Client Assessment

Name: ______________________________ Client ID: __________ Date: ____________

Clinician: ____________________________

PRESENTING CONCERN: ☐ Mental health ☐ Substance abuse ☐ Co-occurrence ☐ Co-Occurring Disorders Court

What does the client say is the reason(s) for seeking services from C&C? ______________________________

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CURRENT MENTAL STATUS: (Client report, family report, provider report, observed by worker)

Eye Contact:	☐ Normal	☐ Avoided	☐ Scanning	
	☐ Staring	☐ Other		
Motor Activity:	☐ Normal	☐ Agitated	☐ Restless	
	☐ Lethargic	☐ Tardif	☐ Altered gait	
	☐ Tics	☐ Other		
Attitude:	☐ Cooperative	☐ Passive	☐ Apathetic	
	☐ Uncooperative	☐ Combative	☐ Other	
Orientation:	☐ Person	☐ Time	☐ Situation	
	☐ Place			
Mood:	☐ Depression	☐ Irritability	☐ Sadness	
	☐ Anxiety	☐ Anger	☐ Fear	
	☐ Panic Attacks	☐ Apathy		
Appearance (dress, hygiene, posture, self care):				
Sleep Disturbance: ☐ Y ☐ N				
Appetite Disturbance: ☐ Y ☐ N				
Energy Level:	☐ Normal	☐ Increased	☐ Decreased	
Observable Affect:	☐ Full Range	☐ Flat	☐ Euphoric	
	☐ Blunted	☐ Labile	☐ Restricted	
	☐ Tearful	☐ Other		
Affect Appropriate to Situation: ☐ Y ☐ N				
Hallucinations:	☐ Command	☐ Auditory	☐ Gustatory	
☐ Y ☐ N	☐ Visual	☐ Olfactory	☐ Tactile	
Delusions:	☐ Bizarre	☐ Grandeur	☐ Religious	
☐ Y ☐ N	☐ Non-Bizarre	☐ Paranoid	☐ Persecutory	
	☐ Somatic			
Thought Disturbance:	☐ Irrational	☐ Loose Association	☐ Tangential	
☐ Y ☐ N	☐ Distracted	☐ Perseveration	☐ Blocking	
	☐ Circumstantial	☐ Flight of ideas		
Memory Impairment: ☐ Y ☐ N				
Difficulty Concentrating: ☐ Y ☐ N				

Name: ____ **Client ID**: _____________

Speech:	☐ Normal	☐ Variable	☐ Mute	
	☐ Loud	☐ Mumble	☐ Slurred	
	☐ Soft	☐ Slow	☐ Pressured	
	☐ Incoherent			

Obsessions: ☐ Y ☐ N

Compulsions: ☐ Y ☐ N

Insight:	☐ Excellent	☐ Good	☐ Poor	☐ Severe
Judgment:	☐ Excellent	☐ Good	☐ Poor	☐ Severe
Impulse Control:	☐ Excellent	☐ Good	☐ Poor	☐ Severe
Decision Making:	☐ Excellent	☐ Good	☐ Poor	☐ Severe
Intellectual Ability:	☐ Mild Impairment	☐ Moderate Impairment	☐ Severe Impairment	

Meeting basic needs/keep self safe: ☐Y ☐N ☐ DHHS report Describe:_______________________________

History of trauma, physical abuse or sexual abuse: ☐Y ☐N Describe:_______________________________

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Family history of mental illness? ☐Y ☐N Describe: ____

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SUBSTANCE USE/ABUSE: 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:	☐	☐				
Comment:						

Name: ____ **Client ID**: _____________

- What is the client's primary substance of choice? ____
- What is the client's secondary substance of choice? ____

Complete for each significant substance use indicated above.

	Substance:		***Substance:***		***Substance:***		***Substance:***	
Indicators of Dependence	**Current**	**Past**	**Current**	**Past**	**Current**	**Past**	**Current**	**Past**
☐ Increased Tolerance	☐	☐	☐	☐	☐	☐	☐	☐
☐ Withdrawal Symptoms	☐	☐	☐	☐	☐	☐	☐	☐
☐ 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 criteria are not met, continue by assessing the following:								
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:								

For SA clients, has the client had a physical within the past 30 days? ☐Y ☐N

Any history of attempts to quit Substance Use? ☐Y ☐N ☐ NA If yes, describe, including supports and barriers: ________

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During relapse periods, describe what was happening with the client's relationships (spouse, partner, children, parents), work/school, money, mental health issues: ____

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Family history of substance abuse? ☐Y ☐N *Describe*: ____

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Name: ____________________________ **Client ID**: ____________

PATTERN OF CO-OCCURRENCE:

Does the client think there is an interaction between his/her mental health issues and substance use? ☐Y ☐N ☐ NA

Explain: ____

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If any criminal history, does the client feel that his/her mental health and/or substance use influence his/her criminal behavior? ☐Y ☐N ☐ NA *Explain*: ____________________________

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MEDICAL:

Does client (or parent/guardian) feel any medical condition might be affecting his/her mental health or substance use?

☐Y ☐N *Describe*: ____

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Does the client have any dental concerns? ☐Y ☐N *Explain:*____________________________

Are the client's nutritional needs met? ☐Y ☐N *Comment:* ____________________________

Any physical or environmental barriers to the client participating in his/her treatment? ☐Y ☐N *Explain*: ____________

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CLIENT STRENGTHS/RESOURCES:

What strengths does the client bring to the treatment relationship? ____________________________

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How does the client rate his/her natural support system? ____________________________

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Name: ____ **Client ID**: _____________

TREATMENT FOCUS:

What are the areas that the client would like to address in treatment? ____

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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

Clinical Summary including presenting problem, client's perspective of the problem, treatment direction(s): _____________

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Axis	**Code**	**Description**	
I.			
II.			
III.			
IV.			
V.	GAF	On Admission:	Highest in past year:

Treatment Recommendations: ____

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Clinician's Signature/Credentials: ______________________________________Date: ______________________

Supervisor's Signature/Credentials: _____________________________________Date: ______________________