Southern Light Counseling

CD Vendor# 002344001 SLC NPI# 1346513744

Diagnostic Assessment

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Client: DOB: SSN#: Pay Source:
Legal Guardian: Relationship to Client: N/A
SLC Admission Date:

◯ Southern Light Counseling ◯ Home Court Advantage

Provider/Credentials:
Clinical Supervisor/Credentials:
H.C. Case Manager:
Referred by:

- ☐ Self
- ☐ CD Worker/Name/Creds/Agency:
- ☐ RST
- ☐ EAP
- ☐ Other

Date of Service: _____ Start Time:_____End time:_____

Place of Service: ☐11 In Office ☐12 In Home ☐14 Residential

Other:_____

Units of Service Provided: _____

DX Assessment Report Date:_____

Next DX Assessment Due Date:_____

Long Term Placement Goal:

◯ Reunification with : _____
Name/Relationship to Client/Agency

◯ APLA (Another Permanent Placement Living Arrangement)

◯ Career Foster Home

◯ Kinship Placement

◯ Other _____

Diagnostic Assessment

Client : DOB:
Provider/Credentials
Clinical Supervisor/Credentials:

Reason for Referral/Presenting Problem:

Reporter: _____

☐ Client out of parental control ☐ Parental neglect

☐ Physical violence in home ☐ Other _____

Client is Identified as Victim of:

_____

☐ Physical Violence in Home	☐ Alleged	☐ Substantiated	☐ Perpetrator Convicted
☐ Sexual Abuse	☐ Alleged	☐ Substantiated	☐ Perpetrator Convicted
☐ Emotional Abuse	☐ Alleged	☐ Substantiated	☐ Perpetrator Convicted
Other	☐ Alleged	☐ Substantiated	☐ Perpetrator Convicted

Client is Identified as Perpetrator/Abuser:

_____

☐ Physical Violence in Home	☐ Alleged	☐ Substantiated	☐ Perpetrator Convicted
☐ Sexual Abuse	☐ Alleged	☐ Substantiated	☐ Perpetrator Convicted
☐ Emotional Abuse	☐ Alleged	☐ Substantiated	☐ Perpetrator Convicted
Other	☐ Alleged	☐ Substantiated	☐ Perpetrator Convicted

Presenting Problem and Treatment Expectations (For H.C. Clients see CS-9)

Diagnostic Assessment

Client : DOB:
Provider/Credentials
Clinical Supervisor/Credentials:

Statement of Need and Treatment Expectations (For H.C. Clients see CS-9)

Current Symptoms/Behavior

- ☐ Mood_____
- ☐ Depressed – Atchenbach Youth Self Report Score _____
- ☐ Low Self Esteem
- ☐ Sleep Disturbance
- ☐ Self Blame
- ☐ Difficulty Coping with Stressors
- ☐ Change in interest levels
- ☐ Sense of Belonging
- ☐ Fear
- ☐ Worry
- ☐ Panic Attacks
- ☐ Physical Aggression
- ☐ Poor Personal Hygiene
- ☐ Feelings of Insecurity
- ☐ Recent Weight Change
- ☐ Symptoms of Eating Disorder
- ☐ Oppositional
- ☐ Argumentative with Authority Figures
- ☐ Cruelty to Animals
- ☐ Bullying
- ☐ Anger Outbursts
- ☐ Unacceptable Sexual Behavior
- ☐ Property Destruction
- ☐ Failure to Follow Directions/Rules
- ☐ Lying (51% rule)
- ☐ Compliance with Assigned Tasks
- ☐ Fails to Maintain Personal Boundaries
- ☐ Elopement
- ☐ Infringes Upon Other's boundaries
- ☐ Self Harm_____
- ☐ Fire Setting
- ☐ Other _____

Diagnostic Assessment

Client : DOB:
Provider/Credentials
Clinical Supervisor/Credentials:

Current Symptoms/Behavior

Activity /Energy Level

◯ Normal Limits ◯ High ◯ Low

Conflict With

☐ Peers ☐ Authority ☐ Family ☐ Other_____

Self Report

☐ Suicidal Ideation ☐ Homicidal Ideation ☐ Delusions ☐ Obsessions

☐ Compulsions ☐ Other _____

Attention/Concentration

◯ Normal Limits ◯ Below Normal Limits ◯ Above Normal Limits

Verbal Aggression

☐ Authority Figures ☐ Peers ☐ Basic talk ☐ Side talk ☐ Other _____

Psychiatric Treatment History (include previous TX provided *)

Reporter: _____
Name/Credentials/Agency

Age at onset _____

Presenting Issue

Tx provided

Tx Outcome

Duration of previous TX provided _____

Diagnostic Assessment

Client : DOB:
Provider/Credentials
Clinical Supervisor/Credentials:

Substance Abuse Tx History

Substance	None Reported	Onset age	Duration	Patterns	Consequences
Alcohol					
Drugs					
Nicotine					
Other					

*Refer to CS-9 dated _____ for H.C. Clients

Recent Use/Duration Patterns
Alcohol and Drug Use Recent 30 days

Substance	None Reported	Onset age	Duration	Patterns	Consequences
Alcohol					
Drugs					
Nicotine					
Other					

Substance Abuse Tx is Clinically Indicated : ◯ Yes ◯ NO

Information Provided by: _____
Name/Credentials/Relationship to Client or Agency

Referring Agency: _____
Agency Name/Contact Individual/Position/Credentials

Family and Social Status: (current/historical)
*Refer to CS-9 dated _____ for H.C. Clients

***Specific to H.C. Clients:**

Name	**Relationship**	**Desired Contact**

Client : DOB:
Provider/Credentials
Clinical Supervisor/Credentials:

Diagnostic Assessment

Legal Status

Historical information_____ *For H.C. Clients, see CS-9

Currently in **legal custody** of: _____

Criminal Activity

Charge	Date	County	Disposition

Information provided by:
_____
Name/Position/Relationship to Client

Educational/Vocational Status/Functioning

Current Grade Level _____ Attendance _____ Grades _____

Detentions/Suspensions	**Yes (Describe)**	**No**
In School Suspension		
In School Detention		
Expulsion		
Homebound		

Extra Curricular Activities

School Behavior	**Consequences/Reward or Recognition**
Attitude toward Teachers	**Attitude toward Peer/Peer Age Friends**
Comfort Level in School Environment	**Other**

Diagnostic Assessment

Client : DOB:
Provider/Credentials
Clinical Supervisor/Credentials:

Vocational Status/Functioning

Work / Career

Situation	Attendance	Employment/Position	Other
Current Medication Regime/Medical Allergies – See Attachment			

Current Community Resources and Services

- ☐ Individual Counseling
- ☐ Family Counseling
- ☐ Group Counseling
- ☐ Recreational Therapy
- ☐ H.C. Case Management
- ☐ Community Service Opportunities
- ☐ School
- ☐ Mentorship
- ☐ Substance Abuse Tx
- ☐ Tutoring
- ☐ Occupational Therapy
- ☐ Other _____
- ☐ Other _____
- ☐ Other_____

Patient Response

- ☐ Restraint/closed
- ☐ Continues with recurrence of symptoms
- ☐ Needs Maintenance
- ☐ Improvement:
  - ◯ Mild ◯ Moderate ◯ Significant

Prognosis

◯ Excellent ◯ Good ◯ Fair ◯ Poor

Personal/Social Resources and Strengths:
Self report

Insight into own problems:

Motivation:

Personal interests:

Support System:

Quality of Current Living Situation:

Other: _____

Diagnostic Assessment

Client : DOB:
Provider/Credentials
Clinical Supervisor/Credentials:

ICD-10 Code Number	Diagnosis

Clinician _____ ***Day*** _____ ***Date***_____
Signature, Credentials and State license #

Reviewed by _____ ***Date***_____
Signature, Credentials and State license #
Clinical Supervision Utilization Review

Reviewed by _____ ***Date***_____
Signature, Credentials and State license #
Clinical Supervision Utilization Review

Emailed to: _____ ***Date***_____