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| *Kuna Counseling Center, LLC* ***145 E Deer Flat Rd., Kuna, Idaho 83634***  ***(208) 922-9001***  **COMPREHENSIVE DIAGNOSTIC ASSESSMENT**  Version 8.20 | | | | | | | |
| **Type of CDA:  New  Updated  Annual Review** | | | | | **If update or review original CDA Date:** | | |
| **Participant Name:** | | | **Medicaid #:** | | | | **Date:** |
| **Age:**     **Sex:** | | **Ethnicity:**  **Other:** | | | | | **DOB:** |
| **Examiner:** | | | | **Region:** **IV** | | **Agency:** | |
| **Marital Status:** | **Referral Source:** | | | | | **Participation Status:**  **Voluntary**  **Involuntary** | |
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| PSYCHIATRIC AND MEDICAL HISTORY |
| ***PSYCHIATRIC SECTION*** |
| **Behavioral health treatment history** (previous dx, age of onset, any treatment)**:**  **Behavioral health family history** (previous dx, age of onset, any treatment)**:**  **Any previous history of abuse** (self or witness)**:**  **Has client had counseling or CBRS at a different agency in the past year?  Yes  No If so, where?** |
| **Developmental history/problems** (mental or physical problems)**:  Met milestones at appropriate times of life  Did not meet milestones at appropriate times of life** (explain)**:**  **If the child is an adolescent, give a sexual behavioral history:**        **If child (under 18) please give number of hours per day spent on electronics** (include TV, computer, tablet, phone, video games)**:** |
| MEDICAL SECTION |
| **Does the recipient report any of the following? Check all that apply:**  Head injury/stroke Thyroid problems Chronic pain STD  Loss of consciousness Cancer Enuresis/Encopresis Seizures  Respiratory problems Diabetes Allergies Kidney disease  Heart/vascular problems Sleep problems Hypertension Appetite change  Liver disease Weight change Parasites/scabies/lice  **Medical history** (explain any above marked)**:**        **Allergies to medications and other substances:**  **Family medical history:**  **Self-report of infectious diseases** (previous or current)**:** |
| **Medication history including past and current medications** (what medications, purpose, dose, effects, compliance)**:** |
| **Name and contact information of current primary care physician:**        **Health and Physical obtained from the medical provider?  Yes  No** |
| **Name and contact information of current primary psychiatrist/medication manager:**        **Name and contact information of past primary psychiatrist/medication manager:** |
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| CURRENT ISSUES |
| PSYCHIATRIC SECTION |
| **Presenting problem including current Symptoms of each diagnosis:** (current condition, onset, duration, and frequency including assessments administered and results)**:**  CADIC Completed No Yes**:**  Child Depression Screening Completed No Yes**:** |
| **Risk Assessment:**  **Current Suicidal Ideation** No Yes **Current Homicidal Ideation?** No Yes  **If yes, please explain:**  **History of suicidal or homicidal ideation and/or attempts (include how many, when, and method):**  **Safety Plan, if current risk is identified:**  Does not currently appear in need of a safety plan  Presented to treatment with current safety plan and was reviewed during assessment  Plan was developed |
| **Legal History** (charges, probation/parole, CPS, divorce, legal custody, victim in criminal cases, etc)**:** |
| **Family History:**  Client reports their family to be supportiveYes No  Client currently lives with:  Adult client grew up with:  Client reports their childhood to be:  Childhood punishments (past or present):  Other family information: |
| **Client religious preferences:**  **Assessment of spiritual issues impacting treatment:** |
| **Assessment of vocational/educational issues impacting treatment:** |
| **Assessment of cultural issues impacting treatment:** |
| **Assessment of client’s strengths and other resilience factors including social support network:**  Client identified strengths easily Client struggled to identify strengths |
| **Client’s readiness to participate in treatment as well as current resources:**  Client identified the need for treatment as evidenced by:  Client struggled to identify the need for treatment as evidenced by:  **Activities needed to improve the member's readiness for treatment:** |
| ***ALCOHOL/DRUG HISTORY*** |
| **Illegal drug use/abuse Current:** NoYes  **Past 12 months:** NoYes  **Lifetime:** NoYes  **Prescriptive drug abuse Current:** NoYes **Past 12 months:** NoYes **Lifetime:** NoYes  **Alcohol use/abuse Current:** NoYes **Past 12 months:** NoYes **Lifetime:** NoYes     |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Substance** | **Age first use** | **Age last use** | **Frequency** | **Amount** | **Method** | | Caffeine |  |  |  |  |  | | Tobacco |  |  |  |  |  | | Alcohol |  |  |  |  |  | | Prescription drugs: |  |  |  |  |  | | Other: |  |  |  |  |  | | Other: |  |  |  |  |  | | Other: |  |  |  |  |  | | Other: |  |  |  |  |  |   Additional history attached |
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| **Referral for Community Based Services**  Send Referral to CBS services  Not Applicable-not eligible for services as CBRS, CM, Peer Support, etc. Not a behavior  disorder such as ADHD, ODD, CDD, etc., or a persistent and severe diagnosis such as  Depression, Anxiety, Bipolar, PTSD Schizophrenic, Personality Disorder, etc.  Send Referral to Developmental Disability Services-Has disability diagnosis such as  Spectrum Disorder, Delayed Intellectual Functioning, Intellectual Disability, etc. |

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| **MENTAL STATUS EXAM** | | | | | | | |
| ***General Observations*** | | | | | | | |
| **Appearance** | Weight:  Underweight  WNL  Overweight  Other: | | | Hygiene /Grooming:  Neat  Disheveled  Unkempt  Dirty  Other: | | Dressed appropriate for age and season:  Yes  No: | |
| **Speech** | **Rate**  Slow  Rapid  Pauses  WNL | | | **Volume**  Loud  Soft  Whisper  WNL | | Pressured  Slurred  Stuttering  Talking to self  Controlled Speech Impediment | |
| **Motor Activity** | Normal  Abnormal Movements | | | Decreased  Increased | | Catatonia  Agitation/restless | |
| **Eye contact** | Normal  Inconsistent | | | Decreased  Excessive | | Avoidant  Intrusive | |
| **Cooperativeness** | Cooperative  Uncooperative | | | Hostile  Reluctant | | Other: | |
| ***Thinking*** | | | | | | | |
| **Thought Process** | Logical/Coherent  Vague  Incoherent | | | Disorganized  Bizarre  Repeated Thought | | Tangential  Distracted | |
| **Thought Content** | Appropriate  Future oriented  Ruminating  Obsessions | | | Depersonalization  Fears/Phobias  Self-Harm | | Suicidal/Homicidal Ideation  Plan  Means  Able to Contract | |
| **Perception** | Appropriate  Distorted  Inconsistent | | | Delusions  Paranoid  Grandiose  Bizarre | | Hallucinations  Auditory  Visual  Olfactory  Other | |
| ***Emotion*** | | | | | | | |
| **Mood** | Calm  Apathetic  Distraught | | | Angry  Hopeless  Anxious | | Cheerful  Despondent/ Sad  Irritable | |
| **Affect** | Congruent to mood  Hostile  Agitated | | | Labile  Tearful  Expansive | | Inappropriate  Blunted  Flat | |
| ***Cognition*** | | | | | | | |
| **Orientation /Attention** | Oriented to time  Oriented to person | | | Oriented to place  Oriented to situation | | Inattentive  Distracted | |
| Memory | **Immediate**  Intact  NotIntact | | | **Recent**  Intact  Not intact | | **Remote**  Intact  Not intact | |
| Insight/ Judgment | Intact Denies problem  Blames othersBlames self  Poor impulse control | | | Awareness of symptoms and impact on functioning:  Poor  Limited  Good | | Awareness of need for treatment:  Poor  Limited  Good | |
| **Vegetative Signs** | Appetite: | | | Sleep: | | Concentration: | |
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| ***DIAGNOSTIC SECTION*** | | | | | | | |
| |  | | --- | | **DSM-5/ICD-10 ASSESSMENT** | | | | | | | | |
| |  |  |  |  | | --- | --- | --- | --- | | DSM 5 Code | **Disorder:** | DSM 5 Code | **Disorder:** | | | | | | | | |
| **Type of education provided to members/families about prognosis and outcomes from their diagnosis:** | | | | | | | |
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| **TREATMENT RECOMMENDATIONS** | | | | | | | |
| A. Recommended level of care and types of services to address issues outlined including intensity, frequency, and duration of each service (length of time for a specific service in a single encounter): | | | | | | | |
| *Service Type* | | *Intensity* | | | *Frequency* | | *Duration* |
|  | | Other: | | | Other: | | Other: |
|  | | Other: | | | Other: As Needed | | Other: |
|  | | Other: | | | Other: as needed | | Other: |
|  | | Other: | | | Other: as needed | | Other: |
|  | | Other: As Needed | | | Other: As Needed | | Other: |
|  | | Other: | | | Other: | | Other: |
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| **MEDICAL NECESSITY CRITERIA** | | | | | | | |
| **The assessment must provide documentation of the medical necessity for each service to be provided including, but not limited to, psychotherapy, psychological/neuropsychological assessment, CBRS, partial care, and service coordination. Medical necessity must be established for participant to receive enhanced services. Medical necessity must be documented by the following criteria: the service represents the least restrictive setting and other services have failed or are not appropriate for the clinical needs of the participant, and documentation that the services can reasonably be expected to improve the participant’s condition or prevent further regression so that the current level of care is no longer necessary or may be reduced.** | | | | | | | |
|  | | | **Medical necessity documentation: Due to information in Psychiatric section of current diagnosis and symptoms (reference if necessary), what negative consequences may occur if treatment not implemented?** | | | | |
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| **ANNUAL ASSESSMENTS (Document why a new or updated assessment is more appropriate for participant):** | | | | | | | |
| **CLINICIAN’S SIGNATURE, DEGREE, & CREDENTIAL:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:**    \* **By signing the Primary Clinician signifies that they met with client in a face-to-face appointment to gather information for and complete this treatment plan.** | | | | | | | |
| **SUPERVISOR’S SIGNATURE, & CREDENTIAL: \*\*\*\**REQUIRED FOR NON-CLINICAL LICENSURE THERAPISTS***  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: ­­** | | | | | | | |

QMA Review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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