

DIAGNOSTIC ASSESSMENT (Used in conjunction with the Confidential Individual Questionnaire)

CLIENT NAME: _____ **DOB:** _____ **DATE:** _____

After determining the reason for seeking therapy and deciding preliminary goals, the remainder of a more formal assessment required by DHS and our insurance providers follows.

INFORMATION ABOUT YOU

What personal qualities would others say you possess?

Who would you say are the influential and supportive people in your life?

What activities do you enjoy and feel successful when trying?

What activities do you find helpful (e.g. walking, hunting, yoga, painting), or beliefs (e.g. religion)?

FAMILY HISTORY

Who lived in your home when you were a child?

Where are you in the birth order?

What words would you use to describe your family of origin?

Are you aware of any birth trauma your mother endured during her pregnancy with you, or any trauma you endured between birth and 3?

Did/do you have any significant concerns experiences with someone in your family? Please describe

Did you experience or witness any abuse as a child (physical, verbal, emotional, or sexual) or experience these outside your home? Please describe to the extent you feel comfortable

Have you experienced or witnessed any abuse in your adult life (physical, verbal, emotional, or sexual)? Please describe to the extent you feel comfortable

FAMILY COMPOSITION

<u>Relationship</u>	<u>Name</u>	<u>Age</u>	<u>Sex</u>	<u>Type (Bio, Step, Etc)</u>
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Sibling	_____	_____	_____	_____
Sibling	_____	_____	_____	_____
Sibling	_____	_____	_____	_____
Sibling	_____	_____	_____	_____
Sibling	_____	_____	_____	_____
Sibling	_____	_____	_____	_____
Sibling	_____	_____	_____	_____
Sibling	_____	_____	_____	_____
Sibling	_____	_____	_____	_____
Spouse/SO	_____	_____	_____	_____
Children	_____	_____	_____	_____
Children	_____	_____	_____	_____
Children	_____	_____	_____	_____
Children	_____	_____	_____	_____
Children	_____	_____	_____	_____
Children	_____	_____	_____	_____
Children	_____	_____	_____	_____
Children	_____	_____	_____	_____
Children	_____	_____	_____	_____
Children	_____	_____	_____	_____

FAMILY CONCERNS

Please check any family concerns you may be experiencing:

- Fighting
- Drug Use
- Divorce
- Education
- Empty Nest
- Abuse
- Gambling
- Feeling Distant
- Alcohol Use
- Separation
- Finances
- In-laws
- Neglect
- Internet Usage
- Loss of fun
- Disagreeing about relatives
- Remarriage (self or parent)
- Birth of a sibling
- Blended family concerns
- Inadequate Housing
- Employment/Underemployment
- Lack of honesty
- Infidelity (Couple)
- Disagreeing about friends
- Death of a family member
- Leisure time
- Inadequate health insurance
- Other _____

SYMPTOM CHECKLIST

Items that you currently or have been experiencing in the last 30 days.

Symptom	None	Mild	Moderate	Severe	Symptom	None	Mild	Moderate	Severe
Sadness/Depression					Increased or decreased appetite				
Crying					Unplanned weight gain				
Sleep disturbances					Unplanned weight loss				
Dissociation					Paranoid thoughts				
Hyperactivity					Poor concentration/indecisive				
Binging/Purging					Low energy				
Decreased sex drive					Excessive worrying				
Unresolved guilt					Low self-worth				
Irritability					Anger management problems				
Nausea/Acid indigestion					Spiritual concerns				
Anxiety					Hallucinations				
Self-mutilation/cutting					Racing thoughts				
Impulsivity					Restlessness				
Nightmares					Drug Use				
Hopelessness					Alcohol Use				
Elevated mood					Decreased creativity/productivity				
Mood swings					Easily distracted				
Disorganized					Memories of trauma/flashbacks				
Anorexia					Work issues				
Social isolation					Problems at home				
Phobia(s)					Panic attacks				
Obsessive thoughts					Feel panicky/anxious				
Grief					Suicidal thoughts				
Headaches					Attempts of suicide in the past				
Loneliness					Other				

ADDITIONAL INFORMATION

Is there anything else you would like to share that could be helpful in our work?

LEGAL ISSUES

Are there any legal issues that are affecting you or your family at present, or any which have had a significant effect upon you or others.

Any past legal issues that are affected(ing) you or your family?

Please describe your past and current use of any mood-altering drugs or alcohol:

Have you ever felt the need to cut down on your drinking or substance use? Yes No

Have you felt annoyed by people criticizing your drinking or substance use? Yes No

Have you ever felt guilty about drinking or substance use? Yes No

Have you sought medical treatment for any use of the above substances? If so, briefly describe: