

# Newest Assessment

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## Basic Information

### 1. Reason for Therapy

Please describe what has led you to seek therapy now.

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How long has this been a problem for you and what other help have you had with it?

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How do your current difficulties affect you? (Work, school, family, relationships, personal well-being, etc...)

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What are the major causes of your stress? (Marital / Financial / Career / Family / Health / Unfulfilled expectations, etc)

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How do you cope with stress?

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### 2. Goals

What would you like to gain from therapy now?

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How would things be different if the difficulties were resolved?

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How would you know things were getting better?

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What support do you have in your life (Family / Friends / School / Work / Social activities, etc)?

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How have you been coping with your problems up until now?

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## Personal, Family and Social History

### 3. Family/Developmental History

Tell me about the people in your life growing up

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What was your relationship like with them?

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How would you describe your childhood? Where did you grow up?

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Who would you go to when you were upset or had a problem? How were emotions talked about and dealt with in your home growing up? Give an impression of your home atmosphere (i.e., the home in which you grew up). Were you able to confide in your parents? Did your parents understand you? Who were you closest too growing up? Why them and not the other? What was discipline like?

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### 4. Family History

	Mother	Father	Siblings	Aunts	Uncles	Grandparents
Medical Problems						
Asthma/lung disease						
Cancer						
Cardiovascular disease/symptoms						
Diabetes						
Hypertension						
Seizures/neurological disorders						
Stroke						
Thyroid disease/symptoms						
Mental Health						
ADHD						
Alcohol/substance abuse						
Anxiety						

Bipolar Disorder						
Depression						
Psychiatric hospitalization						
Schizophrenia						
Suicide attempts						

### 5. Relationship History

Are you currently in a relationship? Tell me more about your relationship.

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Describe your relationship history.

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Do you have any children?

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### 6. Social History

\* Generally, do you express your feelings, opinions, and wishes to others in an open, appropriate manner?  
 \* Do you have one or more friends with whom you feel comfortable sharing your most private thoughts and feelings?  
 \* Have there been any major changes in your life or your family? Please describe.  
 \* Who do you turn to for support?

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Please describe your current living situation

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Leisure Activities/Hobbies

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## Psychiatric History

### 7. Previous Therapy

Have you received psychotherapy or counseling in the past? If yes, please list the mental health care providers name/organization and when you saw them.

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In case you have received psychotherapy or counseling in the past, please describe about the problems you were having:

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In case you have received psychotherapy or counseling in the past, please share what you found helpful/unhelpful.

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Have you now or ever struggled with thoughts of wanting to hurt yourself, wishing you were dead, or of hurting others?

Yes  No

Have you now or ever struggled with thoughts of wanting to hurt yourself, wishing you were dead, or of hurting others?

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Have you ever been hospitalized for any psychiatric condition?

Yes  No

If yes, when, where and for what reason(s)?

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**8. Please list any psychiatric medications you have taken now OR in the past**

	Medication	Taking currently or in the past?	Effectiveness (1-5)
1			
2			
3			

## Substance Use History

**9. Substance Use History**

	Age first use	Most recent use
Alcohol		
Cannabis/marijuana		
Cocaine		
Stimulants (crystal, speed, amphetamines, etc.)		
Methamphetamine		
Hallucinogens (LSD, PCP, mushrooms, etc.)		

Opioids (heroin, narcotics, methadone, etc.)		
Sedatives/hypnotics (Valium, Phenobarb, etc.)		
Designer drugs (herbal, Steroids, cough syrup)		
Tobacco/nicotine (smoke, chew, vape)		
Caffeine		

**10. What was the reason for your use?**

- Addicted
- Socialization
- Build confidence
- To cope with my problems
- Escape
- Self-medication
- Suicide/Self-harm attempt
- Other (please describe below)

**11. If any, which have been the consequences of substance abuse in your life? Please use the box below to dissert about such consequences:**

- Arrests
- Assaults
- Binges
- Blackouts
- Hangovers
- Job loss
- Loss of control
- Medical conditions
- Overdose
- Relationship conflicts
- Seizures
- Sleep disturbance
- Suicidal impulse
- Tolerance changes
- Withdrawal symptoms
- Other(s)

**If "other(s)", please specify**

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**12. Has anyone ever complained about your drug use?**

- Yes  No

Who?

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Have you ever received a DUI?

- Yes  No

Who?

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Have you ever had any legal problems related to drug/substance use?

- Yes  No

Explain

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Have you ever been drunk first thing in the morning?

- Yes  No

Have you ever woken up in the morning, after a night of drinking, and found that you could not remember part of the night before?

- Yes  No

Have you ever gone for more than 3 days without using and not suffered any discomfort?

- Yes  No

Can you stop drinking or using drugs without a struggle after you have started drinking or using drugs?

- Yes  No

Did you ever need a drink first thing in the morning, before breakfast, or before eating anything?

Yes  No

Have you had any of the following problems when you stopped or cut down on your drinking? (check the ones that apply)

- Shakes  Being unable to sleep
- Seeing or hearing things that aren't there
- Heavy sweating, heart beating fast  DT's
- Feeling anxious or depressed fits or seizures

Have you ever spent a lot of time obtaining, using or getting over the effects of alcohol/drugs?

Yes  No

Have there been many days when you used much larger amounts of alcohol/drugs than you intended to when you began?

Yes  No

Have you tried to cut down on your alcohol/drugs use but found you couldn't?

Yes  No

Did you ever feel sick because you stopped or cut down on alcohol/drugs?

Yes  No

### 13. Substance Use Narrative

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## Physical Health History

### 14. Current or past history of any of the following?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Sexual functioning difficulties |
| <input type="checkbox"/> High cholesterol     | <input type="checkbox"/> Cancer         | <input type="checkbox"/> Diabetes                        |
| <input type="checkbox"/> Stroke               | <input type="checkbox"/> Allergies      | <input type="checkbox"/> GI problems                     |
| <input type="checkbox"/> Respiratory problems | <input type="checkbox"/> Other          |  |

### 15. Physical health/PCP, and other medical providers (please include all current/within the past 12 months)

	Name	Agency/Name of Clinic	Reason	Apx. date last seen
1				
2				
3				

### 16. Please list any current medications that you are taking, including regular OTC medications, daily vitamins/supplements and any prescribed medications.

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	Dosage	Frequency	Date prescribed/Started
1			
2			
3			

**17. Physical health summary (health history, chronic conditions, physical complaints, that may impact functioning)**

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**18. Advanced directive**

Do you have an advanced directive (AD)?  
 Yes  No

If yes, what kind?  
 Living will  Power of attorney  
 Healthcare proxy  
 Other (describe below)

If no, do you wish to provide one or receive more information?  
 No  
 Yes, I'd like more information  
 Yes, I'd like to provide one

Comments

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**19. Sexual Health**

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## Employment, Living and Financial Functioning

**20. Educational/Employment History**

What was school like for you?

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What is your highest level of education

Did you have any learning difficulties in school?

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If you attended college, did you graduate? If so, what was your degree in?

Have you ever served in the military? If so, what branch? For how long?

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Are you currently employed? If so, where? Do you enjoy your job? Why or why not?

Are you having any problems at work? (Please describe)

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### 21. Educational, Employment and Financial Functioning Narrative

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### 22. Current Living Situation

Current living situation

- Renting  Owns  Living with family
- Living with friend  Homeless  Other (describe)

Satisfied with living environment?

- Yes  No

Comments

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### 23. Financial Situation

How does the client describe their current financial situation?

- No current problems/comfortable
- Substantial debt
- Relationship conflicts over finances
- Impulsive spending  Poverty/below
- Other (describe)

Income sources

- Employment/W2  Self-employment
- Unemployment  SSI  SSDI  Veteran benefits
- SNAP benefits  Family/friends  None

Comments

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### 24. Client Strengths

	Describe
Personal Qualities (ex: open, funny, thoughtful, motivated, loyal, caring, friendly, engaging)	
Living Situation (ex: long-term stable housing, gets along with companions)	
Financial/Employment/Education (ex: graduated HS, graduated college, gainfully employed, attended college)	
Health (ex: exercises regularly, good consistent health, visits provider as needed, follows recommendations)	
Leisure (ex: plays sports, social group, volunteers, has hobbies, meditation/yoga)	

Natural Supports (ex: family, close friends, romantic partners, coworkers)	
Spirituality/Cultural (ex: enjoys religious/spiritual activities, enjoys cultural events)	
Other	

## Problem List

### 25. Problem List

Problem	Problem: May be listed as a diagnosis, illness, social determinant of health, z-code, and/or description of an issue.	Practitioner adding the Problem (and credential)	Date Added	Date Removed	Removed by:

# Functional Impairment Rating Scale

**1. Extremely severe functional impairment, needs pervasive supports**

**2. A little of the time;** severe impairment or problems in functioning; extensive level of continuous paid supports needed

**3. Occasionally;** serious to moderately severe impairment or problems in functioning; moderate level of continuous paid supports needed

**4. Some of the time;** moderate impairment or problems in functioning; low level of continuous paid supports needed

**5. (WNL) A good bit of the time;** mild impairment or problems in functioning; moderate level of intermittent paid supports needed

**6. (WNL) A good bit of the time;** mild impairment or problems in functioning; moderate level of intermittent paid supports needed

**7. (WNL) A good bit of the time;** mild impairment or problems in functioning; moderate level of intermittent paid supports needed

**26. Health Practices:** Rate independent self-care for physical and mental health, including managing moods, medications, illness management

○ 1- No self care; breaks in reality ○ 2- Marked limitations

○ 3- Limited self-care, serious impairments in mood

○ 4- Marginal self-care and compliance with health issues; some difficulty in managing mood

○ 5- Moderately self-sufficient, manages mood, but relies on some assistance

○ 6- Independent self-care; minimal support/assistance needed

○ 7- Optimally independent, makes good healthcare decisions

Communication: Rate ongoing and effective verbal/ nonverbal communication.

○ 1- Not effective, high-risk threats, non-communicative

○ 2- Communication is dysfunctional or antagonistic ○ 3- Limited verbal or non-verbal effectiveness

○ 4- Not clear about problems; marginal effectiveness in communication with others

○ 5- Moderately effective in communicating with others

○ 6- Adequately effective in communicating with others

○ 7- Optimal effectiveness in communicating with others

Safety: Rate maintenance of personal safety, e.g. not suicidal, homicidal, etc.)

○ 1- Unsafe; Imminent danger to self or others; needs or requires pervasive level of continuous supervision

○ 2- Marked limitations in safety around home, community; needs/has extensive level of continuous supervision

○ 3- Makes unsafe decisions; "at risk" e.g., abusive or abused, cognitive limitations, needs supervision

○ 4- Marginally safe, aware and self-protective, benefits from regular assistance or monitoring

○ 5- Moderately safe; good decisions; benefits from routine care-givers e.g., home visits by helping persons

○ 6- Safe decisions; Adequate self-protection with minimal assistance from family, neighbors, friends, and others.

○ 7- Optimally safe; alert; takes care of self with no significant assistance from others.

Managing Time: Rate management of time, self-direction (e.g., a 7 = optimal sleep 7-9 hours average/night)

- 1- High risk; aberrant routines or MIA (missing); No management of time; pervasive direction of others
- 2- Marked limitations in routine time management; needs or receives extensive direction by others
- 3- Limited e.g., poor routine management of meds, sleep, mealtimes; might need/use constant direction
- 4- Marginally effective; disruptions in routines; uses regular direction (e.g., prompts)
- 5- Moderately effective time management; benefits from routine direction of others
- 6- Adequate time management; minimal prompts or reliance on direction of others
- 7- Optimal routines for health and wellness; self-directive in managing sleep, meds, mealtimes

Problem Solving: Rate independent management of problems of daily living.

- 1- No problem solving; pervasive dependence on others to handle daily living problems; threat of health endangering threat; no participation in problem solving.
- 2- Very severe limitations in problem solving, often involving constant supervision; minimal participation in problem solving.
- 3- Serious limitations in meeting day-to-day needs, problem solving; often needs or relies on assistance; limited participation in treatment-related problem solving.
- 4- Marginally self-sufficient in day to day problem solving; often needs or uses regular assistance, participates in treatment-related problem solving.
- 5- Moderately self-sufficient in problem solving with routine assistance from others; compliant in treatment-related decision making.
- 6- Adequately self-sufficient in day-to-day problem solving with minimal assistance from others.
- 7- Optimal and independent problem solving with no significant assistance from others.

Family Relationships: Rate family interactions (separate from friends) and quality of family relationship.

- 1- Dysfunctional relationships or deviant behaviors often leading to physical aggression or severe abuse, withdrawn, often rejected by others.
- 2- Very dysfunctional relationships within family (e.g., total withdrawal, unwanted dependency, destructive verbal or physical communication).
- 3- Dysfunctional family relationships ; often no positive communication or participation with family or significant others.
- 4- Marginally functional family relationships (e.g., relationships are often stressed or infrequent, superficial, unreliable).
- 5- Moderately effective continuing and close relationship with at least one family member or significant other.
- 6- Adequate personal relationship with one or more family members or with significant other.
- 7- Positive relationship with family/significant others; assertively contributes to these relationships.

Alcohol/Drug Use: Rate self-control with addictive drugs including cigarettes; or maintenance of alcohol/drug abstinence

- 1- Current abuse or dependence leading to imminent health and safety threats - pervasive substance abuse, no self-control diagnosed; accepts or denies pervasive substance abuse; currently evidences no self-control or safe use; imminent health and safety threats.
- 2- Current abuse or dependence; may deny substance abuse problem, does not participate in treatment; extremely limited self-control for abstinence or safe use.
- 3- Current abuse or dependence, acknowledges serious substance abuse problem but shows limited self-control, struggles with treatment plan.
- 4- Current moderate problem with use, dependence, compliant with treatment, moderate success over alcohol, cigarettes and drugs.
- 5- No current use but recent history of abuse/dependence; adequately aware of risks and seeking help, information, support, treatment to continuously sustain success.
- 6- Safe Use, not smoking or Abstinent with self help groups. May have had a history of substance abuse related issue.
- 7- No history of substance abuse-related problems and optimal self control with substances

Leisure: Rate independent participation in leisure activities.

- 1- Dependent - No independent participation in leisure activities.
- 2- Dependent - min. participation in leisure of any kind without help.
- 3- Limited interests or independent participation in leisure activities.
- 4- Marginally independent leisure activity participation.
- 5- Moderately independent leisure activity participation.
- 6- Adequately independent in at least one leisure activity.
- 7- Optimal interests; independence with 2 or more leisure activities.

Social Network: Rate quality of interactions with immediate social network (e.g. close friends not family)

- 1- Extremely dysfunctional in relationships (e.g., often imminent physical aggression, involves police or severely withdrawn)
- 2- Marked limitations in social network relationships (e.g., excessive dependency or destructive behaviors)
- 3- Limited interpersonally, often no significant friendships, socially isolated or avoids and withdraws.
- 4- Marginal functioning with others (e.g., friendships are often minimal, unreliable, strained).
- 5- Moderately effective continuing and close relationship with at least one friend.
- 6- Adequate interpersonal relationships with one or more friends.
- 7- Positive relationship with one or more friends; optimally independent with assertively contributions.

Coping skills: Rate knowledge and effective use of coping mechanisms.

- 1- Pervasive stresses, no mindful use of coping skills approach health endangering threat, needs/requires pervasive supervision.
- 2- Negative use of coping skills often leading to relapse, crises, involving constant interventions, in or out of protective environment.
- 3- Ineffective use of few coping skills prompting regular interventions (e.g., extra contacts, frequent use of over-the-counter medications).
- 4- Marginally effective knowledge and use of coping mechanisms; seeks assistance to create or initiate coping mechanisms.
- 5- Moderately effective range of coping mechanisms, WNL routine reminders, assistance to initiate coping mechanisms.
- 6- Effective use of coping mechanisms with only expected, minimal assistance, knows self, acts to reduce stressors and use options to restore confidence.
- 7- Optimally effective use of coping mechanisms under various stresses with no significant assistance from others.

Productivity: Rate functioning primarily in the most appropriate expected role (e.g., wage earner, homemaker, employee, student).

- 1- Productivity severely limited; often unable to work or adapt to homemaking or school; virtually no attempt to be productive.
- 2- Occasional attempts at productivity unsuccessful; no routine or structure at home or in day activities.
- 3- Limited productivity; often with currently restricted capabilities for school, independent employment and home making.
- 4- Marginal productivity with mental distress (e.g. reduced ability to work in sheltered or independent setting).
- 5- Moderately functional working in independent job, at home or in school; fluctuates with the limited skills experience.
- 6- Adequate functioning; working in independent jobs, home or school; often not applying all available abilities.
- 7- Optimally performs employment-related functions, homemaking, or school tasks with ease and efficiency.

## Assessment

### 27. Mental Status Exam

Client Presentation

- Oriented/Alert  Disorganized
- Tangential  Preoccupied
- Circumstantial  Not Assessed

Mood (observed)

- Euthymic  Depressed
- Dysphoric  Anxious  Angry
- Euphoric  Stable
- Not Assessed

Behavior

- WNL  Cooperative  Uncooperative  Overly compliant
- Withdrawn  Avoidant/guarded  Suspicious  Nervous/anxious
- Preoccupied  Angry  Aggressive  Compulsive  Impulsive
- Hyperactive

Mood (stated)

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Affect  
 Appropriate  Inappropriate  
 Labile  Constricted  
 Blunted  Flat  Not Assessed

Interpersonal  
 Interactive  Hyper-verbose  Guarded  Withdrawn  Hostile

Functional Status  
 Intact  Impaired  
 Progressing  Digressing  
 Variably Impaired  
 Not Assessed

Sleep Functioning  
 Early Insomnia/Difficulties Falling Asleep  
 Broken/Waking Up Multiple Times  
 Late Insomnia/Waking Up Too Early  No Sleep Disturbance  
 Did Not Assess

Appearance/clothing  
 Neat and appropriate  
 Unkempt  Disheveled

Eye contact  
 WNL  Avoidant  Intense  Intermittent

Delusions  
 None reported  Grandiose  
 Persecutory  Somatic  
 Religious  Illogical  Chaotic

Hallucinations  
 Auditory  Tactile  Olfactory

Thought content  
 WNL  Preoccupied  
 Obsessional  Guarded  
 Phobic  Suspicious  Guilty

Thought process  
 WNL  Incoherent  Decreased thought flow  Blocked  
 Flight of ideas  Loose  Racing  Chaotic  Concrete  
 Tangential

**28. Risk Assessment**

Past attempts to harm self/others  
 None reported  Yes, self  Yes, others

Self-harm thoughts  
 None reported  Cutting  Burning  
 Other (describe)

Comments

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Suicidal thoughts  
 None reported  Passive thoughts  Intent  
 Plan  Means

Aggressive thoughts/thoughts of harming others  
 None reported  Intent  Plans  Mean

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**29. Measurements Utilized and Interpretation**

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**30. Diagnostic Impressions and Diagnoses**

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Signature

Date