YOUTH COMPREHENSIVE DIAGNOSTIC ASSESSMENT

PLEASE COMPLETE ALL AREAS OF THIS FORM PRIOR TO APPOINTMENT

(1) IDENTIFYING INFORMATION

Name: ______________________________ DOB: ____________________

Assessor: ______________________________ Date of Assessment: ____________________

Legal Guardian(s)*: ______________________________

*Can the person(s) identified as the legal guardian legally authorize medical treatment for the client? ☐ Yes ☐ No

*If the guardian is someone other than a parent, has proof of guardianship been provided to this agency? ☐ Yes ☐ No

☐ New Clinic Participant – No Medicaid mental health clinic services have been received in Idaho in the past 12 months

☐ Active Clinic Participant – Medicaid mental health clinic services have been received in Idaho in the past 12 months

(2) PRESENTING PROBLEM

Please state the principal reason this consultation or treatment has been requested: ______________________________

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Please describe the current episode of the child's problems/illness from the time of his/her first symptom to the present, including dates and significant events: ______________________________

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Please list recent stressful life events: ______________________________

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Please tell us what you hope to accomplish by coming to therapy (your treatment goals): ______________________________

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Client Name:___________________________________

Specific Questions Regarding Psychiatric Problems	For Clinician Use Only:
Depression – Has your child had a period of time in which they felt unhappy, depressed, irritable, and felt no interest in life consistently for at least two to four weeks? ☐ Yes, now. ☐ Yes, in the past. ☐ No	
High Periods or Mania – Has your child had moods that lasted one week or more in which they had so much energy they did not sleep for several nights, or felt they could accomplish many difficult tasks easily? Were they feeling so good that others commented on their elevated mood? ☐ Yes, now. ☐ Yes, in the past. ☐ No	
Chronic Feelings of Unhappiness – Has your child felt mildly unhappy or unable to enjoy life for many years, for no apparent reason? ☐ Yes, now. ☐ Yes, in the past. ☐ No	
Suicide Attempts – Has your child attempted suicide? ☐ Yes, now. ☐ Yes, in the past. ☐ No	
Self Harm – Besides attempting suicide, has your child attempted to do physical harm to themself in other ways, such as cutting or burning themself? ☐ Yes, now. ☐ Yes, in the past. ☐ No	
Chronic Tension or Anxiety – Has your child ever had problems with chronic anxiety, tension, nervousness, or constant worrying? Do they worry about minor concerns? (Not connected to anxiety attacks) ☐ Yes, now. ☐ Yes, in the past. ☐ No	
Panic Attacks – Has your child had anxiety attacks in which they felt like they were going to die, lose control, were very frightened, extremely anxious, or uncomfortable? ☐ Yes, now. ☐ Yes, in the past. ☐ No	
Panic Associated Fears – Has your child ever been afraid of going out of the house alone, going to the grocery store, driving or using public transportation because of fear of having a panic attack? ☐ Yes, now. ☐ Yes, in the past. ☐ No	
Obsessive/Compulsive Symptoms – Has your child had compulsions to repeat tasks such as checking things, washing hands, counting, or obsessions (ideas that make no sense but keep repeating in their mind?) ☐ Yes, now. ☐ Yes, in the past. ☐ No	
Social Fears or Phobias – Has your child been fearful in specific social situations, or felt uncomfortable doing things in front of other people? Do they worry excessively about being embarrassed or humiliated in social situations? ☐ Yes, now. ☐ Yes, in the past. ☐ No	
Phobias – Has your child had significant phobias such as heights, flying, closed spaces, insects, etc. that interfere with their life? ☐ Yes, now. ☐ Yes, in the past. ☐ No	

Client Name:___________________________________

Specific Questions Regarding Psychiatric Problems	For Clinician Use Only:
Posttraumatic Symptoms – Has your child ever experienced a very traumatic event that has continued to bother them or cause emotional problems later in life, such as nightmares or flashbacks of the event? ☐ Yes, now. ☐ Yes, in the past. ☐ No	
Hyperactivity/Inattention – Was/is your child considered hyperactive and/or inattentive, been treated with Ritalin or another stimulant, or been diagnosed with ADHD? ☐ Yes, now. ☐ Yes, in the past. ☐ No	
Psychotic Symptoms – Has your child had hallucinations, heard voices, felt that they had special powers or were receiving special messages, felt inappropriately suspicious that people were trying to hurt them? ☐ Yes, now. ☐ Yes, in the past. ☐ No	
Chronic Physical Symptoms – Has your child had a period of time in which they felt physically sick or worried about their health when no physical cause could be found? ☐ Yes, now. ☐ Yes, in the past. ☐ No	
Chronic Pain – Has your child had problems with chronic pain such as headaches or stomachaches? If so please specify:____ ☐ Yes, now. ☐ Yes, in the past. ☐ No	
Sleep Problems – Has your child experienced sleep problems such as insomnia, oversleeping, frequent nightmares or sleepwalking? ☐ Yes, now. ☐ Yes, in the past. ☐ No	
Anorexia – Has your child ever been anorexic or purposely lost weight to obtain a weight below normal? ☐ Yes, now. ☐ Yes, in the past. ☐ No	
Binge Eating or Bulimia – Has your child had eating binges associated with inducing vomiting, using laxatives, or exercising to extreme? ☐ Yes, now. ☐ Yes, in the past. ☐ No	
Compulsive Behaviors – Has your child had problems with compulsive behaviors such as gambling, spending, work, sex, pornography, or other problematic compulsions? ☐ Yes, now. ☐ Yes, in the past. ☐ No	
Temper/Anger Problems – Has your child had problems with their temper? ☐ Yes, now. ☐ Yes, in the past. ☐ No	
Oppositional Behaviors – Does your child argue with adults, defy rules, deliberately annoy others, blame others for their misbehavior, or act easily annoyed more that their peers? ☐ Yes, now. ☐ Yes, in the past. ☐ No	
Conduct Disorder Problems – Has your child repetitively exhibited threatening behavior, cruelty to animals, fire-setting, destruction of property, shoplifting, stealing, lying, running away, running away, truancy, gang activity, etc.? ☐ Yes, now. ☐ Yes, in the past. ☐ No	

Client Name:___________________________________

(3) BEHAVIORAL HEALTH TREATMENT HISTORY

	Who provided the service?	When and how often?	Was it helpful? Please explain.
Counseling			
Medication Management			
Family Therapy			
Case Management			
CBRS/PSR			
Addictions Treatment			
Developmental Services			
Occupational Therapy			
Speech Therapy			
Physical Therapy			
IEP or 504 Plan			
Personal Care Services			
Other			

Has your child been admitted to a residential treatment program or psychiatric hospital? ☐ No ☐ Yes – please complete:

Institution	Reason for admission	Date	Length of stay	Did it help?
____________	________________________	__________	__________	________________________
____________	________________________	__________	__________	________________________
____________	________________________	__________	__________	________________________

(4) SUBSTANCE USE/ABUSE

Alcohol Use/Abuse – Does your child drink alcohol? ☐ Yes, now ☐ Yes, in the past ☐ No

☐ My child drinks occasionally: ____ x per month ☐ My child drinks most days: ____ x per week

☐ I believe my child has a drinking problem.

Drug Abuse – Has your child abused “street” or prescription drugs? ☐ Yes, now ☐ Yes, in the past ☐ No

If yes, what drug(s) and what ages with each drug? ____

____

Smoking/Vaping/Other – Does your child smoke, use other tobacco products, or vape? ☐ Yes, now ☐ Yes, in the past

☐ No If yes how much per day/week and for how long? ____

Caffeine – Does your child regularly drink coffee, tea or colas? ☐ No ☐ Yes – How much? ____________________

Clinician Comments:

Client Name:_______________________________________

(5) FAMILY PSYCHIATRIC HISTORY Please include psychiatric problems in your child's biological relatives. Consider problems such as depression, bipolar disorder, anxiety disorders (OCD, panic disorder, PTSD), schizophrenia, ADHD, alcohol or drug abuse, anger or criminal problems, suicides, etc.				
Relative	Yes	No	?	Type(s) of problem(s)
Child's Mother				
Mother's Relatives				
Child's Father				
Father's Relatives				
Child's Siblings				

(6) MEDICAL HISTORY & FUNCTIONING

How is your child's general health? ☐Good ☐Fair ☐Poor Primary Care Physician: ______________________________

Other Medical Doctors/Specialists: ____

____

History of significant illness or medical treatment in the family: ____

____

Health Conditions - Check any health conditions that apply:

☐ Thyroid problem ☐ High blood pressure ☐ Headaches

☐ Heart problem ☐ Sleep problems ☐ High cholesterol

☐ Asthma ☐ Trouble eating ☐ Other: _____________________________

☐ Stomach problems ☐ Seizures ☐ Other: _____________________________

Does your child have

any contagious diseases? ☐ No ☐ Yes What/When: ____

any disabilities or handicaps? ☐ No ☐ Yes What/When: ____

any allergies? ☐ No ☐ Yes What/When: ____

Client Name:_______________________________

Has your child had any

accidents/injuries?	☐ No	☐ Yes	What/When: ___________________
surgeries?	☐ No	☐ Yes	What/When: ___________________
major illnesses?	☐ No	☐ Yes	What/When: ___________________
hospitalizations?	☐ No	☐ Yes	What/When: ___________________
loss of consciousness?	☐ No	☐ Yes	What/When: ___________________

Menstrual History – What was the date of your child's last menstrual period? ________________

Does your child have any history of:

premenstrual syndrome?	☐ No	☐ Yes	What/When: ___________________
amenorrhea (absence of periods)?	☐ No	☐ Yes	What/When: ___________________
irregular periods?	☐ No	☐ Yes	What/When: ___________________
pregnancy?	☐ No	☐ Yes	What/When: ___________________

Current Medication - Please list all current prescribed or over-the-counter drugs/medications that your child takes.

☐ No medications

Medication: ________________ Dosage: ________ Doctor: ________________

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Medication: ________________ Dosage: ________ Doctor: ________________

Medication: ________________ Dosage: ________ Doctor: ________________

Medication: ________________ Dosage: ________ Doctor: ________________

Can your child self-administer their medication? ☐ No ☐ Yes

Medication compliance: ☐ Regularly taken as prescribed ☐ Occasionally misses a dose
☐ Misses doses regularly ☐ Refuses/forgets to take meds most days

Past Medication - Has your child been treated in the past with psychiatric medication? ☐ No ☐ Yes – please complete:

Antidepressants		Mood Stabilizers	Tranquilizers	Sleeping Aids	Stimulants	Others
Prozac	Serzone	Lithium	Xanax	Ambien	Ritalin	Rispedal
Zoloft	Wellbutrin	Depakote	Klonopin	Sonata	Dexedrine	Zyprexa
Paxil	Amitriptyline	Tegretol	Ativan	Trazodone	Adderall	Seroquel
Luvox	Nortriptyline	Lamictal	Valium		Clonidine	Haldol
Celexa	Desipramine	Neurontin	Buspar		Concerta	Prolixin
Effexor	Anafranil	Abilify			Provigil	Thorazine
Remeron					Vyvanse	Trilafon
					Strattera	Antabuse

Clinician Comments:

Client Name:___________________________________

DEVELOPMENTAL HISTORY

Early Development - Did your child or their biological mother experience any significant medical problems during the pregnancy, labor, delivery, or newborn period? ☐ No ☐ Yes – please explain: ___________________________________

____

Was your child exposed to alcohol, tobacco, or illicit drugs while in utero? ☐ No ☐ Yes – please explain: _____________

____

Did your child ever spend a significant period of time separated from their primary caregiver(s) for any reason?
☐ No ☐ Yes – please explain: ____

____

Have you or your child's pediatrician ever expressed concerns about your child's development? ☐ No ☐ Yes – please explain: ____

____

Clinician Comments:

(7) FAMILY HISTORY & FUNCTIONING

Place of child's birth: ________________________________

Parents at the time of birth were: ☐ Married ☐ Separated ☐ Unmarried

Are the parents divorced? If so, when?__________________________Remarriages? _______________________________

Father's Name: ______________________________ Mother's Name: _____________________________

Where is he living: ___________________________ Where is she living: ___________________________

Stepmother's Name: __________________________ Stepfather's Name: ___________________________

Custody: ☐ Lives in one home with both legal parents. ☐ Mother has physical custody.
☐ Father has physical custody. ☐ Physical custody is shared.
☐ Other: ____

Household members:

Name	Age	Relationship
______________________	_____	___________________________________
______________________	_____	___________________________________
______________________	_____	___________________________________
______________________	_____	___________________________________
______________________	_____	___________________________________
______________________	_____	___________________________________

Client Name:______________________________

Siblings not in household: Name Age Relationship

Name	Age	Relationship

If any siblings are deceased, please give name and year: ______________________________

Was the child adopted? ☐ No ☐ Yes – Age at time of adoption: __________ Circumstances:__________________

Has the child ever been placed outside of the home? ☐ No ☐ Yes – please explain: __________________

Has the child been physically or sexually abused, assaulted or molested, or perpetrated the abuse of others? ☐ No ☐ Unsure ☐ Yes – please specify when and circumstances: ______________________________

Please describe the child's relationship with his/her

Father: ______________________________

Mother: ______________________________

Siblings: ______________________________

Stepparent(s): ______________________________

Please describe the type of structure and discipline used in the home: ______________________________

Please explain your family's cultural and/or spiritual background: ______________________________

Where did the child live while he/she was growing up? Did the family move frequently?__________________

What resources and supports does the child/family have? ______________________________

What are the child's strengths in the family setting? ______________________________

Clinician Comments:

Client Name:___________________________________

(8) SOCIAL HISTORY & FUNCTIONING

How would you describe your child's friendships? ☐ No friends ☐ Only acquaintances ☐ Acquaintances & Friends

How would you describe your child's behavior when they are in social situations? ___________________________________

____

Please indicate the child's sexual orientation: ___________________________________

Please indicate your child's gender: ___________________________________

Has your child experienced any difficulties related to age, gender, sexual orientation, culture, race, or religion? ☐ No ☐ Yes – please explain: ___________________________________

Is your child sexually active or do they demonstrate overly sexualized behavior? ☐ No ☐ Yes – please explain (number of partners, risky behavior, etc): ___________________________________

____

What leisure/recreational/extracurricular activities is your child involved in? ___________________________________

____

What are your child's talents and social strengths? ___________________________________

____

Clinician Comments:

(9) VOCATIONAL/EDUCATIONAL HISTORY & FUNCTIONING

Education - School: ___________________________ Grade Level: _________

Is your child in a specialized classroom setting or receive special education? ☐ No ☐ Yes – please explain: _____________

____

Regarding school, has your child ever

had an IEP or 504 plan? ☐ No ☐ Yes – please explain: ___________________________________

been tutored? ☐ No ☐ Yes – please explain: ___________________________________

been suspended? ☐ No ☐ Yes – please explain: ___________________________________

been expelled? ☐ No ☐ Yes – please explain: ___________________________________

Have you been contacted by school personnel because of your child's school performance or behavior? ☐ No ☐Yes – please explain: ___________________________________

What are the average grades your child received:

in elementary school? ___________________________

in junior high? ___________________________

in high school? ___________________________

What are your child's strengths/talents in the school setting? ___________________________________

Employment - Has your child ever been employed? ☐ No ☐ Yes – please describe job(s) and duration of employment: ___

____

Has your child ever

been reprimanded at work? ☐ No ☐ Yes – please explain: ______________________________

been fired from a job? ☐ No ☐ Yes – please explain: ______________________________

participated in a work program? ☐ No ☐ Yes – please explain: ______________________________

What are your child's work skills/interests? ____

Clinician Comments:

(10) FINANCIAL HISTORY & FUNCTIONING

Please describe the family's source(s) of income: ____

Are finances adequate to meet the family's needs? ☐ Yes ☐ No – please explain problems and supports/resources available: _

____

Does the child/family receive

child support? ☐ No ☐ Yes – amount/frequency: ___________________________

SSDI? ☐ No ☐ Yes – amount/frequency: ___________________________

SSI? ☐ No ☐ Yes – amount/frequency: ___________________________

food stamps? ☐ No ☐ Yes – amount/frequency: ___________________________

cash assistance? ☐ No ☐ Yes – amount/frequency: ___________________________

other income? ☐ No ☐ Yes – amount/frequency:___________________________

Please explain any financial responsibilities/obligations your child has and how they manage these responsibilities: _________

____

____

Clinician Comments:

Client Name:___________________________________

(11) BASIC LIVING SKILLS HISTORY & FUNCTIONING

Please indicate your child's habits with regard to the following basic living skill practices:

Bathing (using soap, washing hair) ☐ Daily ☐ A few times per week ☐ Once per week or less

Brushing teeth ☐ Daily ☐ A few times per week ☐ Once per week or less

Dress in clean/appropriate clothes ☐ Daily ☐ A few times per week ☐ Once per week or less

Does your child require repeated prompting in order to accomplish any of these hygiene tasks? ☐ No ☐ Yes

Is your child able to perform the following basic safety skills?

Call 911 in an emergency? ☐ Yes ☐ No

Refrain from playing with matches or other fire hazards? ☐ Yes ☐ No

Use adequate caution when crossing the street? ☐ Yes ☐ No

Use adequate caution when engaging with strangers (are they aware of stranger danger?) ☐ Yes ☐ No

Lock doors and use a key? ☐ Yes ☐ No

Please indicate your child's care of his/her personal possessions: ☐ Good care/age appropriate ☐ Careless ☐ Destructive

Will your child be turning 18 soon and/or preparing to live on their own? ☐ No ☐ Yes – if "yes", please indicate your child's ability to do the following:

Prepare meals ☐ Good ☐ Fair ☐ Poor

Shop for items ☐ Good ☐ Fair ☐ Poor

Develop regular schedules/routines ☐ Good ☐ Fair ☐ Poor

Clinician Comments:

(12) HOUSING HISTORY & FUNCTIONING

Does the current housing situation meet the child's needs in the following areas?

Health and safety? ☐ Yes ☐ No – please explain: ___________________________________

Access to services? ☐ Yes ☐ No – please explain: ___________________________________

Is there any history of homelessness? ☐ No ☐ Yes – please explain: ___________________________________

Is there any risk of homelessness? ☐ No ☐ Yes – please explain: ___________________________________

Clinician Comments:

Client Name:____________________________________

(13) COMMUNITY/LEGAL HISTORY & FUNCTIONING

Does the child have any current or past involvement with the following?

Diversion Court	☐ No	☐ Yes, please explain: ____________________
Probation	☐ No	☐ Yes, please explain: ____________________
Arrest	☐ No	☐ Yes, please explain: ____________________
Illegal activity	☐ No	☐ Yes, please explain: ____________________
Juvenile detention	☐ No	☐ Yes, please explain: ____________________

Does your child have transportation to and from school, appointments, etc? ☐ Yes ☐ No – please explain: _______________

____

Does your child have a

Social Security card? ☐ Yes ☐ No Driver's license? ☐ Yes ☐ No

Clinician Comments:

(14) CLIENT/PARENT SIGNATURE

Name of Person completing this form: ____________________________ Relationship to Client: _______________________

Signature: ____ Date: ______________________________________