COMPREHENSIVE CLINICAL ASSESSMENT & INTAKE – Adult

Crossroads COUNSELING CENTER

Name _____ DOB _____ Date _____
Medicaid # _____ County _____ Chart # _____
Gender: ___ Male ___ Female ___ Other
Ethnicity: ___ White ___ Black ___ Biracial ___ Hispanic ___Asian ___ Other: _____
Individuals 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 _____

Household Information

Address _____
Current status of significant relationship:
___ Single ___ Separated ___ Living together ___ Dating ___ Other
___ Married ___ Divorced ___ Life partner ___ Widowed

List all members of your household:

Name	Relationship to You	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who were you raised by? _____
List significant family members who do not live with you. (parents, siblings, grandparents, caregivers, etc.)

Name	Relationship	Still living?
_____	_____	___ Yes ___ No
_____	_____	___ Yes ___ No

Social Information

Spiritual preference _____
List any support systems: _____
Hobbies and community activities:_____

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

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

___ Childhood trauma _____
___ Adult trauma _____
___ 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: _____
_____

Mental Health Treatment History

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: _____
___ Physical/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 ___ Couples Therapy

___ Family Therapy ___ Psychological/Educational Testing

___ Other (explain): _____

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

___ Adjustment to new cultural

___ Sleep, eating, or physical concerns

___ Relationships with family or peers

___ Divorce

___ Grief / Loss

___ Other: _____

___ Work place issues

Adult Assessment: Check all the following that currently apply.
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
_____ Incontinence or bedwetting
_____ Rage or "meltdowns"
_____ Conflicting parenting styles
_____ Parental marital problems
_____ Adoption/foster care history
_____ Lots of physical complaints
_____ Eating issues
_____ Addictions

_____ Hurts others
_____ Lying
_____ Stealing
_____ Destroying property
_____ Defiance
_____ Blames others for mistakes
_____ Angry/resentful
_____ Lack of conscience
_____ Bizarre behavior
_____ Clingy
_____ Separation anxiety
_____ Seems to overreact
_____ Feel overwhelmed
_____ Argumentative
_____ Life has been unstable
_____ Life changes pending
_____ Cultural Adjustments

_____ Hyperactive
_____ Attention problems
_____ Worries all the time
_____ Impulsive
_____ Low self-esteem
_____ Suicidal thoughts
_____ Suicide attempts
_____ Self-harming
_____ Sexually acting out
_____ Pornography
_____ Difficulty with change
_____ Needs predictability/routine
_____ Unexplainable mood shifts
_____ Running away
_____ Deliberately annoys people
_____ Takes excessive risks
_____ Experienced Discrimination

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

Please use the space below to tell us anything else you would like for us to know to best help you:

_____

_____

_____

_____

How did you hear about us? ___ Yellow Pages ___ Attorney: _____
___ Friend/Client ___ Doctor: _____
___ Internet ___ Other agency: _____
___ Court-ordered ___ Other: _____

Crossroads offers appointment reminders. Check below all the ways you wish to receive a reminder.

☐ To Be Called Telephone Number: _____
☐ Text Message Text Number: _____
☐ Emailed Email Address: _____

I certify that the information provided in this document is correct to the best of my knowledge.

×_____ ×_____
Signature of Client **Date**

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
☐ Psychiatric Treatment ☐ Outpatient MH Treatment ☐ Other: _____
☐ Inpatient MH Treatment

I certify that the above therapy is medically necessary, and that the information provided is accurate to the best of my knowledge.

×_____ ×_____
Signature of Therapist Completing Assessment Date