**Provider Record #:**

**Comprehensive Clinical Assessment**

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| **Provider Agency:** | | | | | **Phone Number of Evaluating Clinician:** | | |
| **Name/Credentials of Clinician:** | | | | |
| **Name of Consumer**: | | | | | | | Record #: |
| Age: | Ethnicity: | | | Marital Status: | | | |
| DOB: | | | Medicaid Number: | | Receives SSI:  Yes NO | | |
| Address:  Phone:       Resides with: | | | | | | | |
| **Housing Stability**:  Stable Unstable Homeless Housing Unsafe History of Instability | | | | | | | |
| **Type of Housing:** Private residence  Group Home | | | | | | | |
| **Persons present at assessment**: | | | | | | | |
| **Legal Guardian/Custodian:**  Participated in assessment? NO YES  Address:  Home Phone:       Cell Phone:  Results of Assessment Discussed? | | | | | | | |
| **Referred by**: | | | | | | | |
| **Course of Illness/Concerns:**  Description of Presenting Problem:  Onset:  Triggers:  Intensity:  Frequency:  Associated Symptoms:  Duration of symptoms:  Other info: | | | | | | | |
| **Chronological General Health/Behavioral History (**include MH/SA/IDD)  Symptoms:  Treatment:  Treatment Response:  Attitudes about treatment over time that may contribute/inhibit recovery: | | | | | | | |
| **History of Mental Health/Substance Abuse Treatment** (include inpatient and outpatient TX and dates): | | | | | | | |
| Date | | Provider/Type | | | | Outcome | |
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| **Review of Relevant Dimensions:**  **Familial**(include any MH/SA history; immediate and prior family make-up):  Include Strengths:  Challenges:  Protective Factors:  **Social** :  Include Strengths:  Challenges:  Protective Factors:  **Psychological** :  Include Strengths:  Challenges:  Protective Factors:  **Biological** :  Include Strengths:  Challenges:  Protective Factors:  **Environmental** :  Include Strengths:  Challenges:  Protective Factors: | | | | | | | |
| **Information About Environmental and Psychosocial Factors Potentially Contributing to Functional Status:**  Housing:  Legal:  Financial:  Nutrition:  Sleep: | | | | | | | |
| **Marital Status:** | | | | | | | |
| **Military Status:** | | | | | | | |
| **Informal Supports**: | | | | | | | |
| **Recovery Environment/Barriers to Treatment**: (include problems, risk of harm, functional status, etc.): | | | | | | | |
| **History of Traumatic Events** (consider neglect/abuse, significant losses, domestic violence, exploitation):  History of Concussion or Traumatic Brain Injury | | | | | | | |
| **Cultural circumstances that may affect treatment**? | | | | | | | |
| **DSS and/or Legal History** (arrests/probation/parole – include name of probation/parole officer and telephone #): | | | | | | | |
| **Educational History** (Current school, grade level completed, any school difficulties or special programs attended): | | | | | | | |
| **Learning Disabilities**: | | | | | | | |
| **Developmental History**  Was the client a result of normal gestation?  Were there any complications with birth?  Was there maternal alcohol, illicit substances or other risk exposure during pregnancy?  Did the client meet developmental milestones on time?  Did the client engage in age appropriate social interactions?  Developmental History review of  Strengths:  Challenges:  Protective Factors: | | | | | | | |
| **Adaptive Abilities (please indicate any concerns or no known issue after each domain, or assessment needed)**  Self Care:  Language:  Learning:  Mobility:  Self Direction:  Capacity for Independent Living: | | | | | | | |
| **Vocational History** (include current employment, vocational training): | | | | | | | |
| **Co-Morbidity** (medical and/or psychiatric): | | | | | | | |
| **Medications** (physical and psychiatric):   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Name | Dosage | Prescribing Doctor | Status | Effectiveness/Side effects | |  |  |  | Current History |  | |  |  |  | Current History |  | |  |  |  | Current History |  | |  |  |  | Current History |  | |  |  |  | Current History |  | |  |  |  | Current History |  | | | | | | | | |
| **Alternative/Natural/Herbal Medications**: | | | | | | | |
| **Over the Counter Medications (current**): | | | | | | | |
| **Allergies or adverse reactions:**  No known allergies | | | | | | | |
| **Recovery Environment/Barriers to Treatment**: (include problems, risk of harm, functional status, etc.): | | | | | | | |
| **Integrated Care Activities (To be completed by Health Care Professional or review of medical record as available)- Recommended** | | | | | | | |
| **Name/Number of Primary Physician**:  Last Physical Examination:  Height:  Weight:  BMI: | | | | | | | |
| **Coordination with Primary Care Physician** (as evidenced by):  medication reconciliation  coordination of PCP visit  review of physical symptoms  monitoring of physical s symptoms | | | | | | | |

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| **Mental Status Assessment** |
| Appearance:  Unremarkable  Unkempt  Atypical Clothing |
| Orientation:  Person  Place  Date  Situation |
| Insight: Poor Average Good |
| Estimate of Intellectual Capacity:  Below Average  Average  Above Average |
| Judgment: Poor Average Good |
| Memory: Short Term:  Impaired Not Impaired  Long Term: Impaired Not Impaired |
| Motor Activity: Unremarkable Restless Withdrawn |
| Speech: Unremarkable Pressured Halting Nonverbal Excessive  Inarticulate Loud Soft |
| Mood & Affect: Unremarkable Anxious Depressed Sad  Hopeless/Helpless Crying Angry Guarded  Hostile Elevated Liable Blunted  Dull Flat Silly |
| Behavior: Unremarkable  DEPRESSION MANIA ANXIETY  Decreased Pleasure Inflated Self-Esteem Agitated  Sleep + or - Talkative, Pressured Speech Panic Attacks  Appetite + or - Agitated Restless  Weight + or - Pleasure-Seeking Fatigue  Isolation Racing Thoughts Poor Concentration  Poor Concentration Muscle Tension  Excessive Guilt  Fatigue  OTHER:  Impulsive Compulsive Aggressive Sexualized Behavior: Aggression, Compulsion  Oppositional Threatening Self-Injurious Eating issues: Binge/Purge, Weight Concerns |
| Thought Content: Unremarkable Delusional Ideas of Reference Loose Association  Obsessions Phobias Thought Insertion Blocking |
| Suicidal: Ideation Gesture Plan History None |
| Homicidal: Ideation Intent Plan None |
| Description of SI/HI Ideation and protective measures taken: |
| Hallucinations: Auditory Command Olfactory Tactile Visual None |
| Mental Activity: Unremarkable Confused Flight of Ideas  Grandiose Paranoid Dissociative  Tangential Circumstantial Disorganization |

**Substance Abuse** ❑NONE

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| Name of Substance | Age of First Use | Route of Use | Frequency of Use | Average per Use | Last Use |
| Alcohol |  | 1. Oral  2. Smoke  3. Inhale  4. Inject  5. Other |  |  |  |
| Marijuana |  | 1. Oral  2. Smoke  3. Inhale  4. Inject  5. Other |  |  |  |
| Cocaine |  | 1. Oral  2. Smoke  3. Inhale  4. Inject  5. Other |  |  |  |
| Opiates (heroine, codeine, etc.) |  | 1. Oral  2. Smoke  3. Inhale  4. Inject  5. Other |  |  |  |
| Prescription pills |  | 1. Oral  2. Smoke  3. Inhale  4. Inject  5. Other |  |  |  |
| Hallucinogens |  | 1. Oral  2. Smoke  3. Inhale  4. Inject  5. Other |  |  |  |
| Other (methamphetamines, club drugs, inhalants) |  | 1. Oral  2. Smoke  3. Inhale  4. Inject  5. Other |  |  |  |
| Consequences from use: | | | | | |
| When you use alcohol/drugs do you use until you get….  High Intoxicated Pass Out | | | | | |
| Have you ever tried to quit using? YES NO If YES, for how long?  What did you do?       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Has your drinking/drug use resulted in any of the following  Affected your relationship with significant other/family? YES NO  Increased arguments? YES NO  Separation or divorce due to substance abuse? YES NO  Told by family/friends/work that you drink/use too much? YES NO  Has your level of work decreased? YES NO  Absences from work? YES NO  Loss of job? YES NO  Any health problems (i.e., liver problems, diabetes)? YES NO  If YES, please specify: | | | | | |
| Have you experienced… Blackouts? YES  NO If YES, how often?  Overdoses? YES NO If YES, specify: | | | | | |
| The morning after, do you experience…..  SHAKING SEIZURES NAUSEA HEADACHES  ANXIETY INSOMNIA DEPRESSION SWEATING | | | | | |
| Have you decreased your recreation activities that do not include using alcohol or other drugs? YES NO | | | | | |
| Have you ever been told by a doctor to stop using?  YES NO | | | | | |
| Please check current level of functioning (SU):  Tolerance Withdrawal Increased Use  Unsuccessful efforts to cut down or quit Significant time spent to obtain/recover  Activities decreased | | | | | |

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| **Diagnostic Formulation with analysis and interpretation of assessment information**: (to include MH/SU/IDD disorders, as well as physical health conditions and functional impairments, biosocial factors) | |
| **DSM V Diagnostic Profile** | |
| **DX (primary):** |  |
| **DX (additional):** |  |
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| **Psychosocial Stressors:** |  |
| **LOCUS** |  |
| **CALOCUS** |  |
| **ASAM** |  |
| **SNAP/SIS** |  |
| **Strengths/Protective Factors/Problem Summary: (may be addressed in Diagnostic Formulation above:** | (must address the following: risk of harm, functional status, co-morbidity, recovery environment and treatment and recovery history): |
| **Recommendations based on CCA** | Additional assessment needs?  Recommended Services:  Recommended Supports/Treatments?  Specific Evidence Based Practices? |
| **Recommended Benefit Plan (Target Pop) not required for Medicaid** (represents the client’s principal or primary diagnosis and the main focus of treatment for the current episode of care):  Generic Assessment Payment (GAP)  Child with Developmental Disability (CDSN)  Adult with Mental Illness (AMI)  Adult with Developmental Disability (ADSN)  Adult Substance Use Treatment & Engagement (ASTER)  Adult Substance Use Women (ASWOM)  Adult Substance Use Injecting Drug User/Communicable Disease (ASCDR)  Child with Serious Emotional Disturbance (CMSED)  Child with SA Disorder (CSSAD)  All Military Veterans & Family Members (AMVET) | |

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| **Name/Credential:**  **Signature:**  **Date:** |