# 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 Legal Name: _____ Date: ____/____/____ CATT #: _____**

**Client Preferred Name: _____ Preferred Pronouns: _____**

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

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

| | | | |
|---|---|---|---|
| ☐ Unreliable transportation | ☐ Family disapproves | ☐ Scheduling conflicts | ☐ Travel too far |
| ☐ Unable to drive | ☐ Fearful about therapy | ☐ Finances/co-payment | ☐ Health concerns |
| ☐ Legal difficulties | ☐ Child care | ☐ Illness in family | ☐ 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/Self Describe _____<br>**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):**<br>☐ Mental Health Issues ☐ Substance Abuse ☐ Trauma ☐ Legal Issues |
| **Who in your (child's) home/family is <u>most supportive</u>?** _____<br>**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):**<br>☐ Volunteer Activities ☐ Recreational Activities ☐ Community Involvement ☐ Other:_____ |
| **I am (my child is) involved in the following support Groups (check all that apply):**<br>☐ 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.*** |
|---|
| ***How can we help make your cultural/ethnic experience more successful?*** _____ |

**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: ☐ Straight/Heterosexual ☐ Gay ☐ Lesbian ☐ Bi-Sexual ☐ Asexual ☐ Other<br>_____ |

Client Name: CATT #:

**Gender**

Client identifies as: ☐ Male ☐ Female ☐ Transgender ☐ Gender Fluid ☐ Self-Describe: _____

**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 of Client/Guardian** Date Signature of Witness Date