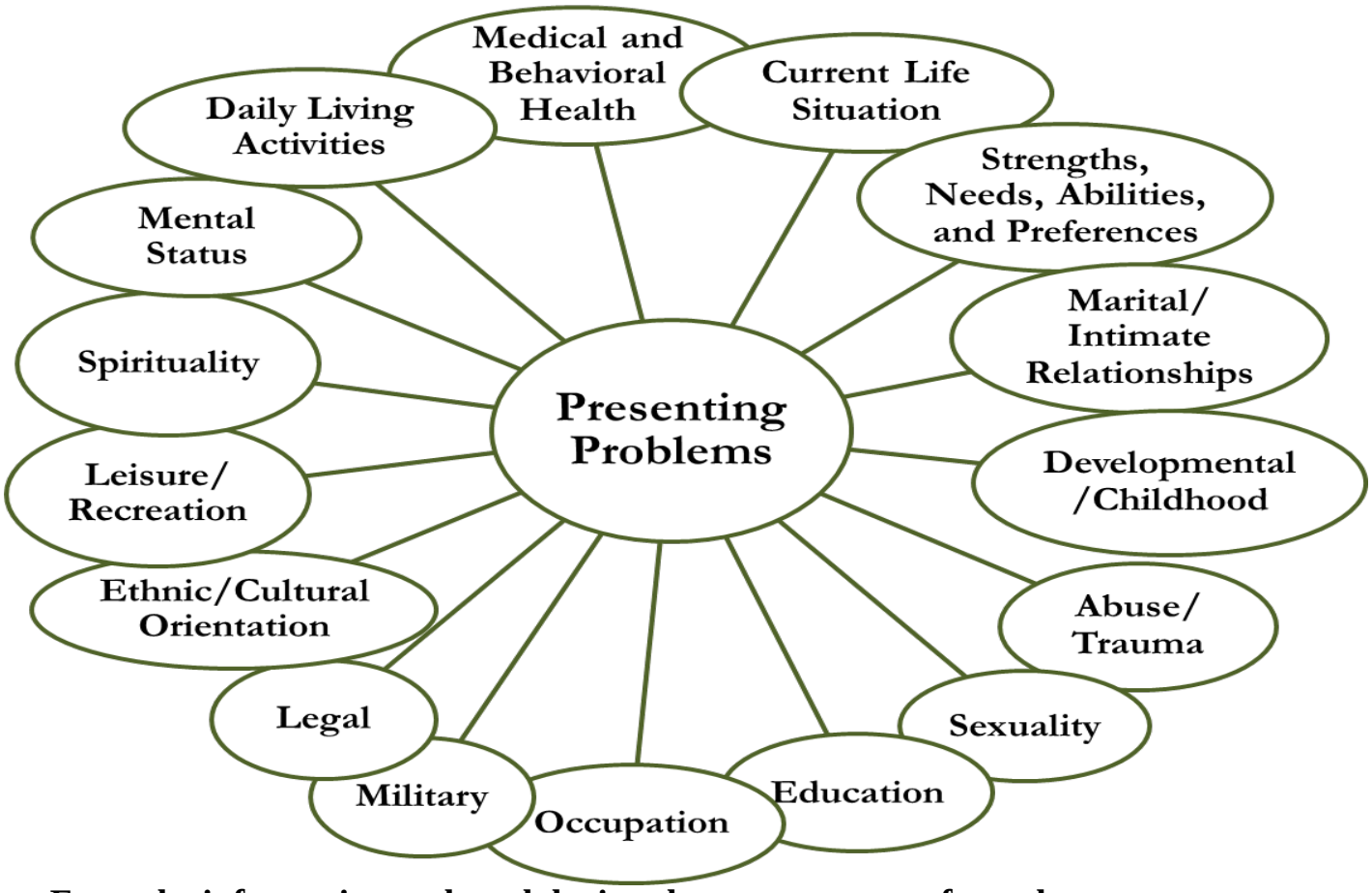
HIGH COUNTRY BEHAVIORAL HEALTH
ADULT COMPREHENSIVE ASSESSMENT

A comprehensive assessment helps us to understand your present life circumstances and the problems that are interfering with your overall quality of life.

GOOD TREATMENT BEGINS WITH A GOOD ASSESSMENT



From the information gathered during the assessment we formulate:

1. **A diagnosis,**
2. **A prioritized list of problems and needs, and**
3. **A treatment plan with measurable goals and objectives to address the problems and needs you have identified.**

We thank you for your active participation in the assessment process. This will help us to facilitate a comprehensive assessment, and design an individualized treatment plan to address your specific needs.

It will typically take 1-2 sessions to complete the assessment process. Then we can develop a treatment plan to resolve your presenting problems.

HIGH COUNTRY BEHAVIORAL HEALTH
ADULT COMPREHENSIVE ASSESSMENT

IDENTIFYING INFORMATION

1.Name:_____
Last First Middle Initial

2. Address: _____
Street Address City State Zip

3. Phone: _____

4. Date of Birth:___/___/___ 5. Age:_____ 6. Gender: _____

PRESENTING PROBLEM(s)

1. Please describe why you are seeking help at this time and how long these problems have been occurring:
2. What are the circumstances that seem to make the problem(s) worse?:
3. What interventions or treatments have you previously tried to resolve the problem(s): (what has helped or has not helped with the problems)
4. Have you been thinking of hurting yourself or others? Have you been feeling suicidal? Have you ever attempted suicide? If so, how many attempts have you made and what did you do?

CURRENT LIFE SITUATION

1. What are your current living arrangements: (where; how many in household; how are relationships and support)

2. How long have you lived in these current arrangements? _____ Are you satisfied with this? ❑ Yes ❑ No

3. Do you have a driver's license?: ❑ Yes ❑ No If NO, reason for not having one:_____

4. Do you have an automobile available for use?: ❑ Yes ❑ No

5. Will transportation be a barrier to attend treatment?: ❑ Yes ❑ No

6. Have you lived in a controlled environment (jail, hospital, inpatient or residential treatment center) in the last 30 days?

❑Yes ❑No If yes, how many days: _____

7. How would you describe the current quality of your life? ❑Excellent ❑Good ❑Fair ❑Poor

8. What seems to interfere the most with your current quality of life?

9. How supportive are your current relationships with friends or community members?:

Close friends or community members	Age	How supportive is the relationship:	How long have you known this person?
		❑Excellent ❑Good ❑Fair ❑Poor	
		❑Excellent ❑Good ❑Fair ❑Poor	
		❑Excellent ❑Good ❑Fair ❑Poor	
		❑Excellent ❑Good ❑Fair ❑Poor	

10. **During the past 90 days** have there been issues in your current life situation that are related to your presenting problems and need to be a focus of your treatment? ❑Yes ❑No If yes, what are these and how motivated are you to address these in counseling? Please explain:

MEDICAL AND BEHAVIORAL HEALTH HISTORY

Medical History (List all major illness, surgeries, major injuries. Begin with most recent and work backwards):

1. Past Conditions | Date of Onset | Type of Treatment | Continuing Effects (if any)

2. Current Medications (prescribed and non-prescribed):

Type	Strength	Dosage	Side Effects	Benefits/Compliance

3. Past Medications (no longer using)

Type	Strength	Dosage	Side Effects	Benefits/Compliance

4. Are there any family members with chronic medical conditions (type of illness and relationship to family member):

5. Within the past 30 days, have you experienced any significant physical symptoms?
(Convulsions; Persistent Pain; Severe headache with blurred vision; Unusual Bleeding; Head Injury; Bruises; etc., etc)

❑Yes ❑No If yes, how many days in the last 30? _____ Please explain:

6. Do you have any chronic medical problems which continue to interfere with your life? ❑ Yes ❑ No

7. Do you receive a pension for a physical disability? ❑ Yes ❑ No If yes, specify:_____

8. Do you have any allergies (food, medications, chemicals, vapors)? ❑ Yes ❑ No If yes, list allergies:

9. Who is your Primary Care Physician: _____ Phone: _____

When was the last time you had a medical checkup with your primary care physician?_____

10. Are you currently involved in any behaviors that risk compromising your safety and/or health? ❑Yes ❑No
(Examples: Unprotected sex, needle sharing to inject drugs, multiple sexual partners, binging or purging, etc.) If yes, explain:

11. **During the past 90 days** have there been medical/physical health issues that are related to your presenting problems and need to be a focus of your treatment? ❑Yes ❑No If yes, what are these and how motivated are you to address these in counseling? Please explain:

Behavioral Health History

1. Are you currently receiving any mental health or substance abuse services from any other treatment provider?
❑Yes ❑No If Yes, where:

2. Have you had a significant period (that was not the direct result of drug/alcohol use), in which you have experienced:

Serious depression: ❑Yes ❑No Serious anxiety or worry: ❑Yes ❑No Seeing/hearing things not there: ❑Yes ❑No
Trouble controlling violent behavior: ❑Yes ❑No Trouble understanding, concentrating, or remembering: ❑Yes ❑No
Cutting or other self-harm: ❑Yes ❑No Lying to people: ❑Yes ❑No Feeling detached from place/time: ❑Yes ❑No
Spending excessively: ❑Yes ❑No Spending more time on the internet than with people: ❑Yes ❑No Other:_____

3. How many days in the past 30 days have you experienced any psychological or emotional problems?:_____

4. Have you had previous behavioral/psychiatric treatment: ❑Yes ❑No If Yes:

1. Where:_____ Diagnosis:_____

Dates of Service:_____

Why did you seek the services:_____

What were the results:_____

2. Where: _____ Diagnosis: _____

Dates of Service:_____

Why did you seek the services:_____

What were the results:_____

Substance Use Assessment (If no current or history of substance use, skip to question 11)

Substances used	Age of first use	Last date of use; amount used; & route of administration or method of use	Do family members, friends, or co-workers use/abuse
❑ Alcohol			❑Family ❑Friends ❑Co-workers
❑ Amphetamines			❑Family ❑Friends ❑Co-workers
❑ Cannabis/Marijuana			❑Family ❑Friends ❑Co-workers
❑ Cocaine			❑Family ❑Friends ❑Co-workers
❑ Tranquilizers			❑Family ❑Friends ❑Co-workers
❑ Hallucinogens			❑Family ❑Friends ❑Co-workers
❑ Inhalants			❑Family ❑Friends ❑Co-workers
❑ PCP			❑Family ❑Friends ❑Co-workers
❑ Opioids/Narcotics			❑Family ❑Friends ❑Co-workers
❑ Inhalants			❑Family ❑Friends ❑Co-workers
❑ Nicotine			❑Family ❑Friends ❑Co-workers
❑ Caffeine			❑Family ❑Friends ❑Co-workers
Other:			❑Family ❑Friends ❑Co-workers

5. If multiple use, which substance is preferred: _____

6. During the past week did you stop, try to stop, cut down, or limit your use of substances? ❑Yes ❑No ❑NA If YES, did you experience any of the following withdrawal symptoms during the past week? ❑Yes ❑No (Check all that apply)

❑ Feeling tired, yawning ❑ Moving or talking slow ❑Having bad dreams or trouble sleeping ❑Feeling sad, tense
❑ Feeling nervous, angry ❑ Fidgeting, pacing ❑Having diarrhea ❑Having convulsions or seizures
❑Having muscle aches ❑Having runny nose or eyes watering ❑Having a fever ❑Having the shakes ❑Sweating

7. How much money would you say you spent during the past 30 days on: Alcohol _____ Drugs_____

8. How long was your last period of voluntary abstinence?:_____ When:_____

9. Has anyone close to you ever asked you to stop drinking/using? ❑Yes ❑No

10. Have you ever received formal treatment for a substance abuse problem? ❑Yes ❑No If yes, where:

Name of treatment organization:	Year:	Length of program:	Results & length of abstinence:
a)_____	_____	_____	_____
b)_____	_____	_____	_____
c)_____	_____	_____	_____

11. Have close family members received treatment for mental health or substance abuse? ❑Yes ❑No If yes, please explain:

12. Do you participate in other behaviors that feel like they have become habitual or addictive? ❑Yes ❑No If yes, please explain: _____

13. **During the past 90 days** have there been mental health or substance use issues that are related to your presenting problems and need to be a focus of your treatment? ❑Yes ❑No If yes, what are these and how motivated are you to address these in counseling? Please explain:

DEVELOPMENTAL/CHILDHOOD HISTORY

1. Do you have difficulty remembering your childhood? ❑Yes ❑No

2. Where did you live and who lived in your house as a child?

3. How would you describe yourself as a child growing up in your family? (read the list to client and check all that apply):
❑ Popular ❑ Rebellious ❑ Unhappy ❑ Serious ❑ Calm ❑ Awkward
❑ Happy ❑ Unpopular ❑ Shy/quiet ❑ Aggressive ❑ Nervous

4. Did you experience any of the following problems during childhood? (read the list to client and check all that apply):

❑ Conflict with mother	❑ Conflict with father	❑ Conflict with caretaker	❑ Conflict with siblings
❑ Conflict with peers	❑ Conflict with teachers	❑ Nightmares	❑ Bed-wetting
❑ Overweight	❑ Underweight	❑ Excessive worries/fears	❑ Drug/alcohol use
❑ Frequent arguing	❑ Financial problems	❑ Cutting or burning	❑ Bullying/being bullied

5. What is the quality of current relationships with family members:

Father, mother, brothers, or sisters (or other close family)	Age	Explain the quality of current relationship:	Frequency of contact:

6. **During the past 90 days** have there been issues regarding your childhood development that are related to your presenting problems and need to be a focus of your treatment? ❑Yes ❑No If yes, what are these and how motivated are you to address these in counseling? Please explain:

MARITAL/INTIMATE RELATIONSHIP HISTORY

1. Marital Status: ❑ Single ❑ Married ❑ Co-Habitation ❑ Divorced ❑ Separated ❑ Widowed

2. Number of previous marriages: _____ ❑N/A

3. Length of time with current partner:_____ ❑N/A

4. If widowed, how long: _____ ❑N/A

5. How would you describe your relationship with your current partner? (read the list and check the ones that apply):
❑ Does Not apply

❑Warm ❑Unhappy ❑Distant ❑Affectionate ❑Caring ❑Abusive ❑Critical ❑Boring ❑Happy ❑Tense

6. Is there violence in your current primary relationship? ❑Yes ❑No ❑Not apply If yes, explain:

7. Has there been violence in your past primary relationships? ❑Yes ❑No ❑Not Apply If yes, explain:

8. If you are currently in a primary relationship, which of the following problems, if any, do you have with your partner (read the list and check those that apply): ❑Not apply

❑Conflict over money ❑Conflict over sex ❑Conflict over employment ❑Conflict over children ❑Physical abuse
❑Emotional abuse

9. Current Relationship with children:

Sons and Daughters	Age	Current Relationship: (1) Regular Contact (2) Irregular Contact (3) No Contact	Living (L) Deceased (D)

10. **During the past 90 days** have there been issues in your marriage or primary intimate relationship that are related to your presenting problems and need to be a focus of your treatment? ❑Yes ❑No If yes, what are these and how motivated are you to address these in counseling? Please explain:

SEXUALITY

1. Are you experiencing any problems/concerns regarding your sexuality? ❑Yes ❑No If yes, what are they?

2. How would you describe your sexual or relational preference/identity? ❑Heterosexual ❑Homosexual ❑Bi-Sexual
❑Transgender ❑Other_____

3. **During the past 90 days** have you experienced issues regarding your sexuality that are related to your presenting problems and need to be a focus of your treatment? ❑Yes ❑No If yes, what are these and how motivated are you to address these in counseling? Please explain:

ABUSE/TRAUMA HISTORY

<u>Adverse Childhood Experiences (ACE):</u> While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often…**
   Swear at you, insult you, put you down, or humiliate you?
   OR
   Act in a way that made you afraid that you might be physically hurt? ❑Yes ❑No If YES enter 1_____
2. Did a parent or other adult in the household **often or very often…**
   Push, grab, slap, or throw something at you?
   OR
   Ever hit you so hard that you had marks or were injured? ❑Yes ❑No If YES enter 1_____
3. Did an adult or person at least 5 years older than you **ever…**
   Touch or fondle you or have you touch their body in a sexual way?
   OR
   Attempt to actually have oral, anal, or vaginal intercourse with you? ❑Yes ❑No If YES enter 1_____
4. Did you **often or very often** feel that…
   No one in your family loved you or thought you were important or special?
   OR
   Your family didn't look out for each other, feel close to each other, or support each other?
   ❑Yes ❑No If YES enter 1_____
5. Did you **often or very often** feel that…
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   OR
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it? ❑Yes ❑No If YES enter 1_____
6. Were your parents **ever** separated or divorced? ❑Yes ❑No If YES enter 1_____
7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   OR
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   OR
   Ever repeatedly hit at least a few minutes or threatened with a gun or knife? ❑Yes ❑No If YES enter 1_____
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   ❑Yes ❑No If YES enter 1_____
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   ❑Yes ❑No If YES enter 1_____
10. Did a household member go to prison? ❑Yes ❑No If YES enter 1_____

Now add up your "YES" answers to get your ACE Score_____

11. What is the worst thing that has ever happened to you?

12. Have you ever experienced or witnessed an event in which you were seriously injured or your life was in danger, or you thought you were going to be seriously injured or endangered? If yes, please explain:

13. Have you ever been the victim, a perpetrator, or been exposed in any way to……? (check all that apply)

Physical Abuse:	❑ Victim	❑ Perpetrator	❑ Direct exposure	❑ Indirect exposure	❑ Current
Domestic Violence:	❑ Victim	❑ Perpetrator	❑ Direct exposure	❑ Indirect exposure	❑ Current
Community Violence:	❑ Victim	❑ Perpetrator	❑ Direct exposure	❑ Indirect exposure	❑ Current
Physical Neglect:	❑ Victim	❑ Perpetrator	❑ Direct exposure	❑ Indirect exposure	❑ Current
Emotional Abuse:	❑ Victim	❑ Perpetrator	❑ Direct exposure	❑ Indirect exposure	❑ Current
Elder Abuse:	❑ Victim	❑ Perpetrator	❑ Direct exposure	❑ Indirect exposure	❑ Current
Sexual Abuse:	❑ Victim	❑ Perpetrator	❑ Direct exposure	❑ Indirect exposure	❑ Current

If victim, perpetrator, or type of exposure were checked to any of the above, please explain below:

1. Type:_____ Age it occurred:_____

   Length (single event, several events, ongoing/number of years):_____

   _____

   Other person(s) involved: _____

   Current relationship, if any, with person(s) involved: _____

   Treatment, if any, and outcome of treatment: _____

2. Type:_____ Age it occurred:_____

   Length (single event, several events, ongoing/number of years):_____

   _____

   Other person(s) involved: _____

   Current relationship, if any, with person(s) involved: _____

   Treatment, if any, and outcome of treatment: _____

3. Type:_____ Age it occurred:_____

   Length (single event, several events, ongoing/number of years):_____

   _____

Other person(s) involved: _____

Current relationship, if any, with person(s) involved: _____

Treatment, if any, and outcome of treatment: _____

14. **During the past 90 days** do you believe issues regarding any past or current abuse or trauma are related to your presenting problems and need to be a focus of your treatment? ❑Yes ❑No If yes, what are these and how motivated are you to address these in counseling? Please explain:

EDUCATION

1. What was the highest grade you completed (circle) Elementary K 1 2 3 4 5 6
Jr. High 7 8 9
Sr. High 10 11 12
College 13 14 15 16

Degree(s) held:_____

Graduate School: Years_____

Degree(s) held: _____

2. Other schooling: (vocational/technical, training programs, on-the-job training, etc.) ❑N/A

_____

3. How would you rate your performance in school: ❑Above average ❑Average ❑Below average

4. Did you experience any problems in school? ❑Yes ❑No If yes, explain:_____

_____

5. Do you have any learning, hearing, of seeing disabilities that would prevent you from reading, writing, or understanding English and would be a barrier to your full participation in treatment? ❑Yes ❑No If YES, are there assistive technologies that would help to overcome this barrier:
❑Yes ❑No If YES, please explain:_____

6. **During the past 90 days** do you believe issues regarding your education and learning abilities are related to your presenting problems and need to be a focus of your treatment? ❑Yes ❑No If yes, what are these and how motivated are you to address these in counseling? Please explain:

OCCUPATION

1. Are you currently employed: ❑Yes ❑No

2. Current employment:_____ How long:_____

3. Does someone else contribute to your financial support in any way?: ❑ Yes ❑ No If yes, who _____

4. What is your work history over the last five years: (starting with the most recent)

Job/occupational type (carpenter, baker, banker, etc)	Length of Job	Date Left	Job Satisfaction: (S) = Satisfied (U) = Unsatisfied

5. Have you experienced any of the following employment problems: (read the list and check those that apply:

❑Attendance ❑Relationships with co-workers/employer ❑Frequent job changes ❑Disciplined/fired

❑Other: _____

6. If you are employed, are you satisfied with your current job situation? ❑Yes ❑No If no, explain:

7. How much money did you receive from the following sources in the past 30 days?:

Employment (net income) _____ Unemployment _____ Mate, family, or friends_____

Pension, benefits or social security_____ Illegal sources _____

8. How many people depend on you for the majority of their food, shelter, etc.? _____

9. **During the past 90 days** have there been issues in your occupation that are related to your presenting problems and need to be a focus of your treatment? ❑Yes ❑No If yes, what are these and how motivated are you to address these in counseling? Please explain:

MILITARY HISTORY

1. Have you ever served in the military? ❑Yes ❑No If YES---complete the following. If NO---skip to legal section.

2. If yes, Branch: ❑Army ❑Navy ❑Marines ❑Air Force ❑Coast Guard ❑Merchant Marine ❑National Guard

3. Years in service: _____ to _____

4. Discharge type: ❑Honorable ❑General, under honorable conditions ❑General, less than honorable ❑Dishonorable ❑Medical

5. Combat: ❑Yes ❑No If yes, Where _____ When_____

6. If you have experienced combat, have you experienced any of the following problems associated with your combat experience:

❑Nightmares ❑Flashbacks ❑Startle reflex ❑Intrusive thoughts/memories ❑Uncontrollable outbursts of anger

7. Have you ever been treated for service related concerns or problems associated with combat experience: ❑Yes ❑No

8. **During the past 90 days** have there been issues regarding your military experiences that are related to your presenting problems and need to be a focus of your treatment? ❑Yes ❑No If yes, what are these and how motivated are you to address these in counseling? Please explain:

LEGAL HISTORY

1. Legal Involvement (check all that apply):
   - ❑ None, no history (if none, proceed to next section regarding Ethnic/Cultural Orientation)
   - ❑ Past legal involvement, no charges pending
   - ❑ Present legal involvement, charges pending
   - ❑ Present legal involvement, probation or parole

2. If past involvement, no charges pending:

Charges:	Year:	Outcome (conviction, incarceration, probation):

3. If present legal involvement, what charges are pending: _____

4. If present legal involvement, and on probation or parole, what are the conditions of probation or parole:_____

_____

Name of Probation or Parole Officer: _____ Phone:_____

5. Have you ever spent time incarcerated (jailed): ❑Yes ❑No If yes, how many days in the last 30?_____

If yes: When, why, how long, and where:_____

_____

6. How many days in the past 30 have you engaged in illegal activities for profit? _____

7. **During the past 90 days** have there been issues in your current or historical legal experiences that are related to your presenting problems and need to be a focus of your treatment? ❑Yes ❑No If yes, what are these and how motivated are you to address these in counseling? Please explain:

ETHNIC/CULTURAL ORIENTATION

1. How would you categorize your ethnic/cultural orientation (size of community raised in; political beliefs; religious observation; racial minority; social economic status; value of education): Please explain:

2. Did your family practice traditions and rituals associated with past family or religious history? ❑Yes ❑No

If yes, what traditions and rituals:_____

If yes, was there a sense of pride in participating in those traditions and rituals? ❑Yes ❑No

3. Are there any cultural practices linked to your racial/ethnic background that are important to you? ❑Yes ❑No
If yes, explain:

4. What are the most important things to you about your ethnicity or culture?

5. **During the past 90 days** have there been issues in your ethnic or cultural orientation that are related to your presenting problems and need to be a focus of your treatment? ❑Yes ❑No If yes, what are these and how motivated are you to address these in counseling? Please explain:

LEISURE/RECREATIONAL

1. What are your usual free time activities? a. _____ b. _____ c. _____

2. What are your hobbies? a. _____ b. _____ c. _____

3. How much free time do you have in a week? ❑1-5 hours ❑ 5- 10 hours ❑ 10+ hours

4. **During the past 90 days** have there been issues in your leisure/recreational pursuits that are related to your presenting problems and need to be a focus of your treatment? ❑Yes ❑No If yes, what are these and how motivated are you to address these in counseling? Please explain:

SPIRITUALITY

1. Are you involved in a church or a religion? ❑Yes ❑No

2. If yes, with what faith do you identify with: _____

3. Do you believe that there is a "higher power" or a "God"? ❑Yes ❑No

4. What activities do you engage in spiritually (read list and check those that apply):
❑ Prayer ❑ Meditation ❑ Church attendance ❑ Active participation in church activities ❑ Sweat Lodge
❑ Pilgrimages to religious sites or events ❑ Reading spiritual materials ❑ Other: _____

5. Are you bothered by guilt or shame for past events that you believe are wrong or against your spiritual beliefs?
❑Yes ❑No If yes, explain:

6. **During the past 90 days** have there been issues in your spirituality that are related to your presenting problems and need to be a focus of your treatment? ❑Yes ❑No If yes, what are these and how motivated are you to address these in counseling? Please explain:

(This section is completed by a clinician)

DAILY LIVING ACTIVITIES

1. Using the table below, rate how often or how well the consumer independently performed or managed each of the 20 Activities of Daily Living in the community during the last 30 days. If the consumer's level of functioning is varied, rate the lower score. Consider impairments in functioning due to physical limitations as well as those due to mental impairments. Do not consider environmental limitations (eg. "no jobs available").

   Strengths are scored >=5 in an activity and indicates functioning "within normal limits (WNL) for that activity.

1	2	3	4	5 (WNL)	6 (WNL)	7 (WNL)
None of the time. Pervasive, continuous intervention required. Dysfunctional. **Disabling impairment**.	**Almost never**. Not functional. Dependent. **Severe impairment**.	**Occasionally**. Functioning depends on continuous support. **Substantial impairment**.	**Some of the time.** Marginal independence. Low level of continuous support. **Serious impairment.**	**A good bit of the time.** Independent with moderate, routine support. **Moderate problems.**	**Most of the time.** Independent with intermittent support or follow-up. **Intermittent problems**.	**All of the time**. Optimal and independent asset. **No problems**.

Activities	Example of scoring strengths as WNL behaviors (scores 5-7)	Score
1. Health Practices	Takes care of health issues, manages moods, infections; takes medication as prescribed; follows up on medical appointments. If SA client: HALTS to avoid relapse; Manages exercise; Negative TB.	
2. Housing Stability, Maintenance	Maintains stable housing; organizes possessions, cleans, abides by rules and contributes to maintenance if living with others. If SA client: Living environment is supportive of recovery.	
3. Communication	Listens to people, expresses opinions/feelings; makes wishes known effectively.	
4. Safety	Safely moves about community—adequate vision, hearing, makes safe decisions. Safely uses small appliances, ovens/burners, matches, knives, razors, other tools. If SA client: Avoids high risk places, situations for AOD relapse, and physical abuse.	
5. Managing Time	Follows regular schedule for bedtime, wake-up, meal times, rarely tardy or absent for work, day programs, appointments, scheduled activities.	
6. Managing Money	Manages money wisely. Has an independent source of funds. Controls spending habits. If SA client: Pays bills first; no theft of deceit with money.	
7. Nutrition	Eats at least 2 basically nutritious meals daily.	
8. Problem Solving	Resolves basic problems of daily living. Asks questions for clarity and setting expectations. WNL cognitive functioning, concentrating, remembering, making decisions.	
9. Family Relationships	Gets along with family. Positive relationships as parent, sibling, child, significant other, family member. If SA client: Works to resolve conflicts and learn about impact of SA on the family.	
10. Alcohol/Drug Use	Avoids abuse or abstains from alcohol/drugs, cigarettes. Understands signs and symptoms of abuse or dependency. Avoids misuse or combining alcohol, drugs, medication. If SA client: Knowledgeable of special risks.	

11. Leisure	Relaxes with a variety of activities. Attends/participates in sports or performing arts events. Reads newspapers, magazines, books. Recreational games with others. Involved with arts/crafts. Goes to movies. If SA client: Participates in drug free activities; Avoids alcohol/drug places alone or with others.	
12. Community Resources	Uses other community services. Self-help groups. Telephone, public transportation, religious organizations, shopping.	
13. Social Network	Gets along with friends, neighbors, co-workers, other peers. If SA client: Finds and participates in drug-free social network, peer groups.	
14. Sexuality	Appropriate behavior towards others. Comfortable with gender. Respects privacy and rights of others. Practices safe sex or abstains. If SA client: No behavior known to be high risk for STD's, AIDS, unwanted pregnancies; Sexually appropriate behavior—not hostile or exploiting.	
15. Productivity	Independently working, volunteering, homemaking, or learning skills for financial self-support. If SA client: Finishing GED (if not completed).	
16. Coping Skills	Knows about nature of disability/illness, probable limitations, symptoms of relapse. Behaviors that cause relapse or make things worse. Options for coping, improving, preventing relapse, restoring feelings of self-worth, competence, being in control.	
17. Behavior Norms	Complies with community norms, probation/parole, court requirements, if applicable. Controls dangerous, violent, aggressive, bizarre or nuisance behaviors. Respects rights of others. If SA client: Law abiding with full restitution; no court orders.	
18. Personal Hygiene	Care for personal cleanliness, such as bathing, brushing teeth.	
19. Grooming	Care for hair, hands, general appearance—bathes, showers, makeup, shaves.	
20. Dress	Dresses self. Wears clean clothes that are appropriate for weather, job, and other activities. Clothing is generally neat and intact. If SA client: Clothing does not include alcohol/drug related logos or messages.	
Scoring Instructions: Ratings for all 20 DLA's can be added and then divided in half to estimate the GAF score.	Sum (max. 140)	
	GAF Score	

2. What are the most important things in the client's life that provide meaning, purpose, and makes life worth living?:

3. What are the prioritized problems that interfere the most with the client's life worth living goals? **Summarize the client's problems/needs and corresponding goals/expectations of treatment services.**

Priority #	Problems/Needs	Goals/Expectations

4. Summarize the behavioral health problems/**issues that the agency can realistically assist the client in resolving; what type of services/treatment are needed; what is the estimated length/intensity of treatment:**

5. What **additional services and/or referrals** (to other community agencies) will the client need in order to improve their quality of life and/or to facilitate recovery?:

Assessment Completed by: _____ Credentials _____

Date:_____