DASHOMETRICS, LLC
EMPOWERING PSYCHOLOGICAL TOOLS

- STANDARD - DIAGNOSTIC ASSESSEMENT-I

Client Name ______________________________ **Age/DOB** ______________

Date of Face to Face ____________________ **Therapist** ______________________

Sources of Information: ❍ Interview(s) of Client ❍ Review of previous Diagnostic Assessment
❍ Interview(s) with Others (Family/supports) ❍ Health Records Review ❍ Observations
Comments ____
Who made the phone call to schedule this appointment or otherwise scheduled it? ______________
What exactly was happening at this time and what was the motive for making the appointment? ________
____

CURRENT LIFE SITUATION

FOR DEMONSTRATION ONLY

Emotional Dashboard : Please indicate if you have experienced any of these mood or mental conditions within the last week or since our last meeting. Please scale them from 0 (lowest level) to 10 (highest level):

____ Anger ____ Anxiety ____ Confusion
____ Depression ____ Grief ____ Guilt

Additional Life Situation Notes ____
____

Living Situation: ❍ Homeless ❍ Owns home ❍ Rental property ❍ Lives with others
❍ Group Residential setting ❍ Subsidized housing ❍ Other ____________________

Developmental History: ❍ Unable to read/write ❍ Delayed developmental milestones
❍ History of special education ❍ Need for developmental adaptations
❍ No known or identified developmental challenges ❍ Other ____________________

FOR DEMONSTRATION ONLY

Abuse/Trauma History: ❍ None identified ❍ Death of a parent ❍ Death of someone very close
❍ Separation/divorce ❍ Accident/serious injury ❍ Neglect ❍ Witness to traumatic event(s)
❍ Learned about traumatic events of family or friends ❍ Death or loss of a pet
❍ Exposure to combat/war conditions ❍ Lived in refugee camp ❍ History of long-term homelessness
❍ Other ____

ECONOMIC/EDUCATION STATUS

Education: ❍ No formal education ❍ Some education *(HS diploma not obtained)*
❍ HS diploma or GED equivalent ❍ Some post-secondary education *(no degree obtained)*
❍ Associates degree ❍ Bachelors degree ❍ Masters degree or higher

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Employment: ❍ Not employed ❍ Employed part-time ❍ Employed full-time ❍ Volunteer
❍ Other ____

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ECONOMIC/EDUCATION STATUS *(continued)*

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Financial: ❍ No income ❍ General assistance ❍ Receives SSI ❍ Job-related income
❍ Representative payee ❍ Receives income from family, gift, or trust fund ❍ Other ____________

Legal Status/Concerns: ❍ None ❍ Criminal/Traffic ❍ Civil/Family
❍ Guardian/Conservator/Power of Attorney ❍ Other ______________________________

PHYSICAL HEALTH

Current Healthcare Resources: ❍ Primary Care Provider ❍ Not connected with health provider
❍ Dental Care ❍ Use or interest in complementary health approaches ❍ Physical healhcare directive
❍ None identified ❍ Other ______________________________

Contact information for Primary Care Provider: ______________________________

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Medical Concerns: ❍ Asthma ❍ COPD ❍ Heart disease ❍ Hypertension ❍ Cancer ❍ Diabetes
❍ Stroke ❍ Chronic Pain ❍ Seizures ❍ Traumatic brain injury ❍ Other ____________

List of Medications: ______________________________
____
____

SUBSTANCE ABUSE

Substance Abuse History? ❍ Yes ❍ No

Type of Substance Use Reported: ❍ Alcohol ❍ Marijuana ❍ Cocaine/Crack ❍ Hallucinogens
❍ Stimulants (amphetamines) ❍ Opiates ❍ Synthetics ❍ Other ______________________________

Treatment History: ❍ None ❍ Inpatient ❍ Outpatient ❍ AA/Peer-led support groups
❍ Other ______________________________ Dates/Locations: ______________________________

FOR DEMONSTRATION ONLY

Stage of Change/Readiness: ❍ Pre-contemplation ❍ Contemplation ❍ Action
❍ Maintenance ❍ Relapse ❍ Other ______________________________

MENTAL HEALTH HISTORY

Current Mental Healthcare Resources: ❍ Psychiatric provider ❍ Therapist ❍ ARMHS
❍ Psychiatric healthcare directive ❍ Other ______________________________ ❍ None identified

Mental Health History: ______________________________
____
____

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MENTAL HEALTH EXAM

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Appearance: ❍ Well-groomed ❍ Groomed ❍ Dishevelled ❍ Poor hygiene ❍ Other ____________

Speech: ❍ Clear ❍ Slowed ❍ Pressured ❍ Accelerated ❍ Slurred ❍ Other ____________

Affect: ❍ Appropriate ❍ Flat ❍ Blunted/constricted ❍ Expansive ❍ Other ____________

Orientation: ❍ Person ❍ Place ❍ Time ❍ Disoriented ❍ Other ____________

Psycho-motor Functioning: ❍ Within normal limits ❍ Agitated ❍ Retarded ❍ Other ____________

Attitude Toward Interview: ❍ Cooperative/Engaged ❍ Irritable ❍ Withdrawn ❍ Guarded/Suspicious ❍ Anxious ❍ Aggressive ❍ Other ____________

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Thought Process: ❍ Linear ❍ Circular ❍ Intact ❍ Circumstantial ❍ Disorganzied ❍ Tangential ❍ Loose associations ❍ Other ____________

Thought Content: ❍ Within normal limits ❍ Delusions ❍ Hallucinations ❍ Disassociation ❍ Preservation ❍ Paranoia ❍ Bizzare ❍ Other ____________

Memory: ❍ Intact ❍ Impaired/Recent ❍ Impaired/Remote ❍ Other ____________

Mood: ❍ Calm ❍ Depressed ❍ Anxious ❍ Irritable ❍ Heightened ❍ Other ____________

Insight: ❍ Intact ❍ Impaired/Mild Impaired/Moderate Impaired/Severe

Judgement: ❍ Intact ❍ Impaired/Mild ❍ Impaired/Moderate ❍ Impaired/Severe

RISK ASSESSMENT

Are you experiencing any suicidal thoughts, plans, intentions or self-injurious behavior? ❍ No ❍ Yes

Which are you experiencing? ❍ Thoughts ❍ Plans ❍ Intentions ❍ Self-injurious behavior

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Have you attempted suicide in the past? ❍ No ❍ Yes

Can the client entertain options/future? ❍ No ❍ Yes

Is there access to lethal means of self-harm? ❍ No ❍ Yes Violent toward self or others? ❍ No ❍ Yes

Family history of suicide or violence? ❍ No ❍ Yes Support system available? ❍ No ❍ Yes

Do you or have you ever wanted to hurt someone, had homicidal thoughts, plans, intent, done damage to property?

❍ No ❍ Yes Notes: ____________

____

Action taken/referral given based on risk assessment? ____________

____

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CLINICAL SUMMARY

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SERVICE RECOMMENDATIONS

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Meets Criteria for: ❍ Serious & Persistent Mental Illness ❍ Serious Mental Illness
❍ Severely Emotionally Disturbed

Recommended Assessments: ❍ Neuro-psychological Evaluation ❍ Chemical Health Assessment
❍ Elderly or CADI waiver ❍ TBI waiver ❍ Long term care ❍ Guardian or Conservator
❍ Physical/Wellness exam ❍ Dental ❍ Other ______________________________

Mental Health Services Needed: ❍ Case Management Services ❍ Behavioral Health Home Services
❍ Partial Hospitalization ❍ Intensive Residential Treatment Services (IRTS) ❍ Day Treatment
❍ Adult Rehabilitative Mental Health Services (ARMHS) ❍ Adult Foster Care ❍ Individual Psychotherapy
❍ Psychiatry ❍ Crisis Stabilization ❍ ACT Services ❍ Other ______________________

Recommended frequency of individualized psychotherapy ______________________________

FOR DEMONSTRATION ONLY

DIAGNOSIS ____

Clinical Indicators/Justifications

____

____

____

____

____

______________________________ Staff Signature

______________________________ Date Completed

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