Assessment Information Sample

DURATION, ONSET, FREQUENCY AND IMPAIRMENTS IN LIFE FUNCTIONING CAUSED BY THE SYMPTOMS/BEHAVIORS (from perspective of client and others)

Client is a 27-year-old African American male seeking services because over the past few months he has found it difficult to cope with feelings of depression. Client reported excessive crying, trouble sleeping, trouble concentrating, and no interest in usual activities. Client reported impairments in home and social life functioning. Client stated, "I get irritated and raise my voice. People just don't seem to understand what I am going through." Client reports that he has days in which he wishes he were dead however has not thought about actually killing himself. These symptoms have been present over the past two months.

PRECIPITATING EVENTS(S)/REASON FOR REFERRAL

Client reports he feels that in the past year his symptoms have gotten worse. Client is unable to pinpoint exactly when he noticed feeling more depressed, but he reports the loss of his mother last year to cancer made him depressed.

TRAUMA OR EXPOSURE TO TRAUMA:

Client reported no trauma or exposure to trauma.

EDUCATION/SCHOOL HISTORY

Client reported he did exceptionally well in school, graduating with a 3.7 grade point average. He reported no school problems

EMPLOYMENT HISTORY, READINESS FOR EMPLOYMENT AND MEANS OF FINANCIAL SUPPORT

Client reported no work related problems. He reports he has been able to maintain employment as a mechanic, manage his money, and maintain his source of income.

CURRENT LIVING ARRANGEMENT AND SOCIAL SUPPORT SYSTEMS

Client reported living in an apartment in Lancaster with his 5-month old son, girlfriend, and stepdaughter and reported no problems.

Client grew up in the Lancaster area, reports that his parents used to argue a lot, but that there was no abuse. Client reports he grew up with 2 biological siblings and 3 half siblings. He is the middle child.

Describe ages of children, school attendance/behavior problems of children, special needs of dependents, foster care/group home placement issues, child support, etc.:

Client has 5-month baby boy and 8-year-old stepdaughter. Client reports his children having no issues with school attendance/behavioral problems, special needs nor foster/group home placement. Client reports that his children are his reason for living.

FAMILY HISTORY / RELATIONSHIPS

Client reported his family includes his son, stepdaughter, and girlfriend. Client denied physical and sexual abuse. Client reported history of DCFS case due to domestic violence. Client denied safety issues in the home. Client reported having a close family despite his history of aggression towards his girlfriend.

CLIENT'S STRENGTHS *(to assist with achieving treatment goals)*

Client reported having the initiative to change, being strong willed, courageous and open as his strengths.

CLINICAL FORMULATION AND DIAGNOSTIC JUSTIFICATION

Client is a 27-year-old African American male seeking mental health services to address depressive symptoms that have worsened since the loss of his mother within the past year causing impairments in his functioning at home and social relationships. Based on clients reported symptoms, he meets criteria for a primary DSM 5 dx of Major Depressive Disorder, Mild. Client's symptoms include feeling sad daily, excessive crying daily, trouble sleeping daily, trouble concentrating daily, and no interest in usual activities daily. Onset was 1-2 years ago. Client reported strengths are having initiative to make changes in his life, being strong willed and courageous.

DIAGNOSTIC DESCRIPTOR ICD DIAGNOSIS CODE

Major depressive disorder, single episode, mild F32.0

Treatment Plan for Client Described in Assessment Information Sample

Objective:
Client will improve depression as evidenced by decrease in family altercations and increase in reported improved mood

Interventions:

- TCM 1-2x/week to link client to domestic violence programs for perpetrators
- Individual therapy 1x/week using CBT to improve client mood and improve communication with family
- Family therapy 2x/month to improve family communication

*See survey questions below

QA KNOWLEDGE ASSESSMENT SURVEY # 4 QUESTIONS (Total of 5)

1. What is the purpose of the Assessment?

   A. To get a complete picture of the client in order to understand the interrelationship between the client's symptoms/behaviors and the client as a whole person in order to provide the most effective clinical interventions
   B. To determine how quickly someone needs to be seen for an appointment
   C. To enable the clinician to diagnose and effectively treat the client
   D. To establish Medical Necessity
   E. A, C and D

2. In order to get a complete picture of the individual described in the Assessment Information Sample, what areas/information could have been better developed or would have been helpful to have?

   A. Current relationship/circumstances with partner and children
   B. Circumstances of the DCFS involvement
   C. Family of Origin/Childhood history
   D. Impairments resulting from the diagnosis
   E. Potential risks (history of aggression, passive suicidal ideation)
   F. All of the Above

3. The following is TRUE regarding the documentation of the client's family situation in the documentation sample

   A. The description of the client's current family situation is sufficient in that it describes who the client lives with, and mentioned that there are no problems presently
   B. A complete picture of this client's situation should include more clear documentation/description around client's reported history of DCFS involvement due to domestic violence
   C. In order to be compliant with privacy rights of the client, it is important to avoid documenting overly detailed information, for example, specific circumstances around domestic violence.
   D. Given that treatment is focused on the client's current situation, detailed information about the client's own childhood environment and dynamics is not necessary or important

4. The following is TRUE regarding the documentation of a client's history of symptoms

A. It is acceptable to provide general, non-specific information about the history of symptoms since this is a general overview
B. It is important to provide as much concrete, specific information as possible about the history and development of the client's symptoms in order to provide a clear picture of the relevant factors impacting the client's current functioning
C. In order to protect the client's privacy, very detailed information about the contexts and circumstances of the development of symptoms should be avoided
D. A non-specific and general overview of the history of symptoms is acceptable given that the focus of treatment is on the client's current presenting symptoms, behaviors, and impairments

5. The following is TRUE regarding the Treatment Plan

A. The Objective is based on information that is articulated in the Clinical Formulation
B. TCM interventions must relate to a "TCM Objective"; therefore the TCM intervention as formulated cannot be listed under the stated Objective
C. The TCM intervention is relevant, assuming that Domestic Violence is a presenting problem for the client
D. The rationale that the decrease in family altercations is linked/reflects a reduction in depression makes sense and is clear