Eagle Rock Counseling & Psychology Group

COMPREHENSIVE DIAGNOSTIC ASSESSMENT

Client Name:	**DOB:**	**MC/INS #:**
Address:		**Phone:**
Evaluator:		**Date of Assessment:**

Presenting Problem
(Onset duration and frequency of symptoms)

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Family History

☐Parent/Guardian's Home ☐Own Home ☐Foster Care Home ☐Respite Care
☐Homeless living with Friend ☐Homeless in Shelter/No Residence ☐Other

Resident Care/Treatment Facility
☐Hospital ☐Temporary Housing ☐Residential Housing ☐Nursing Home ☐Supportive Living
Identify Facility or Person's Name:

Primary Language: ☐English ☐Spanish ☐Other
Interpretive Services Needed: ☐Yes ☐No ☐Services Declined

Legal Guardian/Custodian Name and Address of Legal Guardian/Custodian Phone No
☐None reported

Primary/Family/Marital/Significant Other Support Systems

Basic Living Skills

Abuse issues/concerns: (past or present)

Trauma concerns: (past or present)

Sexual Behavior:

Social Relationship/Support

Strengths/Capabilities

Friendship/Social/Peer Support Relationships

Leisure Activities/Interest/Hobbies

Community Supports/Self Help Groups

Religion/Spirituality

Cultural/Ethnic Issues/Information/Concerns

Educational/Vocational

Education History (check all that apply) ☐Enrolled	Highest Grade Completed	Post Secondary Compelted

Discuss Problems in school if not addressed in presenting problems:

History of Learning Difficulties

☐None Reported ☐Learning Disability/Type:
☐Mental Retardation
☐Special School Placement: **IEP or 504**
☐Other:

Developmental Issues (physical, psychological, social, Intellectual and academic)**:**

Employment (check all that apply)

☐Disabled ☐Retired ☐Homemaker ☐Student ☐Other:

Not In Labor Force

☐Disabled ☐Retired ☐Homemaker ☐Student ☐Other:

Medical/Mental Health Treatment History

Primary Care Physician (name, phone no)

Current physical and date:

Other Physicians:

Outpatient Mental Health ☐None Reported

Psychiatric Hospitalizations ☐None Reported

Previous Behavioral Health History:

Dates:
Providers:
Interventions:
Responses:

Known Medical Issues:

☐No Issues ☐ Asthma ☐Seizures ☐ Vision Impairment ☐Hearing Impairment ☐Allergies:
☐Other:

Current Medication Information (include meds/dose/Dr.):

Previous Medication History (include meds/dose/Dr.):

Current known contagious diseases or illness: ☐Yes ☐No ☐None Reported
If yes, list:

Pertinent Family Medical/Mental illness history:

Prenatal/Perinatal:

Legal History

(if client is not an adult, discuss family involvement with legal system)

Current Legal Status

☐ None Reported ☐ On Probation ☐Detention ☐ On Parole ☐ Awaiting Charge
☐ AoD Related Legal ☐Court Ordered To Treatment ☐ Other:

Court Involvement (related to child abuse, neglect, or dependency)
☐None Reported
Current: ☐No ☐ Yes Comment:
Past: ☐No ☐Yes Comment:

Adult/Children's Protective Services Involvement **if yes explain and caseworker name**
☐No ☐ Yes

Family History of Legal Issues: ☐Yes ☐No ☐Other:

Alcohol/Drug/Nicotine History

(if client is not an adult, discuss family history if applies)

☐**None Reported**
Illegal drug use/abuse past 12 months? ☐No ☐Yes Prescription drug abuse past 12 months? ☐No ☐Yes
Alcohol abuse past 12 months? ☐No ☐ Yes
Alcohol/drug history: ☐Yes ☐No ☐Other:
Nicotine Use in past 12 months? ☐Yes ☐No ☐None Reported
Nicotine History: ☐Yes ☐No ☐Other:

☐**None Reported**
Family alcohol/drug history: ☐Yes ☐No ☐Other:
Family Nicotine History: ☐Yes ☐No ☐Other:

AoD Treatment History
☐None Reported
Current: ☐OP ☐IOP ☐Residential ☐Other:
Past: ☐OP ☐IOP ☐Residential ☐Hospital ☐Detox ☐Other:
Current or past providers:
Family History if applicable: ☐Yes ☐No ☐Other: