**Course: HN330**

**Assessment Form**

**Client Name:**

**Date of Birth:**

**Date of Assessment:**

**Presenting Situation:** (Use this section to describe the client’s presenting situation. Specifically address what the client is requesting in terms of assistance, services, and change objectives/goals. Use the client’s own words in this section as much as possible.)

**Strengths and Resources:** (This is a very important section. Help the client brainstorm personal strengths and resources in their environment that will help them make the changes they desire.)

**Potential Barriers:** (This is another critical area to explore with the client. Help them think about barriers to achieving their change goals — barriers that already exist as well as barriers that may come up as they begin to work toward their goals. You do not have to solve them here; just identify them. Explain to the client that their case manager will come back to these barriers when they work with the client on developing their individualized service plan.)

**Culture and Language Considerations:** (Are there any particular culture or language issues or needs that the client wishes you to be aware of? These may not be apparent, so you need to ask in a supportive and welcoming way if there are special or unique things about them or their family that they want you to know. Also ask if they have any special learning issues or needs regarding written or verbal communications.)

**Current Client Involvement with Other Agencies and Services:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Agency** | **Contact Name/Phone** | **Service** | **Dates of Service** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Assessments of Client Domains:** (Briefly describe the client’s status in each of the following domains. If they indicate none or choose not to answer a particular item, just note “client declines at this time.” This is a valid option for any of the questions and information requested in this assessment. Case managers should never force a client to respond to something that makes them uncomfortable.)

Family:

Social:

Spiritual:

Housing:

Education:

Employment:

Access to health and dental care:

Transportation:

Hobbies and recreation:

Other:

**Current Medications:**

Name/Dosage:

Side effects:

Medication allergies:

Prescribed by:

**Safety and Trauma History:**

Are you safe in your current living situation? (Yes/No) \_\_\_\_\_\_\_

Do you feel threatened in any way? (Yes/No) \_\_\_\_\_

If yes, please describe:

Are you now, or have you in the past, experienced trauma of any kind? (Yes/No) \_\_\_\_

If yes, indicate all that apply:

Emotional:

Sexual:

Physical:

**Provide a brief description of this and your present status.** Include a brief statement of any previous treatments or services you have received for this trauma(s) and whether or not you have any remaining symptoms or issues you would like help with.

**If applicable, do you have a safety plan?** (Yes/No)\_\_\_\_\_\_

**Do you need immediate help today to gain safety?** (Yes/No)\_\_\_\_\_\_

**Client’s Legal History:**

**Suicide/Homicide Risk Evaluation:** (For each of the following, use the scale: 1-None, 2 – Slight, 3 – Moderate, 4 - Extreme/Immediate**)**

**Client’s self-rating of suicide risk:** (Indicate 1, 2, 3, or 4)

**Client’s self-rating of becoming violent:** (Indicate 1, 2, 3, or 4)

**Client’s self-rating of homicide risk:** (Indicate 1, 2, 3, or 4)

**Self-harm Risk Evaluation:** (1-Never, 2 – Once, 3 – Occasionally, 4 - Frequently**)**

**Have you ever cut yourself or purposely injured yourself in any way?** (1-Never, 2 – Once, 3 – Occasionally, 4 - Frequently**)**

**Safety Plan Based on Client Risk Self-Assessment**: (You must complete this section if the client rates any of the previous areas as a 2, 3, or 4. Describe what the client reports and their assessment of their current level of risk or safety. If they have a safety plan briefly describe it here.)

**Client Status (caseworker observation of client report)**

Appearance:

Age appropriate (Yes/No) \_\_\_\_\_\_

Well groomed (Yes/No) \_\_\_\_\_\_

Disheveled/unkempt (Yes/No) \_\_\_\_\_\_

Other – explain (Yes/No) \_\_\_\_\_\_

Orientation (Is client aware of the following?):

Where they are (Yes/No) \_\_\_\_\_\_

Why they are here (Yes/No) \_\_\_\_\_\_

Day and time (Yes/No) \_\_\_\_\_\_

Their situation (Yes/No) \_\_\_\_\_\_

Current events (Yes/No) \_\_\_\_\_\_

Behavior/Body Language:

Open (Yes/No) \_\_\_\_\_\_

Good (Yes/No) \_\_\_\_\_\_

Limited (Yes/No) \_\_\_\_\_\_

Avoidant (Yes/No) \_\_\_\_\_\_

None (Yes/No) \_\_\_\_\_\_

Relaxed/calm (Yes/No) \_\_\_\_\_\_

Restless (Yes/No) \_\_\_\_\_\_

Rigid (Yes/No) \_\_\_\_\_\_

Agitated (Yes/No) \_\_\_\_\_\_

Slumped posture (Yes/No) \_\_\_\_\_\_

Tense (Yes/No) \_\_\_\_\_\_

Tics (Yes/No) \_\_\_\_\_\_

Tremors (Yes/No) \_\_\_\_\_\_

Other – explain

Motor Activity:

Full ability (Yes/No) \_\_\_\_\_\_

Minor impairment (Yes/No) \_\_\_\_\_\_

Serious impairment (Yes/No) \_\_\_\_\_\_

Catatonic behavior (Yes/No) \_\_\_\_\_\_

Other – explain (Yes/No) \_\_\_\_\_\_

Manner:

Friendly (Yes/No) \_\_\_\_\_\_

Trusting (Yes/No) \_\_\_\_\_\_

Cooperative (Yes/No) \_\_\_\_\_\_

Nervous (Yes/No) \_\_\_\_\_\_

Withdrawn (Yes/No) \_\_\_\_\_\_

Playful (Yes/No) \_\_\_\_\_\_

Evasive (Yes/No) \_\_\_\_\_\_

Guarded (Yes/No) \_\_\_\_\_\_

Quiet (Yes/No) \_\_\_\_\_\_

Passive (Yes/No) \_\_\_\_\_\_

Defensive (Yes/No) \_\_\_\_\_\_

Hostile (Yes/No) \_\_\_\_\_\_

Agitated (Yes/No) \_\_\_\_\_\_

Demanding (Yes/No) \_\_\_\_\_\_

Speech:

Clear (Yes/No) \_\_\_\_\_\_

Understandable (Yes/No) \_\_\_\_\_\_

Incoherent (Yes/No) \_\_\_\_\_\_

Rapid (Yes/No) \_\_\_\_\_\_

Quiet (Yes/No) \_\_\_\_\_\_

Loud (Yes/No) \_\_\_\_\_\_

Slurred (Yes/No) \_\_\_\_\_\_

Slow (Yes/No) \_\_\_\_\_\_

Mood:

Appropriate (considering presenting situation) (Yes/No) \_\_\_\_\_\_

Depressed (Yes/No) \_\_\_\_\_\_

Irritable (Yes/No) \_\_\_\_\_\_

Anxious (Yes/No) \_\_\_\_\_\_

Euphoric (Yes/No) \_\_\_\_\_\_

Fatigued (Yes/No) \_\_\_\_\_\_

Angry (Yes/No) \_\_\_\_\_\_

Expansive (Yes/No) \_\_\_\_\_\_

Unable to evaluate – explain (Yes/No) \_\_\_\_\_\_

Affect:

Appropriate (considering presenting situation) (Yes/No) \_\_\_\_\_\_

Warm (Yes/No) \_\_\_\_\_\_

Welcoming (Yes/No) \_\_\_\_\_\_

Tearful (Yes/No) \_\_\_\_\_\_

Blunted (Yes/No) \_\_\_\_\_\_

Constricted (Yes/No) \_\_\_\_\_\_

Flat (Yes/No) \_\_\_\_\_\_

Labile (Yes/No) \_\_\_\_\_\_

Excited (Yes/No) \_\_\_\_\_\_

Anhedonic (Yes/No) \_\_\_\_\_\_

Sleep:

Excellent (Yes/No) \_\_\_\_\_\_

Good (Yes/No) \_\_\_\_\_\_

Fair (Yes/No) \_\_\_\_\_\_

Poor (Yes/No) \_\_\_\_\_\_

Increased (Yes/No) \_\_\_\_\_\_

Decreased (Yes/No) \_\_\_\_\_\_

Initial insomnia (Yes/No) \_\_\_\_\_\_

Middle insomnia (Yes/No) \_\_\_\_\_\_

Terminal insomnia (Yes/No) \_\_\_\_\_\_

Client reports concern about sleep pattern (Yes/No) \_\_\_\_\_\_

Appetite:

Excellent (Yes/No) \_\_\_\_\_\_

Good (Yes/No) \_\_\_\_\_\_

Fair (Yes/No) \_\_\_\_\_\_

Poor (Yes/No) \_\_\_\_\_\_

Increased (Yes/No) \_\_\_\_\_\_

Decreased (Yes/No) \_\_\_\_\_\_

Weight gain (Yes/No) \_\_\_\_\_\_

Weight loss (Yes/No) \_\_\_\_\_\_

Client reports concern about appetite or weight (Yes/No) \_\_\_\_\_\_

Thought Process:

Logical and well organized (Yes/No) \_\_\_\_\_\_

Illogical (Yes/No) \_\_\_\_\_\_

Flight of ideas (Yes/No) \_\_\_\_\_\_

Circumstantial (Yes/No) \_\_\_\_\_\_

Loose associations (Yes/No) \_\_\_\_\_\_

Rambling (Yes/No) \_\_\_\_\_\_

Obsessive (Yes/No) \_\_\_\_\_\_

Blocking (Yes/No) \_\_\_\_\_\_

Tangential (Yes/No) \_\_\_\_\_\_

Spontaneous (Yes/No) \_\_\_\_\_\_

Perseverative (Yes/No) \_\_\_\_\_\_

Distractible (Yes/No) \_\_\_\_\_\_

Thought Content:

Appropriate (considering presenting situation) (Yes/No) \_\_\_\_\_\_

Delusions (Yes/No) \_\_\_\_\_\_

Paranoid delusions (Yes/No) \_\_\_\_\_\_

Distortions (Yes/No) \_\_\_\_\_\_

Thought withdrawal (Yes/No) \_\_\_\_\_\_

Thought insertion (Yes/No) \_\_\_\_\_\_

Thought broadcast (Yes/No) \_\_\_\_\_\_

Magical thinking (Yes/No) \_\_\_\_\_\_

Somatic delusions (Yes/No) \_\_\_\_\_\_

Ideas of reference (Yes/No) \_\_\_\_\_\_

Delusional guilt (Yes/No) \_\_\_\_\_\_

Grandiose delusions (Yes/No) \_\_\_\_\_\_

Nihilistic delusions (Yes/No) \_\_\_\_\_\_

Ideas of inference (Yes/No) \_\_\_\_\_\_

Unable to evaluate – explain (Yes/No) \_\_\_\_\_\_

Perceptions:

Appropriate (considering presenting situation) (Yes/No) \_\_\_\_\_\_

Illusions (Yes/No) \_\_\_\_\_\_

Hallucinations (Yes/No) \_\_\_\_\_\_

Depersonalization (Yes/No) \_\_\_\_\_\_

Derealization (Yes/No) \_\_\_\_\_\_

Unable to evaluate – explain (Yes/No) \_\_\_\_\_\_

Judgment:

Intact (Yes/No) \_\_\_\_\_\_

Age appropriate (Yes/No) \_\_\_\_\_\_

Impulsive (Yes/No) \_\_\_\_\_\_

Immature (Yes/No) \_\_\_\_\_\_

Impaired (Yes/No) \_\_\_\_\_\_

Mild (Yes/No) \_\_\_\_\_\_

Unable to evaluate – explain (Yes/No) \_\_\_\_\_\_

Client reports (Yes/No) \_\_\_\_\_\_

Insight:

Intact (Yes/No) \_\_\_\_\_\_

Limited (Yes/No) \_\_\_\_\_\_

Very limited (Yes/No) \_\_\_\_\_\_

Fair (Yes/No) \_\_\_\_\_\_

None (Yes/No) \_\_\_\_\_\_

Aware of current situation (Yes/No) \_\_\_\_\_\_

Understands internal and external factors involved in current situation

(Yes/No) \_\_\_\_\_\_

Unable to evaluate – explain (Yes/No) \_\_\_\_\_\_

Client reports (Yes/No) \_\_\_\_\_\_

Memory:

Intact (Yes/No) \_\_\_\_\_\_

Impaired (Yes/No) \_\_\_\_\_\_

Immediate recall (Yes/No) \_\_\_\_\_\_

Remote (Yes/No) \_\_\_\_\_\_

Unable to evaluate – explain (Yes/No) \_\_\_\_\_\_

Amnesia (Yes/No) \_\_\_\_\_\_

(type of amnesia) \_\_\_\_\_\_\_\_\_\_\_

Cognitive functioning:

No issues noted (Yes/No) \_\_\_\_\_\_

Issues noted – describe (Yes/No) \_\_\_\_\_\_

Client reports (Yes/No) \_\_\_\_\_\_

**Substance Use/Abuse:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Type** | **Amount** | **How taken** | **Duration** | **Frequency** | **Date of last use** |
| Tobacco |  |  |  |  |  |
| Alcohol |  |  |  |  |  |
| Illicit Drugs |  |  |  |  |  |
| Prescription Drugs |  |  |  |  |  |
| OTC Drugs |  |  |  |  |  |
| Other |  |  |  |  |  |

**Experiencing:**

**Withdrawal** (Yes/No) \_\_\_\_\_\_

**Blackouts** (Yes/No) \_\_\_\_\_\_

**Hallucinations** (Yes/No) \_\_\_\_\_\_

**Vomiting** (Yes/No) \_\_\_\_\_\_

**Severe depression** (Yes/No) \_\_\_\_\_\_

**DTs and shaking** (Yes/No) \_\_\_\_\_\_

**Seizures** (Yes/No) \_\_\_\_\_\_

**Other** (Yes/No) \_\_\_\_\_\_

**If yes, describe:**

**Patterns of Use:**

**Do you use more under stress?** (Yes/No) \_\_\_\_\_\_

**Do you continue to use when others have stopped?** (Yes/No) \_\_\_\_\_\_

**Have you lied about consumption?** (Yes/No) \_\_\_\_\_\_

**Have you tried to avoid others while using?** (Yes/No) \_\_\_\_\_\_

**Have you been drunk/high for several days at a time?** (Yes/No) \_\_\_\_\_\_

**Do you sometimes neglect obligations when using?** (Yes/No) \_\_\_\_\_\_

**Do you sometimes use more than you intended?** (Yes/No) \_\_\_\_\_\_

**Are you finding you need to increase use to get the effect you desire?** (Yes/No) \_\_\_\_\_\_

**Have you tried to hide consumption?** (Yes/No) \_\_\_\_\_\_

**Do you sometimes use before noon?** (Yes/No) \_\_\_\_\_\_

**Do you find you cannot limit use once begun?** (Yes/No) \_\_\_\_\_\_

**Have you failed to keep promises to reduce use?** (Yes/No) \_\_\_\_\_\_

**Do you arrange your day around your substance use?** (Yes/No) \_\_\_\_\_\_

**Have you attempted to reduce or stop before?** (Yes/No) \_\_\_\_\_\_

What happened?

**Describe the circumstances that usually lead to a relapse for you:**

**Do you want to reduce or stop using the substances described above?** (Yes/No) \_\_\_\_\_\_

**Do you have depression or other mental health issues that you believe affect your use of substances?** (Yes/No) \_\_\_\_\_\_

**If yes, please describe:**

**Are you presently involved in AA/NA?** (Yes/No) \_\_\_\_\_\_

**What are your goals for change in this area?**

**DSM 5 Diagnostic Impression (**Diagnostic Impression means an interpretive statement based upon previous and current evaluative data. A diagnostic impression may or may not make reference to DSM criteria)**:**

**Clinical Summary:** (Using the information you have gathered at this point, provide a brief summary of the presenting issues, client strengths and needs, any immediate risks, and the client’s goals for change. You will be reviewing this assessment and your summary and recommendations with the client and with your clinical supervisor so be sure to write in terms the client can understand and relate to (avoid technical jargon) and maintain a strengths-based and empowerment perspective.)

**Recommendations: (including specific service recommendations)**

**Disposition:** (Clearly describe the next steps and what the client can expect next from your agency. If you have already arranged an intake with a case manager or a counselor, include the name of the worker, their credentials, and the date and time of the next appointment.)

**Client Signature:**

**Date:**

**Legal Guardian’s Signature (if one is assigned or if client is under 18):**

**Date:**

**Case Manager Signature:**

**Date:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**