NEUROBLOOM
PSYCHOLOGICAL CLINIC

# ADULT CLINICAL ASSESSMENT

**Date:** ___________________________________ **Time:** _________________

**Name:** ___________________________________ **Date of Birth:** _________________

**Age:** ___ **Sex:** **M** **F** **Referral:** _____________________

**Presenting Problem:**

**History of Symptoms (When symptoms began and precipitating event):**

**Treatment Expectations:**

**Family of Origin:**

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**Relationship with Family Members:**

**Present Family:**

**Education (Highest Level, Special Education, Behavior Problems):**

**Employment History (Satisfaction, Relationship to peers and supervisors, Reason for leaving):**

**Assessment of Substance Abuse History (Has any family member abused drugs or alcohol?/Treatment Received);**

**Does Client use Alcohol or Drugs? (Frequency, Quantity, History of blackouts, overdose or problems with health/legal/school/work/relationships as a result):**

**Assessment of Sexuality (Degree of satisfaction/problems):**

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**Health History – Past & Present (development problems, major illnesses, surgeries, hospitalizations, diseases that run in the family, does client smoke, diet with weight loss/gain?):**

**Medication (Dosages, Compliance, Effectiveness, Side Effects, Mark current meds with *):**

**Mental Health History (Previous therapy or counseling, in-patient, outpatient, suicidal ideation or attempts, homicidal ideation, inability to control anger):**

**Assessment of Social Functioning (describe any social/community/religious involvement):**

**Assessment of Socioeconomic Status and Financial Factors (Does Client consider his/her income to be inadequate? Level of debt?Does Client manage well? Include Cultural and Ethnic Factors):**

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## Mental Status Examination (Check all that Apply)

- ☐ Cooperative
- ☐ Withdrawn
- ☐ Hostile
- ☐ Evasive
- ☐ Other:________
- ☐ Attitude & Behavior
- ☐ Apathetic
- ☐ Sarcastic
- ☐ Distrusting
- ☐ Passive
- ☐ Dramatic
- ☐ Ambivalent
- ☐ Suspicious
- ☐ Unmotivated
- ☐ Restless
- ☐ Manipulative
- ☐ Resistant

**Grooming:**

- ☐ Appropriate
- ☐ Other:________
- ☐ Seductive
- ☐ Untidy
- ☐ Unusual
- ☐ Inappropriate

**Facial Expression:**

- ☐ Unremarkable
- ☐ Grimacing
- ☐ Sad
- ☐ Composed
- ☐ Angry
- ☐ Other:________
- ☐ Confused
- ☐ Fearful

**Posture:**

- ☐ Unremarkable
- ☐ Other:________
- ☐ Erect
- ☐ Rigid
- ☐ Stooped
- ☐ Limp

**Motor Activity:**

- ☐ Normal
- ☐ Involuntary Movements
- ☐ Agitated
- ☐ Other:___________
- ☐ Retarded
- ☐ Hyperactive
- ☐ Tremor

**Stream of Thought:**

- ☐ Spontaneous
- ☐ Halting
- ☐ Rapid Speech
- ☐ Pressured
- ☐ Flight
- ☐ Ideas
- ☐ Other_____

**Thought Progression:**

- ☐ Normal
- ☐ Overly Detailed
- ☐ Loose
- ☐ Preseverative
- ☐ Circumstantial
- ☐ Intrusive
- ☐ Fragmented
- ☐ Incoherent
- ☐ Obsessive
- ☐ Other:_______

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**Thought Content:**

- ☐ Normal
- ☐ Preoccupied
- ☐ Hallucinations (Auditory or Visual)
- ☐ Homicidal
- ☐ Persecutory
- ☐ Other:________
- ☐ Illusions
- ☐ Paranoid
- ☐ Delusions
- ☐ Hostile
- ☐ Phobic
- ☐ Suicidal

**Language:**

- ☐ Normal
- ☐ Baby Talk
- ☐ Stilted
- ☐ Peculiar Expressions
- ☐ Other:______

**Mood:**

- ☐ Normal
- ☐ Anxious
- ☐ Elevated
- ☐ Angry
- ☐ Irritable
- ☐ Depressed
- ☐ Sad
- ☐ Other:_________

**Orientation:**

- ☐ Normal
- ☐ Disoriented to Person
- ☐ Disoriented to Place
- ☐ Disoriented to Time
- ☐ Other:______

**Memory:**

- ☐ Normal
- ☐ Impaired
- ☐ Remote (Last 3 US Presidents)
- ☐ Recent (3 Objects for 3 Minutes)
- ☐ Immediate (Digit Span)

**General Knowledge/Vocabulary:**

- ☐ Consistent with Education
- ☐ Better than Education
- ☐ Worse than Education

**Common Sense/Judgement:**

- ☐ Good
- ☐ Fair
- ☐ Poor

**Insight/Abstract Reasoning:**

- ☐ Good
- ☐ Fair
- ☐ Minimal
- ☐ Absent

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**Diagnosis:**

**Axis I (Clinical):**

**Axis II (Personality):**

**Axis III (Medical):**

**Axis IV (Stressors):**

**Axis V (GAF):**

**Dynamic Formulation of Client:**

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**Criteria for Termination:**

**Recommended for Treatment Modalities:**

_____ Individual Therapy

_____ Family Therapy

_____ Parent Therapy

_____ Psychiatric Assessment

_____ Medication Review

_____ Other

**Recommended Evaluations:**

_____ Educational Assessment and Planning: ___________________________________

_____ Medical Assessment: ____________________________________________________

_____ Neuropsychological Assessment: ________________________________________

_____ Other (describe): ________________________________________________________

Reviewing Therapist's Comments:

Reviewing Therapist Signature/Credentials: ______________________

Date: ___________________

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## TREATMENT GOALS

**Name:** ______________________________ **Date of Birth:** ______________

**Problem # 1:** **Date:**

**Goal:**

**Objectives:** **Achieved Date:**

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**Problem # 2:** **Date:**

**Goal:**

**Objectives:** **Achieved Date:**

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**Problem # 3:** **Date:**

**Goal:**

**Objectives:** **Achieved Date:**

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**Problem # 4:** **Date:**

**Goal:**

**Objectives:** **Achieved Date:**

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