



CLIENT'S NAME	CASE #

INDIVIDUAL ASSESSMENT FORM

*Completed by Affiliate: Complete a copy of this form for each client seen in the session.
If more space is needed, use the back of this form. For clients 10 years old or younger, use the Child Health Form*

HIGH RISK FACTORS: Assess the client on each factor (write n/a or date factor was present).

	Suicidal Ideation/Plan	Domestic Violence Risk	Sexual Abuse Risk	Homicidal Ideation/Plan	Child Abuse Risk	Current Threat of Violence
Current						<input type="checkbox"/> No Obvious Indicators <input type="checkbox"/> Obvious Indicators, Intent Denied <input type="checkbox"/> Obvious Indicators, Intent Reported <input type="checkbox"/> Victim
Past						

Describe any high risk factors present (If abuse, indicate when a report was made and the outcome): _____

MENTAL HEALTH STATUS

Gen. Appearance: <input type="checkbox"/> appropriate <input type="checkbox"/> inappropriate	Insight: <input type="checkbox"/> present <input type="checkbox"/> partially present <input type="checkbox"/> absent
Orientation: <input type="checkbox"/> oriented X3 <input type="checkbox"/> disoriented	Mood: <input type="checkbox"/> normal <input type="checkbox"/> depressed <input type="checkbox"/> anxious <input type="checkbox"/> other
Thought Content: <input type="checkbox"/> appropriate <input type="checkbox"/> inappropriate	Attitude: <input type="checkbox"/> appropriate <input type="checkbox"/> uncooperative <input type="checkbox"/> guarded
Thought Process: <input type="checkbox"/> logical <input type="checkbox"/> illogical <input type="checkbox"/> tangential	Speech: <input type="checkbox"/> appropriate <input type="checkbox"/> rapid/pressured <input type="checkbox"/> slowed

Describe any inappropriate responses: _____

Current Alcohol Use

No use of alcohol within past 30 days. Reason: _____

Use of alcohol within past 30 days (If so, answer questions below; If no, proceed to "Current Drug Use")

Please answer the following questions about the client's drinking. (Using the scale on the right, record the appropriate response to the left of the question.)*

1. How often do you have a drink containing alcohol?	<input type="checkbox"/> 0 = Never <input type="checkbox"/> 1 = Monthly or less <input type="checkbox"/> 2 = 2-4/month <input type="checkbox"/> 3 = 2-3/week <input type="checkbox"/> 4 = 4 or more/week	2. How many drinks containing alcohol do you have on a typical day when you are drinking?	<input type="checkbox"/> 0 = 1 or 2 <input type="checkbox"/> 1 = 3 or 4 <input type="checkbox"/> 2 = 5 or 6 <input type="checkbox"/> 3 = 7 to 9 <input type="checkbox"/> 4 = 10 or more
3. How often do you have 6 or more drinks on one occasion?			Rating Scale: <input type="checkbox"/> 0 = Never <input type="checkbox"/> 1 = Less than monthly <input type="checkbox"/> 2 = Monthly <input type="checkbox"/> 3 = Weekly <input type="checkbox"/> 4 = Daily or almost daily
4. How often during the past year have you found it difficult to get the thought of alcohol out of your mind?			
5. How often during the last year have you found that you were unable to stop drinking once you had started?			
6. How often during the last year have you been unable to remember what happened the night before because you had been drinking?			
7. How often during the last year have you needed a 1 st drink in the morning to get yourself going after a heavy drinking session?			
8. How often during the last year have you had a feeling of guilt or remorse after drinking?			
9. Have you or someone else been injured as a result of your drinking?			
10. Has a relative or a friend or a doctor or other health worker been concerned about your drinking or suggested you cut down?			

Note: Questions have been reprinted from the Alcohol Use Disorders Identification Test

A score of 8 or above indicates an alcohol problem and should be addressed in the treatment plan

TOTAL SCORE:** _____

CURRENT DRUG USE

No use of other drugs

Use of other drugs- Indicate substance (e.g. ecstasy, marijuana, Rx drugs) & describe present use (i.e. amount, frequency, date of last use):

MENTAL HEALTH & ALCOHOL/DRUG HISTORY

Has there been a noticeable change in consumption of alcohol or drugs in the last 5 years? Yes No

How? _____

Prior Treatment: Mental Health _____ Drug/Alcohol _____

PROBLEM IMPACT: Check areas of life affected by the assessed problems and describe below:

Legal Physical Family Marital Social Financial Leisure Emotional Work School Spiritual

Describe: _____
