| Diagnostic Assessment Form |
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| Demographics: Personal Information |
| Full Name: |
| Date of Birth: Age: Gender: Race: Marital status: |
| Primary Language: Cultural Background: |
| Contact Information: |
| Current Address:<br>Email:<br>Phone: |
| Primary care physician (PCP) Information |
| Name of your PCP:<br>Practice name:<br>Contact phone number:<br>Fax:<br>Date of last visit: |
| History of Present Illness (HPI) |
| Reason for seeking treatment:<br>Presenting symptoms:<br>Triggers:<br>Rating Scale: |
| Mental Health Status |

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| Current mental health status:<br><br>Vital signs:<br><br>Height:<br><br>Weight: |
| Psychiatric History |
| Psychiatric diagnoses:<br><br>Suicidal/Self harm history:<br><br>Outpatient: |
| Medication(s) and dosage(s): |
| Criminal History |
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| Psychiatric Hospitalization |
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| Social History |
| Education History:<br><br>Work History:<br><br>Support System: |
| Developmental History |
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| Medical History |

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| Allergies: |
| Review of System (ROS):<br>Medical conditions:<br>Surgeries:<br>Tobacco use:<br>Pain: |
| Substance Use History |
| Types of substances used:<br>Drug of choice: |
| Quantity used: |
| Route of administration: |
| Frequency of use: |
| Age of first use: |
| Date of last use: |
| Duration and patterns of use: |
| Periods of abstinence: |
| Past Supports and Resources |
| Previous treatment episodes and type of discharge: |
| Previous resources that were effective: |
| Identification and Evaluation |

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| Identification of client's needs: |
| Evaluation of client's needs: |
| Strengths: |
| Barriers to treatment: |
| Goals: |
| Other Addictive Disorders |
| History of other addictive disorders: |
| Family History: |
| Psychiatric history of family members: |
| Use of alcohol and other drugs by family members and significant others: |
| Diagnostic Assessment |
| Diagnostic assessment summary: |
| Clinical Concerns |

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| Issues and areas of clinical concern: |
| Treated, deferred, or referred: |
| Spiritual or Religious Beliefs |
| Attitudes toward alcohol and other drug use: |
| Spiritual or religious beliefs: |
| Placement Recommendations |
| Rationale for placement recommendations: |
| Signatures |
| Signed by Counselor: Date: |
| Reviewed by Clinical Supervisor: Date: |