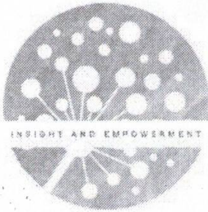

Insight and Empowerment, LLC
1908 Jennie Lee Drive, Idaho Falls, ID 83404
(208) 932-7048 phone
(208) 970-6188 fax
Insightandempowerment@outlook.com

Comprehensive Diagnostic Assessment (Adult)

Name: ______________________________ DOB: ______________________________
Email: ______________________________ Phone: ______________________________

Clinician: ____________________________ Date of Assessment: __________________

Primary Care Physician: ________________________________
Psychiatrist: ____

Do you give permission for ongoing regular updates to be provided to your primary care physician and/or psychiatrist? Yes No

Please indicate the main reasons for seeking consultation and/or treatment or what are the presenting mental health concerns?

____
____
____
____
____

Prior Psychiatrist History/Diagnosis: ____
____
____

What are your treatment goals?

____
____
____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

( ) Depressed Mood
( ) Decreased or Increase Libido
( ) Sleep Disturbances
( ) Loss of Interest
( ) Attention/Concentration
( ) Eating Disturbances
( ) Excessive Guilt/Shame
( ) Suicidal Thoughts
( ) Fatigue
( ) Increased Irritability
( ) Racing Thoughts
( ) Impulsivity
( ) Increase Risky Behavior
( ) Self-Harm
( ) Flashbacks
( ) Obsessive/Compulsive
( ) Excessive Energy
( ) Chronic Pain
( ) Crying Spells
( ) Excessive Worry
( ) Anxiety Attacks
( ) Avoidance
( ) Hallucinations
( ) Suspiciousness

( ) Dissociation ( ) Temper/Anger ( ) Other

Family of Origin

Place of birth/city/state: ______________________

Ethnicity: ______________________________ Language: ____________________________

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? ___________, if yes, please describe:

____

Are you aware of any significant history about your mother's pregnancy or birth with you such as substance use, major complications during delivery, or born prematurely?

____

____

Are your parents currently: Married Divorced, when ___________ Remarried

Were you adopted? ______ Age at the time of adoption: ________

Circumstances:____

Did you ever witness any abuse within your parents' marriage?________________________

Were either of your parents or other close family members imprisoned during your childhood/ youth?

____

____

Were you ever physically or sexually abused, assaulted, or molested?

_____No _____Don't know_____Yes – Please specify when and by whom:

____

____

____

Were your physical needs provided for when you are growing up?

______ No ________Yes _______Other (Explain)

____

____

____

Were your emotional needs provided for growing up?

______ No ________Yes _______Other (Explain)

____

____

Father_________________________________

Deceased, year ____________

What was his level of education?______________________

Occupation?_________________________________

Please describe the relationship with your father:

____
____
____

Mother___________________________________
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 ____ Step-sisters _____Step-brothers _____Deceased, age(s) at death _______________________

How was conflict handled in your household growing up?

____
____

How were emotions viewed and managed in your household growing up?

____
____

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

____

How important to you is spirituality or religion presently? Is there any aspect of spiritualty/ religion you would like to address in therapy? Do you want your spiritual beliefs integrated into our work as a source of strength for you?

____
____

Did you have any other significant adults as you grew up that positively impacted your life?
__________No ___________Yes

Please list names and relationship to you:

____
____

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, incarceration, or any suicides.

Mother:____

Mother's relatives:

____

____

Father:

____

Father's relatives:

____

____

Siblings:

____

____

____

Children:

____

____

____

Family History and Functioning

Circle Current Status: Single Dating Exclusively Married Remarried Separated Divorced Widowed Living Together

Sexual Orientation: ______________________________

Gender Identity: ________________________________

Marital history: Age Year Duration # Children

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)

Marital/Partner conflicts: ____

Current Household Members:

Name Age Relationship

____
____
____
____
____
____
____

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

____
____

Is there a custody/visitation order? If yes, please explain: ____________________________

____

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 would you describe your overall health? ______________________________

Medical doctor(s) / Specialists:

____

____

Date of Last Physical or Wellness Exam: ______________________________

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

____

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 Diarrhea

Other (please describe):

____

Have you had any of the following?

	Yes/No	What	When
Contagious or Infectious Diseases			
Disabilities or Handicaps			

Allergies/FoodAllergies______________________________

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			

Do you regularly engage in any health promoting activities? Relaxation/ Sleep/ Exercise?

____

____

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____________________

Supplements ____

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

Can you self-administer your medications? _____Yes _____No

Medication Compliance:

____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? ______Yes _______No

Please list medications:

____

____

____

____

Caffeine: ____

Substance Use/ Abuse

No Use__________________

	Age of 1st Use	Frequency	Amount	Last Use
Nicotine:				
Vaping:				
Alcohol:				
Marijuana:				
Amphetamines:				
Hallucinogens:				
Cocaine/Crack:				
Heroin:				
Prescription Meds:				
Other:				

Behavioral Health Treatment History

	Service Provider	When / How often?	Was it helpful? Please explain
Counseling			
In-Patient Psychiatric Center			
Case Management			
Medication Management			
CBRS / PSR			
Addictions Treatment			
Developmental Services			
Occupational Therapy			
Speech Therapy			
Physical Therapy			
Personal Care Services			
Home Health Provider			

If you have been to therapy before what as your experience? What did your therapist do that you wished was on differently? What did your therapist do that was beneficial/ helpful?

____
____
____
____

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, extra-curricular activities etc)?

____
____

Do you have a: Social Security card _____Yes _____No
Driver's License _____Yes _____No

Vocational/Educational History and Functioning

What is your highest level of education? _____________
What is your partner's highest level of education? _____________
Have you ever completed any vocational training? ______Yes _____No

Please describe how you did in elementary school:
Academically__________________
Behaviorally__________________
Socially______________________

Please describe how you did in junior high/high school:
Academically__________________
Behaviorally__________________
Socially______________________

If you had any difficulty in school please explain:

____

____

Were you in a specialized classroom setting or receive special education? _____Yes_____No
Were you ever on an Individual Education Plan (IEP) or a 504plan:

____

Do you currently have educational goals? _____Yes _____No

____

Employment
Are you currently employed? ______Yes _____No
Job Title/description___________________
How long have you been at this job? ___________________months/years
Are you satisfied with the job? _____ Yes ______ No
How many hours per week do you work? ____________________________

Work History:
Job Length of time Reason for leaving

____

____

____

____

Do you currently have employment goals? _____Yes _____No

____

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 do you like to do for fun?

____

____

What are your talents and/or social strengths?

____

____

Financial History and Functioning

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

____

____

Sources of Income: ____

Any History of Financial difficulty/Credit Concerns:

____

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/evictions? ____No ___Yes-please explain____
Is there any risk of homelessness? ____No ____Yes-please explain____

Signatures

Responsible party completing this form: ______________________________
Relationship to Client: ______________________________

Signature: ______________________________
Date: ____________________

* Medicaid only

ALERT®

Wellness Assessment - Adult

Completing this brief questionnaire will help us provide services that meet your needs. Answer each question as best you can and then review your responses with your clinician. Please shade circles like this ●

Client Last Name ______ , First Name ______ Date of Birth: (mm/dd/yy) __ / __ / __

Subscriber ID ______ Authorization # ______

Clinician Last Name ______ , First Name ______ Today's Date: (mm/dd/yy) __ / __ / __

Clinician ID/Tax ID ______ Clinician Phone ___ ___ - ____ State __ *MRef* ○

Visit #: ○ 1 or 2 ○ 3 to 5 ○ Other

For questions 1-16, please think about your experience in the past week.

How much did the following problems bother you?	*Not at All*	*A Little*	*Somewhat*	*A Lot*
1. Nervousness or shakiness	○	○	○	○
2. Feeling sad or blue	○	○	○	○
3. Feeling hopeless about the future	○	○	○	○
4. Feeling everything is an effort	○	○	○	○
5. Feeling no interest in things	○	○	○	○
6. Your heart pounding or racing	○	○	○	○
7. Trouble sleeping	○	○	○	○
8. Feeling fearful or afraid	○	○	○	○
9. Difficulty at home	○	○	○	○
10. Difficulty socially	○	○	○	○
11. Difficulty at work or school	○	○	○	○

How much do you agree with the following?	*Strongly Agree*	*Agree*	*Disagree*	*Strongly Disagree*
12. I feel good about myself	○	○	○	○
13. I can deal with my problems	○	○	○	○
14. I am able to accomplish the things I want	○	○	○	○
15. I have friends or family that I can count on for help	○	○	○	○

16. In the past week, approximately how many drinks of alcohol did you have? __ Drinks

Please answer the following questions only if this is your first time completing this questionnaire.

17. In general, would you say your health is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor
18. Please indicate if you have a serious or chronic medical condition:
    ○ Asthma ○ Diabetes ○ Heart Disease ○ Back Pain or Other Chronic Pain ○ Other Condition
19. In the past 6 months, how many times did you visit a medical doctor? ○ None ○ 1 ○ 2-3 ○ 4-5 ○ 6+
20. In the past month, how many days were you unable to work because of your physical or mental health? *(answer only if employed)* __ Days
21. In the past month, how many days were you able to work but had to cut back on how much you got done because of your physical or mental health? *(answer only if employed)* __ Days
22. In the past month have you ever felt you ought to cut down on your drinking or drug use? ○ Yes ○ No
23. In the past month have you ever felt annoyed by people criticizing your drinking or drug use? ○ Yes ○ No
24. In the past month have you felt bad or guilty about your drinking or drug use? ○ Yes ○ No

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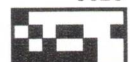

Clinician: Please fax to (800) 985-6894