COMPREHENSIVE CLINICAL ASSESSMENT & INTAKE – Adult

Crossroads
COUNSELING CENTER

Name _____ DOB _____ Date _____
Medicaid # _____ County _____ Chart # _____
Gender: __M __F Ethnicity: __White; __ Black; __ Biracial; __ Hispanic; __ Asian; __ Other
Individual(s) participating in assessment _____

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 _____
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

Please list all members of your household:

Name	Relationship to you
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family of origin: Raised by _____
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: _____
Hobbies and community activities _____

Client: _____ Chart #: _____
Medicaid #: _____ DOB: _____

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

___ Childhood trauma (Explain) _____
___ 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 _____

Primary care physician _____

Current medications	Name	Dosage
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Substance Use History

Alcohol _____
Illegal Drugs _____
Prescription Drugs _____
Other _____

Legal Involvement

List any charges/arrests/convictions: _____
_____

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 _____

Client: _____	Chart #: _____
Medicaid #: _____	DOB: _____

Current Treatment Focus

What brings you to our office today? _____

_____

_____

_____

What services are you seeking:

___ Individual Therapy
___ Family Therapy
___ Other (explain): _____
___ Psychological/Educational Testing
___ Psychiatric Services or Medication Management

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

___ My mood or emotional state (depression, anxiety, anger, etc)
___ My behavior / choices
___ My cognitive / mental functioning
___ School / academic performance
___ Parenting
___ Abuse, neglect, or trauma history
___ Sleep, eating, or physical concerns
___ Relationships with family or peers
___ Divorce
___ Grief / Loss
___ Other: _____

Adult Assessment: Please check all of the following that currently apply.
Please indicate past concerns with the letter "P".

____ Anxiety
____ Depressed mood
____ Panic attacks
____ Racing thoughts or speech
____ Obsessions/Compulsions
____ Excessive fears or phobias
____ Dissociative states
____ Touchy/irritable
____ Nightmares
____ Sleep problems
____ Bedwetting or incontinence
____ Tantrums or "meltdowns"
____ Difficult to parent
____ Conflicting parenting styles
____ Parental marital problems
____ Adopted or in foster care
____ Lots of physical complaints
____ Hurts others
____ Lying
____ Stealing
____ Destroying property
____ Defiance
____ Blames others for mistakes
____ Angry/resentful
____ Lack of conscience
____ Bizarre behavior
____ Clingy
____ Separation anxiety
____ Seems to overreact
____ Parent feels overwhelmed
____ Argues with adults
____ Doesn't seem to listen
____ Seems adultlike or older
____ Life has been unstable
____ Hyperactive
____ Attention problems
____ Worries all the time
____ Impulsive
____ Low self-esteem
____ Suicidal thoughts
____ Suicide attempts
____ Self-mutilation
____ Sexually active / acting out
____ Difficulty with change
____ Needs predictability/routine
____ Unexplainable mood shifts
____ Running away
____ Deliberately annoys people
____ Takes excessive risks
____ Seems younger than age
____ Life changes pending

Client: _____ Chart #: _____
Medicaid #: _____ DOB: _____

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

Based on the assessment, the recommended treatment is:

☐ None	☐ Client Declined	☐ 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	☐ Other: _____

I certify that the information provided above is correct to the best of my knowledge.

_____ _____
Signature of Client Date

_____ _____
Signature of Therapist Completing Assessment Date