FREEDOM Behavioral Health Services
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COMPREHENSIVE CLINICAL ASSESSMENT & INTAKE – Adult

Name: _____ DOB: _____ Date: _____

Medicaid # : _____ County: _____ Chart #: _____

Gender: __M __ F Ethnicity: __ White; __ Black; __ Biracial; __ Hispanic; __ Asian; __ Other

Sexual Orientation: _____ Sexual Identity: _____

Individual(s) participating in assessment: _____

Current Treatment Focus

What brings you to our office today? _____

_____

What services are you seeking:

___ Individual Therapy ___ Psychological/Educational Testing

___ Family Therapy ___ Psychiatric Services or Medication Management

___ Other (explain): _____

I/we would like to address the following: (check all that apply)

___ My mood or emotional state (depression, anxiety, anger, etc)

___ My behavior / choices ___ Sleep, eating, or physical concerns

___ My cognitive / mental functioning ___ Relationships with family or peers

___ School / academic performance ___ Divorce

___ Parenting ___ Grief / Loss

___ Communication skills ___ Coping skills

___ Support systems ___ Addictive behaviors

___ Anger management ___ Social functioning

___ Abuse, neglect, or trauma history ___ Other: _____

Employment/Education

Employment Status ___ Employed ___ At-Home Parent ___ Student

___ Unemployed ___ Disabled ___ Military

Employer: _____ ___ Full-Time ___ Part-Time

Job Title / Occupation: _____

Highest level of education completed: _____

Schools attended Dates Degrees/Diplomas earned

_____
_____
_____
_____

If student, list School _____
Course of study _____

Social / Household Information

Current status of significant relationship:

___ Single ___ Separated ___ Living together ___ Dating ___ Other
___ Married ___ Divorced ___ Life partner ___ Widowed

Number of marriages: ___ Dates: _____

Please list all members of your household:

Name	Relationship to you	Gender	Age
_____	_____	_____	___
_____	_____	_____	___
_____	_____	_____	___
_____	_____	_____	___
_____	_____	_____	___
_____	_____	_____	___
_____	_____	_____	___

Family of origin: Raised by: _____
Persons in household: _____
Number of siblings: _____ Place in birth order: _____

List significant relationships in family of origin (parents, siblings, close grandparents, caregivers, etc)

Name	Relationship	Still living?
_____	_____	___ Yes ___ No
_____	_____	___ Yes ___ No

Religious preference: _____
Involved in local church? ___ No ___ Yes: _____
Family values and important beliefs _____
Personal values and important beliefs _____
Hobbies and community activities _____

Medical History Have you experienced any of the following? (please explain)

__ Childhood trauma (Explain) _____
__Witness/experience domestic violence _____
__Witness/experience alcohol/substance abuse _____
__ Witness/experience physical abuse_____
__ Witness/experience sexual abuse _____

__ Witness/experience emotional abuse _____
__ Witness/experience verbal abuse _____

___ Severe illness, injury, surgery _____
___ Allergies (foods, drugs, substances) _____
___ Chronic medical problems _____
__ Significant family medical history _____
__ Significant family mental health history _____
__ Prior mental health diagnosis _____
__ Prior developmental diagnosis _____

Pregnancies

Number of pregnancies ____ Number of live births____ Number of terminations ____

Health issues/challenges during pregnancy_____

Health issues/challenges in conceiving_____

Developmental History

Were you: ___ Planned ___ Breast Fed ___ In Day Care
___ Unplanned ___ Bottle Fed ___ Kept at Home
___ Full term ___ Premature: how many weeks?_____
___ Complications in pregnancy/delivery? _____
___ Exposed to medications/drugs/alcohol in the womb
___ Difficult or high-risk pregnancy or delivery

At what age did you: Talk _____ Walk _____ Potty Train _____

Describe any developmental delays: _____
_____

Primary care physician: _____

Current medications Name Dosage

_____
_____
_____

Past medications Name Dosage Time period used Reason for termination

_____
_____
_____
_____

Substance Use History

Age at first use	Substance	Frequency of Use (# of days per week, month, year, etc.)	Amount per Use (# of drinks/hits/pills, $ amount, etc.)	When was your last use of this substance?
	Alcohol *(Beer, Wine, Liquor)*			
	Marijuana *(Cannabis, "Weed," "Pot")*			
	Cocaine *(Including Crack)*			
	Other Stimulants *(Amphetamines, Methamphetamines, Adderral, Ritalin, etc.)*			
	Heroin			
	Other Opiates *(Oxycodone, Hydrocodone, Methadone, Morphine, Codeine, Buprenorphine, etc.)*			
	Depressants/Sedatives *(Benzos, xanax, barbiturates,*			
	Hallucinogens *(PCP, LSD, "Shrooms," Ecstacy, Ketamine, etc.)*			
	Inhalants *("Whippets," paint thinner, glue, volatile solvents, etc.)*			
	Nicotine/Tobacco			
	Other:			

Have you ever had treatment or "classes" for drug or alcohol abuse or as a result of a DUI or drug related offense? Yes No

If Yes, Please complete the following:

Where? (Name of Facility/Location)	When? (Year/Month/Dates of Attendance)	Did you complete successfully?
1.		
2.		
3.		
4.		

5.		

Legal Involvement

Arrest history:

Dates Charges Convictions/Sentences

_____

_____

_____

_____

_____

_____

Treatment History

Please list all mental health treatment, substance abuse treatment or hospitalizations

Facility/Therapist	Purpose	Current	Past
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Response to Treatment: _____

Other agency services/relationships in the last six months:

___ Child Protective Services ___ Justice System ___ Other: _____

---___ Other DSS Services ___ Disability/Social Security ___ Other: _____

___ Occupational Therapy ___ Speech Therapy

Adult Assessment: Please check all of the following that currently apply.

Please indicate past concerns with the letter "P".

____ Anxiety	____ Hurts others	____ Hyperactive
____ Depressed mood	____ Lying	____ Attention problems
____ Panic attacks	____ Stealing	____ Worries all the time
____ Racing thoughts or speech	____ Destroying property	____ Impulsive
____ Obsessions/Compulsions	____ Defiance	____ Low self-esteem
____ Excessive fears or phobias	____ Blames others for mistakes	____ Suicidal thoughts
____ Dissociative states	____ Angry/resentful	____ Suicide attempts
____ Touchy/irritable	____ Lack of conscience	____ Self-mutilation
____ Nightmares	____ Bizarre behavior	____ Sexually active / acting out
____ Sleep problems	____ Clingy	____ Difficulty with change
____ Bedwetting or incontinence	____ Separation anxiety	____ Needs predictability/routine
____ Tantrums or "meltdowns"	____ Seems to overreact	____ Unexplainable mood shifts
____ Difficult to parent	____ Parent feels overwhelmed	____ Running away

____ Conflicting parenting styles	____ Argues with adults	____ Deliberately annoys people
____ Parental marital problems	____ Doesn't seem to listen	____ Takes excessive risks
____ Adopted or in foster care	____ Seems adultlike or older	____ Seems younger than age
____ Lots of physical complaints	____ Life has been unstable	____ Life changes pending

Please use the space below to tell us anything else you would like for us to know in order to best help you:

_____

_____

_____

_____

_____

How did you hear about us? ___ Yellow Pages ___ Attorney: _____

___ Friend/Client ___ Doctor: _____

___ Internet ___ Other agency: _____

___ Court-ordered ___ Other: _____

To Be Completed By Therapist

Client strengths:

Client risks:

Client needs:

Client preferences:

Dx:

Based on the assessment, the recommended treatment is:

□ None	□ Housing Referral	□ Community Resources
□ Educational Services	□ Financial	□ Legal
□ Medical/Physical	□ Substance Abuse Treatment	□ Twelve-step Program
□ Psychiatric Assessment	□ Psychological Testing	□ Social Services
□ Inpatient MH Treatment	□ Outpatient MH Treatment	□ Parenting

□ Other: _____

I certify that the information provided above is correct to the best of my knowledge, and that I am authorized to provide such information on behalf of this client.

_____ _____

Signature of Legally Responsible Person Date

_____ _____

Signature of Therapist Completing Assessment Date