Comprehensive Diagnostic Assessment

Clinician:
Practice Name:
Contact Number:
Location/Address:

Patient:
Date and Time:
Duration:
Participants:

PRESENTING PROBLEM

CURRENT MENTAL STATUS

General appearance:

Dress:

Motor Activity:

Insight:

Judgment:

Affect:

Mood:

Orientation:

Memory:

Attention / Concentration:

Thought Content:

Perception:

Flow of Thought:

Interview Behavior:

Speech:

Comprehensive Diagnostic Assessment

Clinician:
Practice Name:
Contact Number:
Location/Address:

Patient:
Date and Time:
Duration:
Participants:

SAFETY ISSUES

	Suicidal Ideation	Homicidal Ideations
Patient has intent to act	Yes ❒ No ❒	Yes ❒ No ❒
Patient has plan to act	Yes ❒ No ❒	Yes ❒ No ❒
Patient has means to act	Yes ❒ No ❒	Yes ❒ No ❒

Additional information:

BACKGROUND INFORMATION

Identification:

History of Present Problem:

Past Psychiatric History:

Trauma History:

Family Psychiatric History:

Comprehensive Diagnostic Assessment

Clinician:
Practice Name:
Contact Number:
Location/Address:

Patient:
Date and Time:
Duration:
Participants:

Medical Conditions and History:

Current Medications:

Substance Use:

Family History:

Social History:

Developmental History:

Educational / Occupational History:

Legal History:

Strengths / Liabilities:

Comprehensive Diagnostic Assessment

Clinician:
Practice Name:
Contact Number:
Location/Address:

Patient:
Date and Time:
Duration:
Participants:

DIAGNOSIS:

_____
Print Name

_____
Signature

_____
Date

_____
License Number