

Example of a Clinical Assessment Form

In this chapter, clinical assessment includes elements common to most outpatient clinical assessments: client identifiers, presenting problem, mental status, diagnosis (including medication information), risk assessment, case management (including prognosis), and evaluation of assessment. The following is an example of a clinical assessment form.

CLINICAL ASSESSMENT					
Client ID # (do not use name): _____	Ethnicity(ies): _____	Primary Language: <input type="checkbox"/> Eng <input type="checkbox"/> Span <input type="checkbox"/> Other: _____			
List all participants/significant others: Put a [*] for Identified Patient; [✓] for sig. others who WILL attend; [×] for sig. others who will NOT attend.					
Adult: Age: Profession/Employer <input type="checkbox"/> AM†: _____ <input type="checkbox"/> AF: _____ <input type="checkbox"/> AF/M #2: _____	Child: Age: School/Grade <input type="checkbox"/> CM: _____ <input type="checkbox"/> CF: _____ <input type="checkbox"/> CF/M #2: _____				
Presenting Problem					
<table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Depression/hopelessness <input type="checkbox"/> Anxiety/worry <input type="checkbox"/> Anger issues <input type="checkbox"/> Loss/grief <input type="checkbox"/> Suicidal thoughts/attempts <input type="checkbox"/> Sexual abuse/rape <input type="checkbox"/> Alcohol/drug use <input type="checkbox"/> Eating problems/disorders <input type="checkbox"/> Job problems/unemployed </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Couple concern <input type="checkbox"/> Parent/child conflict <input type="checkbox"/> Partner violence/abuse <input type="checkbox"/> Divorce adjustment <input type="checkbox"/> Remarriage adjustment <input type="checkbox"/> Sexuality/intimacy concerns <input type="checkbox"/> Major life changes <input type="checkbox"/> Legal issues/probation <input type="checkbox"/> Other: _____ </td> <td style="width: 33%; vertical-align: top;"> <u>Complete for children</u> <input type="checkbox"/> School failure/decline performance <input type="checkbox"/> Truancy/runaway <input type="checkbox"/> Fighting w/peers <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Wetting/soiling clothing <input type="checkbox"/> Child abuse/neglect <input type="checkbox"/> Isolation/withdrawal <input type="checkbox"/> Other: _____ </td> </tr> </table>			<input type="checkbox"/> Depression/hopelessness <input type="checkbox"/> Anxiety/worry <input type="checkbox"/> Anger issues <input type="checkbox"/> Loss/grief <input type="checkbox"/> Suicidal thoughts/attempts <input type="checkbox"/> Sexual abuse/rape <input type="checkbox"/> Alcohol/drug use <input type="checkbox"/> Eating problems/disorders <input type="checkbox"/> Job problems/unemployed	<input type="checkbox"/> Couple concern <input type="checkbox"/> Parent/child conflict <input type="checkbox"/> Partner violence/abuse <input type="checkbox"/> Divorce adjustment <input type="checkbox"/> Remarriage adjustment <input type="checkbox"/> Sexuality/intimacy concerns <input type="checkbox"/> Major life changes <input type="checkbox"/> Legal issues/probation <input type="checkbox"/> Other: _____	<u>Complete for children</u> <input type="checkbox"/> School failure/decline performance <input type="checkbox"/> Truancy/runaway <input type="checkbox"/> Fighting w/peers <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Wetting/soiling clothing <input type="checkbox"/> Child abuse/neglect <input type="checkbox"/> Isolation/withdrawal <input type="checkbox"/> Other: _____
<input type="checkbox"/> Depression/hopelessness <input type="checkbox"/> Anxiety/worry <input type="checkbox"/> Anger issues <input type="checkbox"/> Loss/grief <input type="checkbox"/> Suicidal thoughts/attempts <input type="checkbox"/> Sexual abuse/rape <input type="checkbox"/> Alcohol/drug use <input type="checkbox"/> Eating problems/disorders <input type="checkbox"/> Job problems/unemployed	<input type="checkbox"/> Couple concern <input type="checkbox"/> Parent/child conflict <input type="checkbox"/> Partner violence/abuse <input type="checkbox"/> Divorce adjustment <input type="checkbox"/> Remarriage adjustment <input type="checkbox"/> Sexuality/intimacy concerns <input type="checkbox"/> Major life changes <input type="checkbox"/> Legal issues/probation <input type="checkbox"/> Other: _____	<u>Complete for children</u> <input type="checkbox"/> School failure/decline performance <input type="checkbox"/> Truancy/runaway <input type="checkbox"/> Fighting w/peers <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Wetting/soiling clothing <input type="checkbox"/> Child abuse/neglect <input type="checkbox"/> Isolation/withdrawal <input type="checkbox"/> Other: _____			
† Abbreviations: AF: Adult Female; AM: Adult Male; CF#: Child Female with age, e.g., CF12; CM#: Child Male with age; Dx: Diagnosis; IP: Identified Patient; Hx: History; GAF: Global Assessment of Functioning; GARF: Global Assessment of Relational Functioning; NA: Not Applicable.					

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Mental Status for IP		
Interpersonal issues	<input type="checkbox"/> NA	<input type="checkbox"/> Conflict <input type="checkbox"/> Enmeshment <input type="checkbox"/> Isolation/avoidance <input type="checkbox"/> Emotional disengagement <input type="checkbox"/> Poor social skills <input type="checkbox"/> Couple problems <input type="checkbox"/> Prob w/friends <input type="checkbox"/> Prob at work <input type="checkbox"/> Overly shy <input type="checkbox"/> Egocentricity <input type="checkbox"/> Diff establish/maintain relationship <input type="checkbox"/> Other: _____
Mood	<input type="checkbox"/> NA	<input type="checkbox"/> Depressed/sad <input type="checkbox"/> Hopeless <input type="checkbox"/> Fearful <input type="checkbox"/> Anxious <input type="checkbox"/> Angry <input type="checkbox"/> Irritable <input type="checkbox"/> Manic <input type="checkbox"/> Other: _____
Affect	<input type="checkbox"/> NA	<input type="checkbox"/> Constricted <input type="checkbox"/> Blunt <input type="checkbox"/> Flat <input type="checkbox"/> Labile <input type="checkbox"/> Dramatic <input type="checkbox"/> Other: _____
Sleep	<input type="checkbox"/> NA	<input type="checkbox"/> Hypersomnia <input type="checkbox"/> Insomnia <input type="checkbox"/> Disrupted <input type="checkbox"/> Nightmares <input type="checkbox"/> Other: _____
Eating	<input type="checkbox"/> NA	<input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> Anorectic restriction <input type="checkbox"/> Binging <input type="checkbox"/> Purging <input type="checkbox"/> Body image <input type="checkbox"/> Other: _____
Anxiety symptoms	<input type="checkbox"/> NA	<input type="checkbox"/> Chronic worry <input type="checkbox"/> Panic attacks <input type="checkbox"/> Dissociation <input type="checkbox"/> Phobias <input type="checkbox"/> Obsessions <input type="checkbox"/> Compulsions <input type="checkbox"/> Other: _____
Trauma symptoms	<input type="checkbox"/> NA	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic <input type="checkbox"/> Hypervigilance <input type="checkbox"/> Dreams/nightmares <input type="checkbox"/> Dissociation <input type="checkbox"/> Emotional numbness <input type="checkbox"/> Other: _____
Psychotic symptoms	<input type="checkbox"/> NA	<input type="checkbox"/> Hallucinations <input type="checkbox"/> Delusions <input type="checkbox"/> Paranoia <input type="checkbox"/> Loose associations <input type="checkbox"/> Other: _____
Motor activity/speech	<input type="checkbox"/> NA	<input type="checkbox"/> Low energy <input type="checkbox"/> Restless/hyperactive <input type="checkbox"/> Agitated <input type="checkbox"/> Inattentive <input type="checkbox"/> Impulsive <input type="checkbox"/> Pressured speech <input type="checkbox"/> Slow speech <input type="checkbox"/> Other: _____
Thought	<input type="checkbox"/> NA	<input type="checkbox"/> Poor concentration/attention <input type="checkbox"/> Denial <input type="checkbox"/> Self-blame <input type="checkbox"/> Other-blame <input type="checkbox"/> Ruminative <input type="checkbox"/> Tangential <input type="checkbox"/> Illogical <input type="checkbox"/> Concrete <input type="checkbox"/> Poor insight <input type="checkbox"/> Impaired decision making <input type="checkbox"/> Disoriented <input type="checkbox"/> Slow processing <input type="checkbox"/> Other: _____
Socio-Legal	<input type="checkbox"/> NA	<input type="checkbox"/> Disregards rules <input type="checkbox"/> Defiant <input type="checkbox"/> Stealing <input type="checkbox"/> Lying <input type="checkbox"/> Tantrums <input type="checkbox"/> Arrest/incarceration <input type="checkbox"/> Initiates fights <input type="checkbox"/> Other: _____
Other symptoms	<input type="checkbox"/> NA	
Diagnosis for IP		
Contextual Factors considered in making Dx: <input type="checkbox"/> Age <input type="checkbox"/> Gender <input type="checkbox"/> Family dynamics <input type="checkbox"/> Culture <input type="checkbox"/> Language <input type="checkbox"/> Religion <input type="checkbox"/> Economic <input type="checkbox"/> Immigration <input type="checkbox"/> Sexual orientation <input type="checkbox"/> Trauma <input type="checkbox"/> Dual dx/comorbid <input type="checkbox"/> Addiction <input type="checkbox"/> Cognitive ability		

<input type="checkbox"/> Other: _____ Describe impact of identified factors: _____	
<p>Axis I Primary: _____ Secondary: _____</p> <p>Axis II: _____</p> <p>Axis III: _____</p> <p>Axis IV:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Problems with primary support group <input type="checkbox"/> Problems related to social environment/school <input type="checkbox"/> Educational problems <input type="checkbox"/> Occupational problems <input type="checkbox"/> Housing problems <input type="checkbox"/> Economic problems <input type="checkbox"/> Problems with accessing health care services <input type="checkbox"/> Problems related to interactions with the legal system <input type="checkbox"/> Other psychosocial problems <p>Axis V: GAF _____ GARF _____</p>	<p>List DSM symptoms for Axis I Dx (include frequency and duration for each). Client meets _____ of _____ criteria for Axis I Primary Dx.</p> <ol style="list-style-type: none"> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____
<p>Have medical causes been ruled out? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In process</p> <p>Has patient been referred for psychiatric/medical eval? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has patient agreed with referral? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p> <p>List psychometric instruments or consults used for assessment: <input type="checkbox"/> None or _____</p>	<p>Medications (psychiatric & medical) Dose /Start Date</p> <p><input type="checkbox"/> None prescribed</p> <ol style="list-style-type: none"> 1. _____ / _____ mg; _____ 2. _____ / _____ mg; _____ 3. _____ / _____ mg; _____ <p>Client response to diagnosis: <input type="checkbox"/> Agree <input type="checkbox"/> Somewhat agree <input type="checkbox"/> Disagree <input type="checkbox"/> Not informed for following reason: _____</p>
<p>Medical Necessity (Check all that apply): <input type="checkbox"/> Significant impairment <input type="checkbox"/> Probability of significant impairment <input type="checkbox"/> Probably developmental arrest</p> <p>Areas of impairment: <input type="checkbox"/> Daily activities <input type="checkbox"/> Social relationships <input type="checkbox"/> Health <input type="checkbox"/> Work/school <input type="checkbox"/> Living arrangement <input type="checkbox"/> Other: _____</p>	
Risk Assessment	
<p>Suicidality</p> <ul style="list-style-type: none"> <input type="checkbox"/> No indication <input type="checkbox"/> Denies <input type="checkbox"/> Active ideation <input type="checkbox"/> Passive ideation <input type="checkbox"/> Intent without plan <input type="checkbox"/> Intent with means <input type="checkbox"/> Ideation past yr <input type="checkbox"/> Attempt past yr <input type="checkbox"/> Family/peer hx of completed suicide 	<p>Homicidality</p> <ul style="list-style-type: none"> <input type="checkbox"/> No indication <input type="checkbox"/> Denies <input type="checkbox"/> Active ideation <input type="checkbox"/> Passive ideation <input type="checkbox"/> Intent without means <input type="checkbox"/> Intent with means <input type="checkbox"/> Ideation past yr <input type="checkbox"/> Violence past yr <input type="checkbox"/> Hx assault/temper <input type="checkbox"/> Cruelty to animals

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<p>Hx Substance Abuse</p> <p>Alcohol:</p> <p><input type="checkbox"/> No indication</p> <p><input type="checkbox"/> Denies</p> <p><input type="checkbox"/> Past</p> <p><input type="checkbox"/> Current</p> <p>Freq/Amt: _____</p> <p>Drugs:</p> <p><input type="checkbox"/> No indication</p> <p><input type="checkbox"/> Denies</p> <p><input type="checkbox"/> Past</p> <p><input type="checkbox"/> Current</p> <p>Drugs: _____</p> <p>Freq/Amt: _____</p> <p><input type="checkbox"/> Current alc/sub abuse by family/ significant other</p>	<p>Sexual & Physical Abuse and Other Risk Factors</p> <p><input type="checkbox"/> Current child w abuse hx: <input type="checkbox"/> Sexual <input type="checkbox"/> Physical <input type="checkbox"/> Emotional <input type="checkbox"/> Neglect</p> <p><input type="checkbox"/> Adult w childhood abuse: <input type="checkbox"/> Sexual <input type="checkbox"/> Physical <input type="checkbox"/> Emotional <input type="checkbox"/> Neglect</p> <p><input type="checkbox"/> Adult w abuse/assault in adulthood: <input type="checkbox"/> Sexual <input type="checkbox"/> Physical <input type="checkbox"/> Current</p> <p><input type="checkbox"/> History of perpetrating abuse: <input type="checkbox"/> Sexual <input type="checkbox"/> Physical</p> <p><input type="checkbox"/> Elder/dependent adult abuse/neglect</p> <p><input type="checkbox"/> Anorexia/bulimia/other eating disorder</p> <p><input type="checkbox"/> Cutting or other self-harm: <input type="checkbox"/> Current <input type="checkbox"/> Past Method: _____</p> <p><input type="checkbox"/> Criminal/legal hx: _____</p> <p><input type="checkbox"/> None reported</p>	
<p>Indicators of Safety: <input type="checkbox"/> At least one outside person who provides strong support <input type="checkbox"/> Able to cite specific reasons to live, not harm self/other <input type="checkbox"/> Hopeful <input type="checkbox"/> Has future goals <input type="checkbox"/> Willing to dispose of dangerous items <input type="checkbox"/> Willing to reduce contact with people who make situation worse <input type="checkbox"/> Willing to implement safety plan, safety interventions <input type="checkbox"/> Developing set of alternatives to self/other harm <input type="checkbox"/> Sustained period of safety: <input type="checkbox"/> Other: _____</p>		
<p>Safety Plan includes: <input type="checkbox"/> Verbal no harm contract <input type="checkbox"/> Written no harm contract <input type="checkbox"/> Emergency contact card <input type="checkbox"/> Emergency therapist/agency number <input type="checkbox"/> Medication management <input type="checkbox"/> Specific plan for contacting friends/support persons during crisis <input type="checkbox"/> Specific plan of where to go during crisis <input type="checkbox"/> Specific self-calming tasks to reduce risk before reach crisis level (e.g., journaling, exercising, etc.) <input type="checkbox"/> Specific daily/weekly activities to reduce stressors <input type="checkbox"/> Other: _____</p>		
<p>Legal/Ethical Action Taken: <input type="checkbox"/> NA Explain: _____</p>		
Case Management		
<p>Date</p> <p>1st visit: _____</p> <p>Last visit: _____</p> <p>Session Freq:</p> <p><input type="checkbox"/> Once week <input type="checkbox"/> Every other week <input type="checkbox"/> Other: _____</p> <p>Expected Length of Treatment:</p> <p>_____</p>	<p>Modalities:</p> <p><input type="checkbox"/> Individual adult</p> <p><input type="checkbox"/> Individual child</p> <p><input type="checkbox"/> Couple</p> <p><input type="checkbox"/> Family</p> <p><input type="checkbox"/> Group: _____</p>	<p>Is client involved in mental health or other medical treatment elsewhere?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes: _____</p> <p>If Child/Adolescent: Is family involved?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Patient Referrals and Professional Contacts</p> <p>Has contact been made with social worker?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No: explain: _____ <input type="checkbox"/> NA</p> <p>Has client been referred for physical assessment?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No evidence for need</p> <p>Has client been referred for psychiatric assessment?</p> <p><input type="checkbox"/> Yes; cl agree <input type="checkbox"/> Yes, cl disagree <input type="checkbox"/> Not rec.</p>		

Has contact been made with treating physicians or other professionals?

Yes No NA

Has client been referred for social/legal services?

Job/training Welfare/food/housing Victim services

Legal aid Medical Other: _____ NA

Anticipated forensic/legal processes related to treatment:

No Yes _____

Has client been referred for group or other support services?

Yes No NA

Client social support network includes:

Supportive family Supportive partner Friends Religious/spiritual organization Supportive work/social group Other: _____

Anticipated effects treatment will have on others in support system (parents, children, siblings, significant others, etc.):

Is there anything else client will need to be successful?

Client Sense of Hope: Little 1-----10 High

Expected Outcome and Prognosis

- Return to normal functioning
- Expect improvement, anticipate less than normal functioning
- Maintain current status/prevent deterioration

Evaluation of Assessment/Client Perspective

How was assessment method adapted to client needs?

Age, culture, ability level, and other diversity issues adjusted for by:

Systemic/family dynamics considered in following ways:

Describe actual or potential areas of client-therapist agreement/disagreement related to the above assessment: