Example 2 Outpatient Affiliate Services
COMPREHENSIVE ASSESSMENT

Client Name:	**DOB:**	**Client No:**
Clinician:	**Provider No:**	

Physical Location of Appt: ☐ Sweetser Affiliate Office ☐ School ☐ Client's Home ☐ ER ☐ Jail ☐ Other:

Date of Assessment: **Time Spent:**

Age of Client at time of assessment (in years):

Data Sources (check all that apply):	**Present at Session:**
☐ Self	☐
☐ Parent	☐
☐ Guardian (if other than parent)	☐
☐ DHHS worker	☐
☐ Case Manager	☐
☐ Psychiatrist	☐
☐ Clinician	☐
☐ PO/JCCO	☐
☐ Primary Care Physician/Nurse	☐
☐ Records	
☐ Relative/Kin	☐
☐ Other :	☐
☐ Local Education Agency (LEA)	☐

Other / Remarks:

REASON FOR SEEKING SERVICE: (check all that apply):

☐ Substance Abuse	☐ Mental Health	☐ Co-Occurring Disorder
☐ Family difficulties	☐ Health concerns	☐ Relational difficulties
☐ Work difficulties	☐ School Difficulties	☐ Other

Briefly summarize reason for seeking services at this time: **(Mandatory)**

Is this affecting your life in any of the following areas? (check all that apply):

☐ Relationships with family	☐ Relationships with friends or peers	
☐ Home life	☐ School/Work	☐ Self Care
☐ Community	☐ Other:	

Briefly summarize how this is affecting client's life: **(Mandatory)**

Family/Friends perception of client's needs:
☐ N/A

LIVING SITUATION
Where are you currently residing:

Client Name:	**DOB:**	**Client No:**
Clinician:	**Provider No:**	

☐ On own ☐ With parents ☐ Spouse / Partner
☐ With other relatives ☐ Friend's home ☐ Foster Care
☐ Jail (name of facility) ☐ Hospital (name of facility)
☐ Group Home (name facility) ☐ Homeless
☐ Other (identify where)

How long have you been residing there?
Other / Remarks:
What type of housing do you live in?

☐ Own house/apt ☐ Friends' house/apt ☐ Shelter
☐ Relatives' house/apt ☐ Other:

How long have you been residing there?

MENTAL HEALTH ISSUES

Anniversary of Significant Losses	Yes ☐	No ☐	Describe:
Depression:	Yes ☐	No ☐	Describe:
Anxiety:	Yes ☐	No ☐	Describe:
Mood Disorders:	Yes ☐	No ☐	Describe:
Psychosis:	Yes ☐	No ☐	Describe:
Suicidal Ideation:	Yes ☐	No ☐	Describe:
Self-Injurious Behavior:	Yes ☐	No ☐	Describe:
Suicide Attempts:	Yes ☐	No ☐	Describe:
Homicidal/Assaultive Ideation:	Yes ☐	No ☐	Describe:
Homicidal/Assaultive Behavior:	Yes ☐	No ☐	Describe:
Weapons used:	Yes ☐	No ☐	Type of weapon(s):
Other Mental Health Issues:	Yes ☐	No ☐	Remarks:

Current Diagnoses (as reported by client): Information not available: ☐
Past Diagnoses (as reported by client): Information not available: ☐

Comments/Other remarks:

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COMPREHENSIVE ASSESSMENT

Client Name:	**DOB:**	**Client No:**
Clinician:	**Provider No:**	

TREATMENT / PLACEMENT HISTORY

Has the client received mental health or substance abuse treatment services in the past 3 years?
Yes ☐ No ☐ If yes, please complete the following:

Name of Agency	***Name of Clinician***	***Treatment Setting******	***Other / Remarks***	***Dates***	***Treatment Status******	***Reason***

*** Treatment Setting:

Community Based	Hospitalization – Medical	Intensive In-Home Services
Crisis Stabilization	Hospitalization – Psychiatric	Outpatient
Foster Care	Incarceration/Hold for Court	Peer Center
Substance Abuse	Other	Residential Placement

*** Treatment Status: Current Past

DEVELOPMENTAL HISTORY (Child only)

☐ Information not available. Please Explain:
Walking met w/in Normal Limits: Yes ☐ No ☐ Unknown ☐ If No:
(12 mo. – walking w/assistance, by 18 mo. – walking alone)
Talking met w/in Normal Limits: Yes ☐ No ☐ Unknown ☐ If No:
(12-15 mo. saying 2-3 words, 2 yrs. saying 2-3 word sentences…)
Toilet Training met w/in Normal Limits: Yes ☐ No ☐ Unknown ☐ If No:
(3 yrs. – using toilet with help, by 4 yrs. – using toilet alone)
Cognitive Functioning w/in Normal Limits: Yes ☐ No ☐ Unknown ☐ If No:
Did mother experience complications during pregnancy: Yes ☐ No ☐ Unknown ☐ If Yes:
Complications during labor and/or delivery: Yes ☐ No ☐ Unknown ☐ If Yes:

BEHAVIORAL HISTORY

Cruelty to Animals	Yes ☐	No ☐	If Yes:
Fire-setting	Yes ☐	No ☐	If Yes:
Physical aggression by child toward adult	Yes ☐	No ☐	If Yes:
Physical aggression by adult toward child	Yes ☐	No ☐	If Yes:
Physical aggression by child toward peers/siblings	Yes ☐	No ☐	If Yes:
Property Destruction	Yes ☐	No ☐	If Yes:
Running Away	Yes ☐	No ☐	If Yes:
Verbally Abusive	Yes ☐	No ☐	If Yes:
Use of Intimidation (bullying, posturing)	Yes ☐	No ☐	If Yes:

Addictive behaviors other than substance abuse (gambling, sexual compulsivity, spending, etc.)
Yes ☐ No ☐ If Yes:

Example 2 Outpatient Affiliate Services
COMPREHENSIVE ASSESSMENT

Client Name:	**DOB:**	**Client No:**
Clinician:	**Provider No:**	

TRAUMA HISTORY

Has the client experienced any abuse/violence (check all that apply):

☐ No self report of abuse/violence ☐ Elder Abuse ☐ Physical Neglect
☐ Community Violence ☐ Emotional Abuse ☐ Sexual Abuse/Molestation
☐ Domestic Violence/Abuse ☐ Physical Abuse ☐ Witness to Violence
☐ Other

If there is a hx of trauma, is this causing difficulties in your life? Describe:
Other / Remarks:

SEXUAL HISTORY

Sexual Orientation (check all that apply):

☐ Asexual ☐ Heterosexual ☐ Questioning Sexuality
☐ Bisexual ☐ Gay/Lesbian ☐ Unknown ☐ Other:

Gender Identity:

☐ Female ☐ Male ☐ Questioning gender identity
☐ Transgender – male>female ☐ Transgender – female>male
☐ Inter-sexed ☐ Unknown ☐ Other:

Is your sexual orientation or gender identity causing difficulties in your life:
Other / Remarks:
Is the client exhibiting any of the following sexualized behaviors (check all that apply):

☐ Provocative Behaviors (sexualized dress) ☐ Promiscuous Behaviors
☐ Prostitution ☐ Engaged in inappropriate online activity
☐ Exposing Self ☐ Masturbates in public or frequently
☐ Verbal abuse w/sexual overtones ☐ Sexually coercive to others
☐ No reports of sexualized behaviors ☐ Other

If any of the above are checked, are these behaviors causing difficulties in your life:
Other / Remarks:

EDUCATIONAL HISTORY

☐ Information not available. Please Explain:
Highest grade completed:
Highest diploma or degree earned:
☐ HS Diploma ☐ GED ☐ Assoc. Degree ☐ Bachelor's Degree ☐ Master' Degree
☐ Doctorate ☐ Other: ☐ N/A
Describe your interests/strengths at school:
Participation in extracurricular activities (sports/clubs):
Awards/Merits/Recognitions:
Future educational goals:
History of receiving special education services: Yes ☐ No ☐ Remarks:
History of learning disabilities: Yes ☐ No ☐ Remarks:

Client Name:	**DOB:**	**Client No:**
Clinician:	**Provider No:**	

School experiences: (check all that apply)
☐ Academic success ☐ Honor student ☐ No school problems
☐ Academic difficulties ☐ Attendance issues ☐ Dropped Out ☐ Truancy
☐ Suspensions/Expulsions ☐ Relational difficulties ☐ Retention (held back)
☐ Behavioral difficulties ☐ Transportation issues ☐ Other

Other / Remarks:

EMPLOYMENT HISTORY:
Are you currently employed: Yes ☐ No ☐
If Yes: Where and for how long:
Are you satisfied with your job: Yes ☐ No ☐
If no: Why not:
If No: Reason:
☐ Disabled ☐ Homemaker ☐ Retired ☐ Student
☐ Residing in an institution ☐ Other:
Other / Remarks:
Number of jobs in last 5 years:
Are you interested in being employed: Yes ☐ No ☐
Are you concerned about losing benefits: Yes ☐ No ☐
History of vocational rehabilitation involvement? Yes ☐ No ☐
History of vocational training involvement? Yes ☐ No ☐
History of Volunteer work? Yes ☐ No ☐
If Yes, where and for how long:
Comments on past/current skills/interest:
Military Service: Yes ☐ No ☐
If Yes: Current ☐ Past ☐
Branch:
☐ Navy ☐ Army ☐ Coast Guard ☐ Air Force ☐ Marines
Type of Discharge:
☐ Honorable ☐ General (under honorable conditions)
☐ Other than honorable ☐ Bad Conduct ☐ Dishonorable
Date of Discharge:

LEGAL HISTORY
Current legal involvement:
☐ None ☐ Charges Pending ☐ Conditional Release ☐ Detention
☐ Parole ☐ Probation ☐ Other
Other / Remarks:

Client Name:	**DOB:**	**Client No:**
Clinician:	**Provider No:**	

History of legal charges: Yes ☐ No ☐
Legal description of last charge (eg, OUI, Breaking and Entering):
Date of last legal charge:
Convictions: Yes ☐ No ☐ Describe:
Incarcerations: Yes ☐ No ☐ Describe:
Child Protective Services Involvement: Yes ☐ No ☐
Past or Present:
Reason:
Child Support Enforcement Involvement: Yes ☐ No ☐ Describe:
Other current legal issues (divorce, custody issue) Yes ☐ No ☐ Describe:

SOCIAL INFORMATION

Participation in Meaningful Activities (Check/define all that apply):
☐ None Identified ☐ Religious/Spiritual ☐ Community ☐ Cultural/Ethnic
☐ Recreational ☐ Other
Other / Remarks:
Strengths/Capabilities:
Community Supports/Self Help Groups (check all that apply):
☐ AA ☐ NA ☐ Friend / Peer ☐ Neighbor ☐ Parent
☐ Provider ☐ Sibling ☐ Relative ☐ Other ☐ No community supports

Other / Remarks:
Limitations or challenges in client's life: (check all that apply):
☐ Cultural/Ethnic ☐ Financial ☐ Health ☐ Transportation ☐ Other
Other / Remarks:

HEALTH HISTORY

Information not available: ☐ Remarks:
Current & historical Medical issues:

History of Chronic Pain: Yes ☐ No ☐ Describe:
History of Head Injury: Yes ☐ No ☐ Describe:

Date of last physical exam: N/A:
Name of physician who completed last exam: N/A:
Address and phone number of Physician:
Date of last dental exam: N/A:
Name of dentist who completed last exam: N/A:
Healthcare services (medical & alternative) individual identifies as needed but unable to access:
None ☐
Identified Healthcare Services:

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COMPREHENSIVE ASSESSMENT

Client Name:	**DOB:**	**Client No:**
Clinician:	**Provider No:**	

Eating: ☐ Normal ☐ Healthy Diet ☐ Recent Decrease
☐ Weight Gain ☐ Weight Loss ☐ Recent Increase
☐ Pica ☐ Binging ☐ Anorexia
☐ Unusual Eating Habits

Sleeping Patterns:
☐ No Difficulty ☐ Disturbed ☐ Falling Asleep ☐ Staying Asleep
☐ Early Awakening ☐ Nightmares ☐ Uses Sleep Aides

Average hours of sleep per night:

MEDICATION HISTORY

Is the client currently taking any medication (prescribed or OTC) or supplements? Yes ☐ No ☐

Name of Medication	***Daily Dosage***	***Prescribing Physician***	***Medication Type******	***Purpose of Medication***	***Medication Status******	***Compliance *****	***Adverse Reactions***	***Length Taken***

*** Medication Type:	None Over the Counter (OTC)	Herbal/Natural	Medical	Psychiatric
*** Medication Status:	Current	Past		
*** Compliance:	Yes	No	Sometimes	Unknown

If medication has been stopped or changed, what is/was the reason?

ALLERGIES

Is there any Medical, Food or Environmental Allergy history to report? Yes ☐ No ☐

Allergy	***Status******	***Treatment Needs***

*** Status: Past Present

Example 2 Outpatient Affiliate Services
COMPREHENSIVE ASSESSMENT

Client Name:	**DOB:**	**Client No:**
Clinician:	**Provider No:**	

SUBSTANCE USE/ABUSE

SUBSTANCE: Source of information: ☐Client report ☐Documentation ☐Other:_____

Please indicate use:	**Past**	**Present**	**Amount**	**Frequency**	**Age of first use**	**Last Use**
Caffeine	☐	☐				
Nicotine	☐	☐				
Alcohol	☐	☐				
Marijuana	☐	☐				
Cocaine	☐	☐				
Amphetamine	☐	☐				
Sedative	☐	☐				
Hallucinogen	☐	☐				
Inhalant	☐	☐				
Opiate	☐	☐				
Prescription meds:	☐	☐				
Over-the-counter:	☐	☐				
Other:	☐	☐				

- What is/was the client's primary substance of choice? _____
- What is/was the client's secondary substance of choice? _____

Comments:

Complete for each significant substance used as indicated above.

	Substance:		***Substance:***		***Substance:***		***Substance:***	
Indicators of Dependence	**Current**	**Past**	**Current**	**Past**	**Current**	**Past**	**Current**	**Past**
☐ Increased Tolerance	☐	☐	☐	☐	☐	☐	☐	☐
☐ Withdrawal Symptoms *(shakes, tremors, vomiting, severe anxiety or panic, intense craving, severe headaches)*	☐	☐	☐	☐	☐	☐	☐	☐
☐ Loss of control of amount	☐	☐	☐	☐	☐	☐	☐	☐
☐ Persistent desire/effort to reduce or control use	☐	☐	☐	☐	☐	☐	☐	☐
☐ Considerable time spent obtaining, using or recovering	☐	☐	☐	☐	☐	☐	☐	☐
☐ Reduced importance of significant activities	☐	☐	☐	☐	☐	☐	☐	☐
☐ Continued use in spite of problems caused by use.	☐	☐	☐	☐	☐	☐	☐	☐
If three of the above indicators are not met, continue by assessing the following:								

Example 2 Outpatient Affiliate Services
COMPREHENSIVE ASSESSMENT

Client Name:	**DOB:**	**Client No:**
Clinician:	**Provider No:**	

Indicators of Substance Abuse *(Only complete when the criteria for dependence have not been met)*	**Current**	**Past**	**Current**	**Past**	**Current**	**Past**	**Current**	**Past**
☐ Recurrent use in physically hazardous situations	☐	☐	☐	☐	☐	☐	☐	☐
☐ Recurrent substance-related legal problems	☐	☐	☐	☐	☐	☐	☐	☐
☐ Continued use despite persistent or recurrent social/ relationship problems	☐	☐	☐	☐	☐	☐	☐	☐
Comment on additional SA concerns:								

Has your use of drugs or alcohol interfered with
Work: Yes ☐ No ☐ School: Yes ☐ No ☐
Relationships: Yes ☐ No ☐ Other: Yes ☐ No ☐
Summarize how it interferes: **(Mandatory)**
Have you ever experienced any of the following:
Blackouts (times when you could not recall what happened while drinking or drugging):
Yes ☐ No ☐ If Yes when & how often:
Seizures: Yes ☐ No ☐ If Yes when & how often:
Has anyone ever asked you to stop drinking or using drugs? Yes ☐ No ☐
Have you ever received treatment for alcohol or drug abuse: Yes ☐ No ☐
(enter facility information on Treatment History page)
Have you ever tried to quit or decrease substance use? Yes ☐ No ☐
If yes, describe support received and barriers to recovery:

During relapse periods, describe what was happening with the client's relationships (spouse, partner, children, parents), work/school, money, mental health issues:
Family history of substance abuse? ☐ Yes ☐ No
If yes, describe (who & how did this affect you):

PATTERN OF CO-OCCURRING SUBSTANCE ABUSE AND MENTAL ISSUES:

Does the client think there is an interaction between his/her mental health issues and substance use?
☐Yes ☐ No ☐ NA If yes, describe:
If any criminal history, does the client feel that his/her mental health and/or substance use influence his/her criminal behavior?
☐Yes ☐ No ☐ NA If yes, describe:
Client Stage of Change: (For Co-occurring Disorders, complete both below)
MH Disorder: ☐Pre-contemplative ☐Contemplative ☐Preparation ☐Action ☐Maintenance
SA Disorder: ☐Pre-contemplative ☐Contemplative ☐Preparation ☐Action ☐Maintenance

Example 2 Outpatient Affiliate Services
COMPREHENSIVE ASSESSMENT

Client Name:	**DOB:**	**Client No:**
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Client meets Level of Care:

☐ **Level I** Outpatient	☐ **Level II** IOP or Partial Hospitalization Program	☐ **Level III. 3, 5, 7** Clinically Managed or Medically Monitored Inpatient Tx or detox	☐ **Level IV** Medically Managed Inpatient Tx

Child Screening (under 12)
Do you wish that someone in your family would stop drinking beer or wine or using drugs? Yes ☐ No ☐
Do you ever worry about the ways that people in your family behave when they use alcohol or drugs? Yes ☐ No ☐
Have you ever taken a drink of beer or wine, or used a medicine or other pill or substance that made you feel different than normal? Yes ☐ No ☐
Have you ever taken medicine that didn't belong to you? Yes ☐ No ☐
Have you ever smoked a cigarette? Yes ☐ No ☐

FAMILY HISTORY

Pertinent family history:
Identify family activities/interests:
Describe your parenting methods: (supervision, discipline): ☐*N/A*
Identify family supports:

Other Family Concerns

Alcohol Abuse: Yes ☐ No ☐ If Yes, describe:
Drug Abuse: Yes ☐ No ☐ If Yes, describe:
Domestic Violence/Abuse: Yes ☐ No ☐ If Yes, describe:
Financial Concerns: Yes ☐ No ☐ If Yes, describe:
Legal Issues: Yes ☐ No ☐ If Yes, Who: What:
Military Service: Yes ☐ No ☐ If Yes, describe:
Mental Health Issues: Yes ☐ No ☐ If Yes, describe:
If Yes, were medications used to treat the illness:
Significant Losses: Yes ☐ No ☐ If Yes, describe:
Addictive behaviors other than substance abuse (gambling, sexual compulsivity, spending etc.)
Yes ☐ No ☐ If Yes, describe:
Trauma: Yes ☐ No ☐ If Yes, describe:
Health Concerns for Family Members:
Yes ☐ No ☐ If Yes: Who: What:

MENTAL STATUS

Orientation: ☐ x3 ☐ Not to Person ☐ Not to Place ☐ Not to Time

Dress: ☐ Appropriate ☐ Inappropriate ☐ Unkempt ☐ Other

Appearance: ☐ As Stated Age ☐ Younger ☐ Older ☐ Other

Example 2 Outpatient Affiliate Services
COMPREHENSIVE ASSESSMENT

Client Name:	**DOB:**	**Client No:**
Clinician:	**Provider No:**	

Manner: ☐ Cooperative ☐ Uncooperative ☐ Guarded ☐ Agitated ☐ Withdrawn ☐ Combative ☐ Other

Attention: ☐ Attentive ☐ Distractible ☐ Confused ☐ Hyperactive ☐ Selective ☐ Short Attention Span ☐ Other

Eye Contact: ☐ Good ☐ Fair ☐ Poor

Speech: ☐ Slow ☐ Normal ☐ Rapid ☐ Pressured ☐ Mute/Absent ☐ Loud ☐ Mumbled ☐ Soft

Mood ☐ Happy ☐ High Energy ☐ Elated ☐ Stable ☐ Fearful ☐ Anxious ☐ Irritable ☐ Angry ☐ Hopeless ☐ Depressed ☐ Other ☐ Low Energy

Affect: ☐ Appropriate ☐ Inappropriate ☐ Restrictive ☐ Labile ☐ Blunted ☐ Flat ☐ Panic ☐ Anxious ☐ Fearful ☐ Congruent w/Mood ☐ Incongruent w/Mood

Motor / Activity Level: ☐ Age-appropriate ☐ Slow ☐ Passive ☐ Tics ☐ Restless ☐ Combative ☐ Silly ☐ Other

Dangerousness: ☐ Suicidal Ideation with ☐ Intent ☐ Plan ☐ Hx of Attempts
☐ Homicidal Ideation with ☐ Intent ☐ Plan ☐ Hx. of Assault
☐ Access to Intended Victim ☐ Yes ☐ No
☐ Access to Means (specify –guns, pills, etc.) ☐ Yes ☐ No
☐ Fire-setting ☐ Animal Abuse ☐ Cutting Behavior
☐ None

Further information regarding dangerousness:

Judgment: ☐ Age-Appropriate ☐ Impaired ☐ Impulsive

Apparent Intellectual Level: ☐ Age-Appropriate ☐ Possible Impairment

Memory: ☐ Intact ☐ Impaired ☐ Remote ☐ Recent

Insight: ☐ Age-Appropriate ☐ Partial ☐ Absent

Thought Content: ☐ Age-Appropriate ☐ Delusions (type)

Example 2 Outpatient Affiliate Services
COMPREHENSIVE ASSESSMENT

Client Name:	**DOB:**	**Client No:**
Clinician:	**Provider No:**	

Thought Process:
☐ Normal ☐ Concrete ☐ Logical
☐ Relevant ☐ Goal-Directed ☐ Tangential
☐ Abstract ☐ Circumstantial ☐ Racing
☐ Looseness ☐ Impaired Concentration
☐ Paranoid ☐ Other

Impulse Control: ☐ Good ☐ Average ☐ Limited ☐ Poor

Perceptual Distortions: ☐ Denies
Delusions: ☐ Persecutory ☐ Grandiose ☐ Other
Hallucinations: ☐ Visual ☐ Auditory ☐ Tactile ☐ Olfactory ☐ Command

Service Recommendations:
☐ Outpatient Mental Health Treatment ☐ Outpatient Substance Abuse Treatment
☐ Outpatient Co-Occurring Disorders Treatment ☐ Outpatient Medication Management
☐ Referral to other agency: name agency & service recommended:

Potential Need for Crisis Intervention Services: ☐ High ☐ Medium ☐ Low
Describe:

SUMMARY:
Brief clinical formulations/summary to include the following: *(Presenting Problems, Presenting Symptoms, Functional Status, Potential Barriers to Treatment, Client's strengths and supports, Co-occurring issues, Treatment History and Statement of medical necessity/LOC for Recommendations):*

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COMPREHENSIVE ASSESSMENT

Client Name:	**DOB:**	**Client No:**
Clinician:	**Provider No:**	

DIAGNOSIS

Diagnosis: (Please use Comment area for any addition information on Dx)

Axis I	DSM Code	Description	Severity	R/O
				Yes No
				Yes No

Axis II	DSM Code	Description	Severity	R/O
				Yes No
				Yes No

Axis III *Health concerns*	ICD 9 Code (if known)	Description	Severity	Diagnosis given by:

Axis IV	Category	Specific area of difficulty

Axis V	GAF Score	Type

_____ _____

Staff Signature & credentials Date

_____

Staff Name (Please Print)