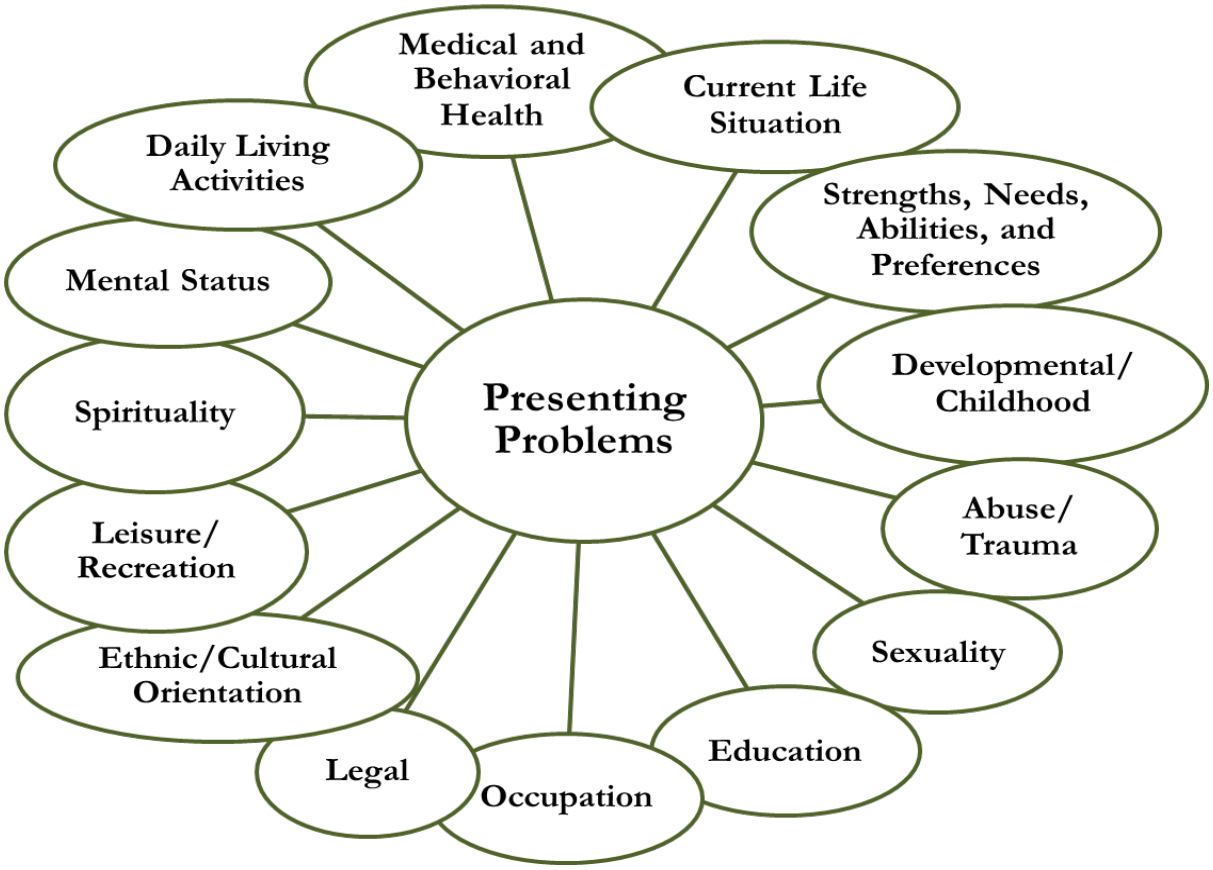
HIGH COUNTRY BEHAVIORAL HEALTH
ADOLESCENT COMPREHENSIVE ASSESSMENT

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.**

The adolescent assessment is intended for youth between 13 to 17 years old. Parents or legal guardians assist in completing the adolescent assessment.

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
ADOLESCENT 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: _____

5. Name of parent or legal guardian who assisted in the completion of the assessment:_____

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 to and from treatment 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 Why?	
		❑Excellent ❑Good ❑Fair ❑Poor Why?	
		❑Excellent ❑Good ❑Fair ❑Poor Why?	
		❑Excellent ❑Good ❑Fair ❑Poor Why?	

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.)
❑ 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 and 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 any periods of time during your earlier childhood? ❑Yes ❑No

2. Where did you live and who lived in your house during your earlier childhood?

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. Have you experience any of the following problems while growing up? (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:

SEXUALITY

1. Are you sexually active? ❑Yes ❑No

2. 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

Adverse Childhood Experiences (ACE) While you were growing up:

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
Graduate ❑Yes ❑No
GED ❑Yes ❑No

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:	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 _____ Family or friends_____

Disability Income _____ Illegal sources _____

8. **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:

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, on probation

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, what are the conditions of probation:_____

_____

Name of Probation 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 youth independently, as age-appropriate, performed each of the 20 Activities of Daily Living 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 appropriate school or 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	Assist or manage adequate weight, moods, outdoor exercise, aches, pains. Take medications or over the counter drugs with adult supervision only.	
2. Housing Stability, Maintenance	Housing is stable and youth contributes to stability in the home (age-appropriate). Respect others and property. Share in chores, involve caretakers in school related projects, grades.	
3. Communication	Greets adults. Listens. Expresses feeling, anger, opinions effectively.	
4. Safety	Play it safe? Avoid guns, knives, matches, danger people or places where there is likely trouble or an abuse potential. If driving, has a safe record.	
5. Managing Time	Assist or manage time for promptness. Regularly attends school and work (age appropriate). Routinely completes tasks. Sleep, wake, meals on regular basis?	

6. Managing Money	Reliably handles or manages monetary allowance. Abstains from overspending personal limits. Betting, stealing, borrowing?	
7. Nutrition	Eats at least 2 basically nutritious meals with caretakers. Eat healthy snacks that reasonably limit sugar and caffeine?	
8. Problem Solving	Understand presenting problems, reasons for seeking services. Focus on possible solutions for age-appropriate time periods. Assist or manage difficult situations?	
9. Family Relationships	Feel close to at least one other person at home. Get along with family or caretakers. Feel loved?	
10. Alcohol/Drug Use	Abstain from smoking cigarettes, drinking alcohol, doing drugs or inhalants of any kind. Avoid high risk drinking situations and people who do drugs?	
11. Leisure	Enjoy two or more fun and relaxing activities: musical instruments, music, watching/playing sports, reading, computer or board games, cards, art, hobbies, movies, TV?	
12. Community Resources	Use community activities, resources such as after-school sponsored tutoring, clubs, sports, scouts, Boys/Girls Clubs, library, church, dances?	
13. Social Network	Make and keep same-age friends. Avoid bullying, gangs, cults, anti-social groups.	
14. Sexuality	Reports age-appropriate sexually responsible behaviors with girls/boys. Educated and avoids sexual activities, infections, pregnancy?	
15. Productivity	Feel good about performance at school. Consider grades to be good. Complete school projects without undue difficulty. Have vocational goals?	
16. Coping Skills	Accept adult correction without undue arguing, temper outburst. Tolerates frustration.	
17. Behavior Norms	Control threatening or physical expression of anger, violent behavior - either to self or others or property. Law abiding, responsible with school, community rules, driving car.	
18. Personal Hygiene	Help or manage general cleanliness - daily shower/bath, brush teeth.	
19. Grooming	Assist or manage general appearance: hair, shave, comply with school rules	
20. Dress	Assist or responsibly care for clean clothes, comply with school dress code.	
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:_____