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**ADULT CLINICAL ASSESSMENT**

DATE COMPLETED:

CLIENT NAME: \_\_\_\_\_

CLIENT DOB: \_\_\_\_\_ CLIENT AGE: \_\_\_\_\_

PRESENTING PROBLEM: \_\_\_\_\_

\_\_\_\_\_

HISTORY OF MENTAL HEALTH TREATMENT/SERVICES: \_\_\_\_\_

HISTORY OF MENTAL HEALTH ISSUES IN FAMILY: \_\_\_\_\_

\_\_\_\_\_

FUNCTIONAL IMPAIRMENT (S): \_\_\_\_\_

\_\_\_\_\_

DEVELOPMENTAL HISTORY: \_\_\_\_\_

\_\_\_\_\_

PEER RELATIONSHIPS: \_\_\_\_\_

\_\_\_\_\_

USE OF DRUGS OR ALCOHOL: \_\_\_\_\_

\_\_\_\_\_

FAMILY MEMBERS/AGES: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_

MEDICAL CONDITIONS: \_\_\_\_\_

MEDICATIONS; \_\_\_\_\_

(GENOGRAM ON BACK)

WORK/EDUCATION

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ACTIVITIES: \_\_\_\_\_

STRENGTHS: \_\_\_\_\_

SUPPORT SYSTEM: \_\_\_\_\_

CHURCH INVOLVEMENT: \_\_\_\_\_

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DIAGNOSIS:

AXIS I: (CLINICAL DISORDER) \_\_\_\_\_

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AXIS II: (PERSONALITY DISORDER) \_\_\_\_\_

AXIS III: (HEALTH) \_\_\_\_\_

AXIS IV:

<input type="checkbox"/> RELATIONSHIP CONFLICT	<input type="checkbox"/> PROBLEM PREGNANCY	<input type="checkbox"/> DRUG MISUSE
<input type="checkbox"/> DIAGNOSED MENTAL ILLNESS	<input type="checkbox"/> PROBLEMS OR CONFLICT IN SCHOOL	<input type="checkbox"/> ALCOHOL MISUSE
<input type="checkbox"/> CHILD CARE PRACTICES	<input type="checkbox"/> EMOTIONAL SYMPTOMS/COMPLAINTS	<input type="checkbox"/> CHILD'S BEHAVIOR
<input type="checkbox"/> PHYSICAL COMPLAINTS	<input type="checkbox"/> INADEQUATE FOOD, CLOTHING, SHELTER	
<input type="checkbox"/> DIVORCE ADJUSTMENT	<input type="checkbox"/> PHYSICAL VIOLENCE BETWEEN ADULTS	
<input type="checkbox"/> REPORTED CHILD ABUSE, NEGLECT OR PARENTAL ALCOHOLISM		
<input type="checkbox"/> OTHER _____		

AXIS V: (GLOBAL ASSESSMENT OF FUNCTIONING): \_\_\_\_\_

RECOMMENDATIONS FOR THERAPY (IND/GRP/FAMILY): \_\_\_\_\_

REFERRALS: \_\_\_\_\_

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CLIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

CLINICIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_