DIAGNOSTIC ASSESSMENT QUESTIONNAIRE

Please answer these questions in order for us to best help the person receiving services.
******The person receiving services will be referred to as "Client" on this form.******

Client Name: _____ Date: ____/____/____ CATT #: _____

What made you decide to come here today? _____
_____
_____

What is the client's most important goal to accomplish with us? _____
_____
_____

Please rate how confident you are in the ability to accomplish this goal.

❑ ……..…..…..❑……..…..…..❑…..……..…..❑……..……..…..❑……..…..…..❑……..……..…..❑……..…..…..❑……..…..…..❑
Not at all confident *Somewhat Confident* *Very Confident*

Please rate how ready you are to take the next steps towards this goal.

❑ ……..…..…..❑……..…..…..❑……..…..…..❑……..…..…..❑……..…..…..❑……..…..…..❑……..…..…..❑……..…..…..❑
Not Ready *Somewhat Ready* *Very Ready*

EXPERIENCES

Please mark which of the following the client has experienced:

- ☐ Feelings of ***sadness or depression***
- ☐ Thoughts of/attempts to ***hurt yourself***
- ☐ A significant ***loss***
- ☐ Feelings of ***worry or anxiety***
- ☐ Experienced a ***traumatic event***
- ☐ Feelings of ***anger*** or have thoughts of hurting someone
- ☐ ***Difficulties with people in authority*** at home, school, or work
- ☐ ***Difficulty concentrating*** or paying attention
- ☐ ***Seeing or hearing things*** that others don't see or hear
- ☐ ***Mood swings*** or having ***too much energy***
- ☐ Misuse of ***drugs or alcohol***
- ☐ ***Acting without thinking*** about consequences
- ☐ Changes to ***appetite or food intake***
- ☐ Difficulty ***falling asleep or staying asleep***
- ☐ Any behaviors the client ***wishes they could stop but can't***
- ☐ Problems with ***unmanageable pain***
- ☐ Additional ***stressors***: _____
_____
_____

IS THE CLIENT FACING ANY OF THESE DIFFICULTIES WITH COMING TO SOUTH COMMUNITY?

- ☐ Unreliable transportation
- ☐ Unable to drive
- ☐ Legal difficulties
- ☐ Family disapproves
- ☐ Fearful about therapy
- ☐ Child care
- ☐ Scheduling conflicts
- ☐ Finances/co-payment
- ☐ Illness in family
- ☐ Travel too far
- ☐ Health concerns
- ☐ Other _____

Client Name: CATT #:

MENTAL HEALTH/SUBSTANCE

PAST TREATMENT

Has the client ever been treated for a mental health condition by any of the following providers?

	Year(s)	Case Mgmt/ Therapy	Meds	Hospital		Year(s)	Case Mgmt/ Therapy	Meds	Hospital
☐ ATS/Wellness	_____	☐	☐	☐	☐ Kettering Hospital	_____	☐	☐	☐
☐ CAM	_____	☐	☐	☐	☐ Miami Valley	_____	☐	☐	☐
☐ DayMont	_____	☐	☐	☐	☐ South Community	_____	☐	☐	☐
☐ Eastway	_____	☐	☐	☐	☐ Summit	_____	☐	☐	☐
☐ Good Samaritan	_____	☐	☐	☐	☐ Twin Valley	_____	☐	☐	☐
☐ Grandview	_____	☐	☐	☐	☐ KBMC	_____	☐	☐	☐
☐ Sam Behavioral	_____	☐	☐	☐	☐ Other	_____	☐	☐	☐

Previous or **Current** Mental Health Diagnosis (if known)? _____

_____

SUBSTANCE HISTORY (Complete each section below as appropriate)

Substance	No Use	Age of 1st Use	Date of Last Use	Frequency of Use	Amount of Use	Date(s)/Location(s) of Treatment
Alcohol/Beer/Wine						
Marijuana						
Hallucinogens						
Stimulants						
Sleep Medication						
Inhalants						
Cocaine/Crack						
Heroin/Opioids						
Pain Medication						
Other:						

Caffeine use? If yes, form (coffee, tea, pop, etc.) ☐No ☐Yes	**How much per week** (cups, bottles)?
Tobacco use? If yes, form (cigarettes, cigars, smokeless, etc.) ☐No ☐Yes	**How much per week (packs, etc.)?**

FAMILY PHYSICIAN

Who is your Family Physician? _____

Would you like a referral to South Community Primary Care ☐ **Yes** ☐ **No** ☐ **Not Sure**

Client Name: CATT #:

A Little About You/Your child!

Please let us know a little about the person to receive services.

For each item, indicate whether that area of your (your child's) life is a source of ***problems/concern***, ***going great***, or is ***OK***.

Living Situation **__ Problem ___ OK ___ Great**

This includes how you (your child) feel about your home or where you (they) live.

Family **__ Problem ___ OK ___ Great**

This includes how well you (your child) get along with others in the family/with those you live.
Marital Status: __ Single __ Married __ Divorced __ Other **Are the members of your (your child's) family supportive**?: __ Yes __ No __ Sometimes __ Unsure
Is there a history in your (your child's) family of (check all that apply): __ Mental Health Issues __Substance Abuse __Trauma __ Legal Issues
Who in your (child's) home/family is <u>most supportive</u>? _____ **With whom do you (child) have <u>the most problems</u>? _____**

Social **__ Problem ___ OK ___ Great**

This includes how you/your child get along with and what you do with other people who are NOT related to you or live with you.
I feel good about the number of and relationships I (my child) have with friends: __ Yes __ No
I am (my child is) involved in the following meaningful activities (check all that apply): ___ volunteer activities ___recreational activities ___community involvement ___Other:_____
I am (my child is) involved in the following support Groups (check all that apply): ___ NAMI ___ AA/NA ___ Other: _____

Caring for Myself **__ Problem ___ OK ___ Great**

This includes how well you believe you (your child) are able to take care of basic tasks of everyday life, such as eating, bathing, dressing, making appointments, managing your money.

Religion/Spirituality **__ Problem ___ OK ___ Great**

This may include your (your child's) religious and spiritual beliefs and actions or others' reactions to your beliefs and actions.

Culture/Ethnicity **__ Problem ___ OK ___ Great**

This may include your (your child's) beliefs, customs, attitudes or race with that you identify or feel distinguishes you.

Sexual Orientation & History **__ Problem ___ OK ___ Great**

This may include your (your child's) feelings toward sex, sexuality, sexual orientation or gender expression.
Client identifies as: ☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bi-Sexual ☐ Asexual ☐ Other _____

Client Name: CATT #:

Education **__ Problem ___ OK ___ Great**

This includes any information related to school, such as learning, peer/teacher relationships, attendance, and behavior.
Are you (your child) currently attending school? ☐ Yes ☐ No **If yes, where?** _____
If yes, do you (your child) have an IEP? ☐ Yes ☐ No **If yes, for what?** _____
History of Learning/Developmental Challenges:
__ NONE __Learning Disability __Developmental Delays __Special School Placement __Other**:** _____
Other Problems: ☐ Suspensions ☐ Attendance ☐ Grades ☐ Behavior ☐ Other _____

Legal **__ Problem ___ OK ___ Great**

This includes any information related to your (your child's) past or current legal involvement.
Current Legal Status:
___ None Reported ___ On Probation ___ Detention ___ On Parole ___ Awaiting Charge ___ Outpatient Commitment
___ Other _____
Past Legal Status::
___ None Reported ___ On Probation ___ Detention ___ On Parole ___ Awaiting Charge ___ Outpatient Commitment
___ Other _____

Lethality **__ Problem ___ OK ___ Great**

This includes any information related to your (your child's) past or current harm to self or others.
Current: __None Reported __Thoughts to harm self __Thoughts to harm others __Attempts to harm self __Attempts to harm others
Past: __None Reported __Thoughts to harm self __Thoughts to harm others __Attempts to harm self __Attempts to harm others

Employment **__ Problem ___ OK ___ Great**

This includes information related to your (your child's) employment, including ability to learn/complete tasks, relationships, attendance, and corrections
I am (my child is) currently:
___ Not employed ___ Employed Full Time ___ Employed Part Time ___ Volunteer Work ___ Seeking Employment
If you (your child) are not employed, are you (your child):
___ Disabled ___ Retired ___ Homemaker ___ Student ___ Other: _____
Are you interested in employment? ☐ Yes ☐ No ☐ Not Sure
Job Performance: **Attendance:** ___ No Problems ___ Frequent Tardiness ___ Frequent Absences ___ Not Applicable
Performance ___ Exemplary ___ Good ___ Average ___ Below Average

Abuse History **__ Problem ___ OK ___ Great**

This includes any information related to past or current abuse where you (your child) were the victim or perpetrator.
___ None Reported __Physical __Sexual ___Emotional __Neglect __Domestic Violence __Community Violence
___Other _____

_____ _____

Signature, Client/Guardian Date Signature, Witness Date