These Exams

Exams Taken	Results		
<b>Reading</b>	<input type="checkbox"/> Passed	<input type="checkbox"/> Did Not Pass	<input type="checkbox"/> Unknown
<b>Math</b>	<input type="checkbox"/> Passed	<input type="checkbox"/> Did Not Pass	<input type="checkbox"/> Unknown
<b>Citizenship</b>	<input type="checkbox"/> Passed	<input type="checkbox"/> Did Not Pass	<input type="checkbox"/> Unknown or N/A
<b>Science</b>	<input type="checkbox"/> Passed	<input type="checkbox"/> Did Not Pass	<input type="checkbox"/> Unknown or N/A
<b>Writing</b>	<input type="checkbox"/> Passed	<input type="checkbox"/> Did Not Pass	<input type="checkbox"/> Unknown or N/A

**Other Test Results** (IQ, achievement, developmental)  
 No Other Test Results Reported



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**Legal History** (continued)

**Name of CPS Caseworker(s) Assigned to Family** (if applicable)  
 None Reported

**Name of Guardian ad Litem (GAL) or Court Appointed Special Advocate (CASA) Assigned to Family**  
 None Reported

**Employment**

Not Pertinent - Skip this Section

**Currently Employed?** If yes, name of employer: \_\_\_\_\_ Job Title \_\_\_\_\_  
 Yes     No

**Employment Interests/Skills/Concerns**

**Mental Health Treatment History**

**Outpatient Mental Health Treatment**     None Reported

Agency	Check if Current	Past (Date)	Clinician Name

**Psychiatric Hospitalizations/Residential Treatment Facilities**     None Reported

Facility	Date of Service	Reason (suicidal, depressed, etc.)

**Previous or Current Diagnoses** (if known)  
 Not Known by Client

**Other Comments Regarding Mental Health Treatment History**  
 No Comment

**Current Medication** (prescription/OTC/herbal)

Medication	Rationale	Dosage/Route/Frequency	Compliance			
			Yes	No	Partial	Unk

<b>Primary Care Physician</b> (name, phone no., and address)	<b>Date of Last Physical Exam</b>
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**Other Prescribing Physician(s)** (name, phone no., and address)

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<input type="checkbox"/> None Reported		<b>Past Psychotropic Medications</b>
Psychotropic Medications	Reason for Discontinuation	

<b>Alcohol/Drug History</b>			
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 use/abuse past 12 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes

**Toxicology screen completed?**  
 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)

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

No Self Reported History of Abuse/Violence   
  Physical Abuse   
  Domestic Violence/Abuse   
  Community Violence  
 Physical Neglect   
  Emotional Abuse   
  Sexual Abuse/Molestation  
 Other:

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

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**Problem Checklist Including Functional Domains**  
 (Check applicable age appropriate needs/preferences for the identified child/adolescent client and comment.)

Check	Check All Current Problem Areas	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>	
	<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>Enuresis/Encopresis</b>	
	<b>Psychosocial Stressors</b>	

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

<b>Check</b>	<b>Check All Current Problem Areas</b>	<b>As Evidenced By</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 age appropriate skills deficits, skills training, and/or community support needs identified.)	
	<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 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.	
	<b>As Evidenced By</b> (Describe the specific age appropriate skill deficits or areas where improvement is needed.)	

**Ohio Scales**

<b>Ohio Scales Administered</b>			
<input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, report results for those forms completed.			
Form	Informant Name	Problem Scale Score	Functioning Scale Score
Parent			
Parent			
Youth (12-17)			
Worker			

**Comment on Ohio Scales**

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**Other Outcomes Tools Utilized?** If yes, summarize results.

Yes     No

**Mental Status Summary**

Not Clinically Indicated   
  Unremarkable   
  Remarkable

If remarkable, describe under the following Mental Status Examination OR  Refer to attached Mental Status Exam form.

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**Mental Status Summary** (continued)

**Mental Status Examination** (Complete the Mental Status Examination 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**

(Describe Applicable Age Appropriate Needs/Preferences for the Identified Child/Adolescent Client and Comment as Relevant)

Clinician, client, and parent/care taker/guardian should have a meaningful dialogue to engage and allow the client and family 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**

**2. Environmental Support Preferences**

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**Clinical/Interpretative Summary**

**This Clinical/Interpretative Summary is Based Upon Information Provided By** (check all that apply)

- |  |   |   |  |                                    |                                  |
|--|---|---|--|------------------------------------|----------------------------------|
| <input type="checkbox"/> Client          | <input type="checkbox"/> Parent(s)        | <input type="checkbox"/> Guardian(s)      | <input type="checkbox"/> Family/Friend | <input type="checkbox"/> Physician | <input type="checkbox"/> Records |
| <input type="checkbox"/> Law enforcement | <input type="checkbox"/> Service Provider | <input type="checkbox"/> School Personnel | <input type="checkbox"/> Other:        |                                    |                                  |

**Narrative** - Include etiology of presenting problem and maintenance of the problem; mental health history; AoD history; severity of problem; where problem occurs (functioning at home, at work, in community); onset of problem (acute vs. chronic); client motivation for treatment, whether problem is known to be responsive to treatment.

<input type="checkbox"/> Not Applicable	<b>Degree of Severity at Admission for the Following Dimensions (AoD clients only)</b>						
Dimension:	Intox/With	Biomedical	Em/Beh/Cog	Treatment Accept/Resist	Relapse Potential	Recovery Environ	Family Func Youth

**Other Information**

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**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):

**Treatment Recommendations/Assessed Needs**

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.

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

**Further Evaluations Needed** (check all that apply)

<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"/> Other:	

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

**Signatures**

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

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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