ADULT DIAGNOSTIC ASSESSMENT

CLEAR FORM

Date of assessment _____

ASSESSING PRACTITIONER (NAME AND DISCIPLINE):

Client/Others Interviewed:

I. DEMOGRAPHIC DATA & SPECIAL SERVICE NEEDS:

DOB: _____ **GENDER:** _____ **ETHNICITY:** _____ **Marital Status:** _____

Referral Source:

☐ Non-English Speaking, specify language used for this interview:

Were Interpretive Services provided for this interview? ☐ Yes ☐ No

☐ Cultural Considerations, specify:

☐ Physically challenged (wheelchair, hearing, visual, etc.) specify:

☐ Access issues (transportation, hours), specify:

II. Reason for Referral/Chief Complaint

Describe **PRECIPITATING EVENTS(S)/REASON FOR REFERRAL**

CURRENT SYMPTOMS AND BEHAVIORS (INTENSITY, DURATION, ONSET, FREQUENCY) and **IMPAIRMENTS IN LIFE FUNCTIONING** caused by the symptoms/behaviors (from perspective of client and others):

CLIENT STRENGTHS (to assist in achieving treatment goals)

SUICIDAL THOUGHTS/ATTEMPTS: *"Columbia Suicide Severity Rating Scale Screener (LACDMH Version)"*

Wish to be Dead: *Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.*

1. Within the past 30 days, have you wished you were dead or wished you could go to sleep and not wake up? ☐ Yes ☐ No

Suicidal Thoughts: *General non-specific thoughts of wanting to end one's life/commit suicide, "I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan.*

2. Within the past 30 days, have you actually had any thoughts of killing yourself? ☐ Yes ☐ No

If YES to 2, ask questions 3, 4, 5, and 6
If NO to 2, go directly to question 6

Suicidal Thoughts with Method (without Specific Plan or Intent to Act): *Person endorses thoughts of suicide and has thoughts of at least one method during the assessment period.*

3. Have you been thinking about how you might kill yourself? ☐ Yes ☐ No

Suicidal Intent (without Specific Plan): *Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts.*

4. Have you had these thoughts and had some intention of acting on them? ☐ Yes ☐ No

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Suicide Intent with Specific Plan: *Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.*

5. Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan? ☐ Yes ☐ No

Suicidal Behavior:

6. Have you done anything, started to do anything, or prepared to do anything to end your life? ☐ Yes ☐ No

If yes, How long ago did you do any of these?
Additional comments regarding suicidal thoughts/attempts:

Self-Harm (without statement of suicidal intent) ☐ Yes ☐ No ☐ Unable to Assess
If yes, describe

III. MENTAL HEALTH HISTORY/RISKS

History of Problem Prior to Precipitating Event: Include treated & non-treated history.

Impact of treatment and non-treatment history: on the client's level of functioning, e.g., ability to maintain residence, daily living and social activities, health care, and/or employment.

PSYCHIATRIC HOSPITALIZATIONS: ☐ Yes ☐ No ☐ Unable to Assess
If yes, describe **DATES, LOCATIONS, AND REASONS**

OUTPATIENT TREATMENT: ☐ Yes ☐ No ☐ Unable to Assess
If yes, describe **DATES, LOCATIONS, AND REASONS**.

TRAUMA or Exposure to Trauma: ☐ Yes ☐ No ☐ Unable to Assess
Has client ever (1) been physically hurt or threatened by another, (2) been raped or had sex against their will, (3) lived through a disaster, (4) been a combat veteran or experienced an act of terrorism, (5) been in a severe accident, or been close to death from any cause, (6) witnessed death or violence or the threat of violence to someone else, or (7) been the victim of a crime?

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IV. HIV AND PSYCHOTROPIC MEDICATIONS

Has the client ever taken psychotropic medications? ☐ Yes ☐ No ☐ Unable to Assess
Has the client ever taken HIV medications? ◯ Yes ◯ No ◯ Unable to Assess
List present medications used, prescribed/non-prescribed, by name, dosage, frequency. Indicate from client's perspective what seems to be working and not working.

PSYCHOTROPICS	DOSAGE/FREQUENCY	PERIOD TAKEN	EFFECTIVENESS/RESPONSE/SIDE EFFECTS/REACTIONS

HIV MEDICATIONS	DOSAGE/FREQUENCY	PERIOD TAKEN	EFFECTIVENESS/RESPONSE/SIDE EFFECTS/REACTIONS

Medication Comments (include medication adherence issues/history):

V. SUBSTANCE USE/ADDICTION Screening and Assessment

A. Alcohol Screening Questions

1 Drink = 12 Ounces of beer, 5 Ounces of wine, or 1.5 Ounces of liquor

1. In the past year, how often did you have a drink containing alcohol? If "Never", proceed to Drug Screening Questions.	☐ Never (0)	☐ Monthly or less (1)	☐ 2-4 times a month (2)	☐ 3 times a week (3)	☐ 4+ times a week (4)
1a. In the past year, how many drinks containing alcohol did you have on a typical day when you are drinking?	☐ 1 or 2 (0)	☐ 3 or 4 (1)	☐ 5 or 6 (2)	☐ 7 to 9 (3)	☐ 10+ (4)
1b. In the past year, how often did you have six or more drinks on one occasion?	☐ Never (0)	☐ Less than monthly (1)	☐ Monthly (2)	☐ Weekly (3)	☐ Daily or almost daily (4)

Alcohol Screening Score: _____ *(For a score of 4 or more, proceed to Assessment. A brief intervention is also indicated)*

Was a brief intervention provided? ☐ Yes ☐ No

B. Drug Screening Questions *("Yes" to any of the questions below indicates a positive screening)*

	Ever Used? Yes	Ever Used? No	Recently Used? (Past 6 Months) Yes	Recently Used? (Past 6 Months) No
1. Have you used nicotine products? *(Cigarettes, cigars, electronic cigarettes, smokeless tobacco)*	☐	☐	☐	☐
2. Do you use products containing caffeine, such as tea, coffee or high-caffeine energy drinks? *(Such as AMP, Monster, Red Bull or 5 Hour Energy*	☐	☐	☐	☐
3. Have you used opioids? *(Heroin, opium, non-prescribed pain medications)*	☐	☐	☐	☐
4. Have you used prescription medications, over the counter medications, and/or non-prescription supplements in a manner other than prescribed? *(For example, to get high)*	☐	☐	☐	☐
5. Have you used stimulants, such as cocaine or methamphetamine?	☐	☐	☐	☐
6. Have you used drugs intravenously?	☐	☐	☐	☐
7. Have you used drugs/alcohol as a means to engage in sexual activity?	☐	☐	☐	☐

C. Are you interested in changing your substance use patterns? ☐ Yes ☐ No ☐ NA

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Assessment/Additional Information (answer only if screening is positive)

PAST AND PRESENT USE OF TOBACCO, ALCOHOL, CAFFEINE, CAM (COMPLEMENTARY AND ALTERNATIVE MEDICATIONS) AND OVER-THE-COUNTER, AND ILLICIT DRUGS, if not determined by screener. Be sure to include route of administration, frequency (amount), withdrawals, etc.

VI. MEDICAL HISTORY

HIV Clinic: _____ **PHONE:** _____ **Last Medical Appointment** _____

Major medical problem (treated or untreated) (Indicate problems with check: Y or N for client, Fam for family history.)

Fam	Y	N		Fam	Y	N		Fam	Y	N		Fam	Y	N	
☐	☐	☐	Seizure/neuro disorder	☐	☐	☐	Cardiovascular disease	☐	☐	☐	Liver disease		☐	☐	Hepatitis
	☐	☐	Head trauma	☐	☐	☐	Tuberculosis	☐	☐	☐	Renal disease	☐	☐	☐	Cancer
	☐	☐	Sleep disorder	☐	☐	☐	Asthma/lung disease	☐	☐	☐	Hypertension		☐	☐	Syphilis
	☐	☐	Weight/appetite chg	☐	☐	☐	Gonorrhea	☐	☐	☐	Diabetes		☐	☐	Herpes

☐ ☐ ☐ **ALLERGIES** (If Yes, specify): _____

☐ ☐ Sensory/Motor Impairment (If Yes, specify): _____

☐ ☐ Pap smear If yes, date: _____ ☐ ☐ Mammogram If yes, date: _____ ☐ ☐ HIV Test If yes, date: _____ ☐ ☐ Pregnant If yes, due date: _____

Comments on above medical problems, co-occurring disorders, recent hospitalizations, etc.

VII. PSYCHOSOCIAL HISTORY

Please state specifically how mental health or HIV status impacts each area below; Be sure to include the client's strengths in each area.

EDUCATION/SCHOOL HISTORY

Special Education: ☐ Yes ☐ No ☐ Unable to Assess Learning Disability: ☐ Yes ☐ No ☐ Unable to Assess

Motivation, education goals, literacy skill level, general knowledge skill level, math skill level, school problems, etc:

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HIV RISK BEHAVIORS/PARTNER SERVICES:

1. Have you had unprotected sex with anyone in the past six months? ◯ Yes ◯ No
2. Have you told all of your present and/or past sexual partners your HIV status? ◯ Yes ◯ No
3. Have you ever used Partner Services? ◯ Yes ◯ No
4. Do you want assistance disclosing your HIV status to anyone? ◯ Yes ◯ No

LEGAL HISTORYAND STATUS

Arrests/DUI, probation, convictions, divorce, conservatorship, parole, child custody, etc:

CURRENT LIVING ARRANGEMENT and Social Support Systems

Type of living setting, problems at setting, community, religious, government agency, or other types of support, etc:

DEPENDENT CARE ISSUES

Number of Dependent Adults: _____ Number of Dependent Children: _____

Ages of children, school attendance/behavior problems of children, special needs of dependents, foster care/group home placement issues, child support, etc:

FAMILY HISTORY/RELATIONSHIPS

History of Mental Illness in Immediate Family: ☐ Yes ☐ No ☐ Unable to Assess

Alcohol/Drug Use in Immediate Family: ☐ Yes ☐ No ☐ Unable to Assess

History of Incarceration in Immediate Family: ☐ Yes ☐ No ☐ Unable to Assess

Family constellation, family of origin, family dynamics, cultural factors, nature of relationships, domestic violence, physical or sexual abuse, home safety issues, family medical history, family legal/criminal issues

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VIII. MENTAL STATUS EVALUATION

Instructions: Check all descriptions that apply

General Description

Grooming & Hygiene: ☐ Well Groomed
☐ Average ☐ Dirty ☐ Odorous ☐ Disheveled
☐ Bizarre
Comments:

Eye Contact: ☐ Normal for culture
☐ Little ☐ Avoids ☐ Erratic
Comments:

Motor Activity: ☐ Calm ☐ Restless
☐ Agitated ☐ Tremors/Tics ☐ Posturing ☐ Rigid
☐ Retarded ☐ Akathesis ☐ E.P.S.
Comments:

Speech: ☐ Unimpaired ☐ Soft
☐ Slowed ☐ Mute ☐ Pressured ☐ Loud
☐ Excessive ☐ Slurred ☐ Incoherent
☐ Poverty of Content
Comments:

Interactional Style: ☐ Culturally congruent
☐ Cooperative ☐ Sensitive
☐ Guarded/Suspicious ☐ Overly Dramatic
☐ Negative ☐ Silly
Comments:

Orientation: ☐ Oriented
☐ Disoriented to:
☐ Time ☐ Place ☐ Person ☐ Situation
Comments:

Intellectual Functioning: ☐ Unimpaired
☐ Impaired
Comments:

Memory: ☐ Unimpaired
☐ Impaired re: ☐ Immediate ☐ Remote ☐ Recent
☐ Amnesia
Comments:

Fund of Knowledge: ☐ Average
☐ Below Average ☐ Above Average
Comments:

Mood and Affect

Mood: ☐ Euthymic ☐ Dysphoric ☐ Tearful
☐ Irritable ☐ Lack of Pleasure
☐ Hopeless/Worthless ☐ Anxious
☐ Known Stressor ☐ Unknown Stressor
Comments:

Affect: ☐ Appropriate ☐ Labile ☐ Expansive
☐ Constricted ☐ Blunted ☐ Flat ☐ Sad
☐ Worried
Comments:

Perceptual Disturbance

☐ None Apparent

Hallucinations: ☐ Visual ☐ Olfactory
☐ Tactile ☐ Auditory: ☐ Command
☐ Persecutory ☐ Other
Comments:

Self-Perceptions: ☐ Depersonalizations
☐ Ideas of Reference
Comments:

Thought Process Disturbances

☐ None Apparent

Associations: ☐ Unimpaired ☐ Loose
☐ Tangential ☐ Circumstantial ☐ Confabulous
☐ Flight of Ideas ☐ Word Salad
Comments:

Concentration: ☐ Intact ☐ Impaired by:
☐ Rumination ☐ Thought Blocking
☐ Clouding of Consciousness ☐ Fragmented
Comments:

Abstractions: ☐ Intact ☐ Concrete
Comments:

Judgments: ☐ Intact
☐ Impaired re: ☐ Minimum ☐ Moderate ☐ Severe
Comments:

Insight: ☐ Adequate
☐ Impaired re: ☐ Minimum ☐ Moderate ☐ Severe
Comments:

Serial 7's: ☐ Intact ☐ Poor
Comments:

Thought Content Disturbance

☐ None Apparent

Delusions: ☐ Persecutory ☐ Paranoid ☐ Grandiose
☐ Somatic ☐ Religious ☐ Nihilistic
☐ Being Controlled
Comments:

Ideations: ☐ Bizarre ☐ Phobic ☐ Suspicious
☐ Obsessive ☐ Blames Others ☐ Persecutory
☐ Assaultive Ideas ☐ Magical Thinking
☐ Irrational/Excessive Worry
☐ Sexual Preoccupation
☐ Excessive/Inappropriate Religiosity
☐ Excessive/Inappropriate Guilt
Comments:

Behavioral Disturbance

Behavioral Disturbances: ☐ None ☐ Aggressive
☐ Uncooperative ☐ Demanding ☐ Demeaning
☐ Belligerent ☐ Violent ☐ Destructive
☐ Self-Destructive ☐ Poor Impulse Control
☐ Excessive/Inappropriate Display of Anger
☐ Manipulative ☐ Antisocial
Comments:

Suicidality/Homicidality

Suicidal: ☐ Denies ☐ Ideation Only
☐ Threatening ☐ Plan
Comments:

Homicidal: ☐ Denies ☐ Ideation Only
☐ Threatening ☐ Target ☐ Plan
Comments:

Other

Passive: ☐ Amotivational ☐ Apathetic
☐ Isolated ☐ Withdrawn ☐ Evasive ☐ Dependent
Comments:

Other: ☐ Disorganized ☐ Bizarre
☐ Obsessive/compulsive ☐ Ritualistic
☐ Excessive/Inappropriate Crying
Comments:

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Los Angeles County – Division of HIV and STD Programs

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IX. Summary and Diagnosis

1. CLINICAL FORMULATION: (Be sure to include assessment of risk of suicidal/homicidal behaviors, significant strengths/weaknesses, observations/descriptions, symptoms/impairments in life functioning, i.e. Work, School, Home Community, Living Arrangements, etc, and justification for diagnosis)

2. DIAGNOSTIC DESCRIPTOR

ICD DIAGNOSIS CODE (check at least one Primary)

☐ Primary Code
☐ Sec Code
Code
Code
Code
Code
Code
Code
Code
Code

3. HIV Medical Care Goals Does client's mental health status interfere with HIV medical care? ☐ Yes ☐ No

4. Disposition/Recommendations/Plan

5. SIGNATURE

Assessor's Signature & Discipline | Date | Co-Signature & Discipline | Date

CLEAR FORM

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