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Diagnostic Assessment

Name: _____ DOB _____ S M C D W

Intake/Assessment date(s): _____ Report date: _____

1. Purpose of Visit/Current Life Situation (Include duration/frequency of symptoms)

2. History of Current Problem/Developmental Incidents/Treatment History/ Medications, etc.

3. Current Functioning, Symptoms, and Impairments (e.g., occupational, social, emotional)

Strengths: _____

Weaknesses: _____

4. Family Mental Health History

5. Other (Substance abuse, suicidal ideations, court referral, etc.)

Mental Status Exam

	Normal		Slight		Moderate		Severe	
Appearance								
Unkempt, unclean, disheveled	0	1	2	3	4	5	6	
Clothing and/or grooming atypical	0	1	2	3	4	5	6	
Unusual physical characteristics	0	1	2	3	4	5	6	
Comments re: Appearance:	<hr/> <hr/> <hr/>							

	Normal		Slight		Moderate		Severe	
Posture								
Slumped	0	1	2	3	4	5	6	
Rigid, tense	0	1	2	3	4	5	6	

	Normal		Slight		Moderate		Severe	
Facial Expressions Suggest								
Anxiety	0	1	2	3	4	5	6	
Depression, sadness	0	1	2	3	4	5	6	
Absence of feeling, blandness	0	1	2	3	4	5	6	
Atypical, unusual	0	1	2	3	4	5	6	

General Body Movements	Normal	Slight	Moderate			Severe	
Accelerated, increased speed	0	1	2	3	4	5	6
Decreased, slowed	0	1	2	3	4	5	6
Atypical, unusual	0	1	2	3	4	5	6
Restless, fidgety	0	1	2	3	4	5	6

Speech

Rapid speech	0	1	2	3	4	5	6
Slowed speech	0	1	2	3	4	5	6
Loud speech	0	1	2	3	4	5	6
Soft speech	0	1	2	3	4	5	6
Mute	0	1	2	3	4	5	6
Atypical, quality (e.g., slurring)	0	1	2	3	4	5	6

Therapist/Client Relationship

Domineering, controlling	0	1	2	3	4	5	6
Submissive, compliant, dependent	0	1	2	3	4	5	6
Provocative, hostile, challenging	0	1	2	3	4	5	6
Suspicious, guarded, evasive	0	1	2	3	4	5	6
Uncooperative, noncompliant	0	1	2	3	4	5	6

Comments re: Behavior: _____

Affect/Mood

Inappropriate to thought content	0	1	2	3	4	5	6
Increased lability of affect	0	1	2	3	4	5	6
Blunted, dulled, bland	0	1	2	3	4	5	6
Euphoria, elation	0	1	2	3	4	5	6
Anger, hostility	0	1	2	3	4	5	6
Anxiety, fear, apprehension	0	1	2	3	4	5	6
Depression, sadness	0	1	2	3	4	5	6

Comments re: Affect: _____

Normal Slight Moderate Severe

Perception

Illusions	0	1	2	3	4	5	6
Auditory hallucinations	0	1	2	3	4	5	6
Visual hallucinations	0	1	2	3	4	5	6
Other hallucinations	0	1	2	3	4	5	6

Comments re: Perception: _____

Intellectual Functioning Impairments

Level-of-consciousness	0	1	2	3	4	5	6
Attention span distractible	0	1	2	3	4	5	6
Abstract thinking	0	1	2	3	4	5	6
Calculation ability	0	1	2	3	4	5	6
Intelligence	0	1	2	3	4	5	6

Orientation

Time	0	1	2	3	4	5	6
Place	0	1	2	3	4	5	6
Person	0	1	2	3	4	5	6
Context	0	1	2	3	4	5	6

Memory Impairment

Recent	0	1	2	3	4	5	6
Remote	0	1	2	3	4	5	6

Insight

Denies psych problems	0	1	2	3	4	5	6
Blames others	0	1	2	3	4	5	6

Judgment Impairments

Decision making	0	1	2	3	4	5	6
Impulse control	0	1	2	3	4	5	6

	Normal	Slight	Moderate	Severe			
Thought Content							
Obsessions	0	1	2	3	4	5	6
Compulsions	0	1	2	3	4	5	6
Phobias	0	1	2	3	4	5	6
Depersonalization	0	1	2	3	4	5	6
Suicidal ideation	0	1	2	3	4	5	6
Homicidal ideation	0	1	2	3	4	5	6
Delusions	0	1	2	3	4	5	6
Comments re: Thinking:	_____						

Diagnosis Validation

Primary diagnosis: _____

Name of test	Results
_____	_____
_____	_____
_____	_____
_____	_____

Biographical Information (Specific BIF references)

Collateral Information

Case/Intake Notes, MSE References (Include brief descriptions, dates, and line numbers)

Diagnosis 2: _____ (Make copies for additional Dx's)

Name of test	Results
_____	_____
_____	_____
_____	_____
_____	_____

Biographical Information (Specific BIF references)

Case/Intake Notes, MSE References (Include brief descriptions, dates, and line numbers)

Diagnostic Impressions

Axis I _____
Axis II _____
Axis III _____
Axis IV _____
Axis V _____

Needed Mental Health Services

Further assessment (specify): _____
 Individual Group Family Psychiatric Other (specify): _____

Other Needed Services

Psychiatric consultation Physical exam Neurological consultation
 CD evaluation Other (specify): _____
Was Dx explained to client? No Yes

Signed _____ Date: ____/____/____