CHIDI NDUBUEZE, LPC, LADC/MH
CHIDI NDUBUEZE, LLC

ADDRESS: 4917 N Portland Ave, #400 **PHONE**: 405-412-6218
Oklahoma City, OK 73112
FAX: 405-285-5590

ADULT DIAGNOSTIC PSYCHOSOCIAL ASSESSMENT

CLIENT'S NAME: _____

SOCIAL SECURITY ##: _____ ____ _____ DATE OF BIRTH _____

INSURANCE #: _____

Today's date _____Source of Information_____

PRESENTING COMPLAINT SECTION

Reason for referral/or treatment _____

Description of presenting problem(s) _____

_____

_____

_____

_____

_____

_____

Briefly describe how the problem(s) noted above cause difficulty for you or your child (work, school, church, relatives) __

_____

_____

_____

_____

SOCIAL/SEXUAL/FINANCIAL/LEGAL HISTORY SECTION

Born/Raised _____ Religion _____
Siblings: # of brothers: _____ # of sisters:__
Education History: _____
Highest grade attained: _____
History of truancy/suspension/school expulsion/special education: _____
_____

Marriage/Relationships: _____
_____

Children: _____
Current Living Situation: _____
Work History: _____

Financial Stresses: _____
Source of income/financial assistance: SSI ____ SSDI ____ TANF ____ Food Stamps _____ Session 8 ____ HUD ____
Legal Problems/convictions//probation/parole: _____
_____
Military History/Type of Discharge: _____
_____
Support/Social Network: _____
Hobbies/Interests: _____
Significant Life Events: _____
_____
Sexual orientation: _____
Sexually active/inactive? _____
Age that you became sexually active? _____
History of sexually transmitted diseases /infections? _____

Other _____
_____
_____

LIFE STRESSORS/PRIORITIES SECTION

In the past 12 months . . .

Primary Stressors: _____

Highest priorities: in life at this time are _____

MEDICAL HISTORY SECTION

Describe current health concerns/changes:_____
_____
Allergies? __No ___Yes (specify) _____

Known infections disease(s)? __No ___Yes (specify) _____

Current psychiatric medications (include purpose/compliance):_____
_____
_____
Past psychiatric medications (include purpose/compliance): _____
_____
_____

Current non-psychiatric medication: _____

Are there known allergies to medications or other substances? __No ___Yes If Yes, please document: _____

_____

Does family history include significant physical problems? __No ___Yes (specify) _____

Family History of Mental Health/Psychiatric Problems: _____

Family History of Substance Abuse: _____

FINANCIAL RESOURCES SECTION

Client is able to support self without assistance __No __Yes If no _____

Client currently receives assistance __No __Yes (describe) _____
Client requires referral for financial aid __No __Yes
Client requires referral for credit counseling __No __Yes
Current problem has affected financial situation __No __Yes (how) _____
_____

PSYCHOTIC DISORDERS SECTION

Psychosis Symptoms (2 or more during 1 month period)

Hallucinations _ Not present _ Auditory _ Visual _ Tactile _ Other Describe _____

Delusions _ Not present

If present, type of delusion _ Special Powers/Grandiose _ Persecution _ Somatic _ Other

Describe the delusion _____

Disorganized speech (e.g. incoherent or frequent derailment) _ Not present _ Present

Grossly disorganized behavior or catatonic behavior _ Not present _ Present

DEPRESSION SYMPTOMS

Over the last 2 weeks, how often have you been bothered by any of the following problems? (circle one)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself B or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite B being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself.	0	1	2	3

add columns: + + ____

TOTAL: _____

10. If you checked off *any problems*, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

ANXIETY SYMPTOMS

Trauma History

_ Individual reports no trauma experiences

Trauma Categories	* Type I	** Type II	*** Victim Status (**P/S/T**)
_ Child/adolescent sexual abuse	_	_	____
_ Child/adolescent physical abuse	_	_	____
_ Child/adolescent emotional abuse	_	_	____
_ Criminal/physical violence	_	_	____
_ Sexual/physical assault	_	_	____
_ Armed robbery	_	_	____
_ War/combat	_	_	____
_ Traffic accidents	_	_	____
_ First Responder	_	_	____
_ Work related	_	_	____
_ Natural disaster	_	_	____
_ Other	_	_	____

Describe trauma event(s) _____

* Type I: single event, acute life threat, unexpected
** Type II: repeated, prolonged, unpredictable course
*** Victim Status: **P**rimary: direct experience with the trauma event
Secondary: witnesses and helpers of trauma event
Tertiary: indirectly affected by the trauma event

Post Traumatic Stress Disorder Symptoms _ Not present _ Present

_ Fear _ Helplessness _ Horror

_ Re-experiencing (1 or more)
distressing recollections, distressing dreams, flashbacks,
psychological or physiological distress to stimuli, **and**

_ Avoidance (3 or more)
efforts to avoid thoughts, feelings, conversations, activities,
places or people associated with the trauma, inability to recall the trauma,
restricted emotions, diminished interest in activities,
sense of a foreshortened future, feeling estranged from others, **and**

_ Arousal (2 or more)
Difficulty falling/staying asleep, irritability or outbursts of anger,
Difficulty concentrating, exaggerated startle response, hypervigilance

Panic Disorder Symptoms (4 or more with abrupt onset peaking in about 10 minutes) _ Not present _ Present

_ Shortness of Breath _ Dizziness/Faintness _ Palpitations/Chest Pain _ Trembling

_ Sweating _ Choking _ Nausea/Abdominal Distress _ Numbness/Tingling

_ Hot/Cold Flashes _ Depersonalization _ Fear of Dying _ Fear of Going Crazy/Out of Control

Describe symptom onset/duration/intensity/frequency_____

Agoraphobia Symptoms _ Not present _ Present (Fear of Being in Places/Situations/Unable to Escape)

Generalized Anxiety Disorder Symptoms _ Not present _ Present

_ Excessive anxiety and worry (apprehensive expectation) pervasive for at least 6 months, **and** _ Has difficulty controlling the worry, **and**
The anxiety and worry are associated with (at least 3 pervasively for at least 6 months) the following symptoms:

_ Restlessness/feeling keyed up _ Being easily fatigued _ Irritability

_ Muscle tension _ Sleep disturbance _ Difficulty concentrating/mind going blank

Describe onset/duration/intensity/frequency_____

Obsessive Compulsive Disorder Symptoms _ Not Present _ Present

Obsessions _ Recurrent and persistent thoughts, impulses, or images, **and**

_ Thoughts, impulses, or images which are more than excessive worries about real-life problems, **and**

_ Recognition that the thoughts, impulses, or images are a product of their own mind, **and**

_ Attempts to ignore or suppress thoughts, impulses or images or to neutralize them with some other thought or action, **or**

Compulsions _ Repetitive behaviors (e.g. hand washing, ordering, checking) or mental acts (counting, praying, repeating words/numbers) compelled to perform in response to an obsession or according to rigidly held rules, **and**

_ The behaviors or mental acts are intended to prevent or reduce distress or preventing some dreaded event or situation

Describe symptom onset/duration/intensity/frequency_____

Other symptoms or features for disorders not previously noted: _____

_____

_____

SUBSTANCE ABUSE HISTORY SECTION

Past Alcohol/Drug Use

Check the following substances(s) of past use	Amount of use	Frequency of use	Time period of your use
__ Alcohol			
__ Marijuana			
__ Cocaine/Crack/Meth.			
__ Inhalants			
__ Stimulants			
__ Hallucinogens			
__ Heroin/Opiates			
__ Prescription Drugs (specify)			
__ Other (specify)			

CRAFFT SCREENING TOOL (Under age 21)

	YES	NO
1. Have you ever ridden in a **CAR** driven by someone (including yourself) who was Ahigh@ or had been using alcohol or drugs?		☐
2. Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?	☐	☐
4. Do you ever **FORGET** things you did while using alcohol or drugs?	☐	☐
5. Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	☐	☐

 Client name: Client ID #:

DRUG USE QUESTIONNAIRE (DAST-10)

These questions refer to the past 12 months only. (cannabis, inhalants, meth., hallucinogens, narcotics, tranquilizers)	**YES**	**NO**
1. Have you used drugs other than those required for medical reasons? If yes, specify drug(s) _____ _____		
2. Do you abuse more than one drug at a time?		
3. Are you always able to stop using drugs when you want to?		
4. Have you had Ablackouts@ or Aflashbacks@ as a result of drug use?		
5. Do you ever feel bad or guilty about your drug use?		
6. Does your spouse (or parent) ever complain about your involvement with drugs?		
7. Have you neglected your family because of your drug use?		
8. Have you engaged in illegal activities in order to obtain drugs?		
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?		
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?		

Dast Score

 Client name: Client ID #:

RISK ASSESSMENT SECTION

Homicidal Ideation _ Not present _ Present _ Thought _ Plan
Target of homicidal thinking _____

****Suicidal Ideation*** _ Not present _ Present _ Thought _ Plan
Details _____

Self-Injurious Behavior (SIB) _ Not present _ Present
Onset/form of SIB _____

Coping Potential Estimate __Excellent _ Good __Fair __Poor
Explain (i.e. impulsive, substance use) _____

**Clinicians may elect to use the FBTA Suicide Risk Assessment instrument for further clinical guidance with the client*

TREATMENT HISTORY SECTION

Substance Abuse Treatment History

	No	Yes	Dates	Provider/Treatment Response
Drug/Alcohol treatment				
Involvement with self-help groups				

Behavioral Health Treatment History

	No	Yes	Dates	Provider/Treatment Response
Counseling/Psychiatric treatment				
Hospitalizations				

Please do not write below this line. For Therapist's Use Only

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DIAGNOSIS SECTION

Axis I -- _____

Axis II -- _____

Axis III -- _____

Axis IV -- ☐ Problems with primary support group

☐ Economic problems ☐ Health related problems

☐ Housing problems ☐ Problems related to legal/criminal system

☐ Occupational problems ☐ Problems related to social environment/school

☐ Other psychosocial and environmental problems _____

Axis V (GAF) -- current _____ Past year _____ _____

CLINICIAN=S ASSESSMENT AND RECOMMENDATIONS SECTION

_____
_____
_____
_____
_____
_____
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_____
_____
_____
_____

_____ _____ _____

Clinician Name (Print) Clinician Signature Date