

Form 650 Comprehensive Assessment

Clark Quality Care

Individual Name:
Admission Date:

Medicaid ID:
DOB:

COMPREHENSIVE ASSESSMENT
FORM# 650

Date:

1. Onset and Duration of Problems:

2. Social (i.e., ability to communicate with others, establish/maintain interpersonal relationships, social compliance/acceptability, manners)

Structure and use of leisure time and recreation: (i.e., hobbies, interests, social outlets, strengths, volunteerism, classes, and consumer preferences)

Behavioral

Conditions/Diagnoses	Onset & Duration <i>(Treatment Dates)</i>	Treating Provider <i>(name, address and phone number if known)</i>	Previous Interventions and outcomes: (MH & MR) <i>(include psychiatric hospitalizations)</i>

Developmental

History: Circle yes or no (If yes, add description for each below.)

Developmental delays/milestones: (speech, motor, social, cognitive, self-help, adaptive)	Head Injuries Yes No
Traumas (include abuse, neglect, accident, pregnancy/delivery complications other)	Unremarkable developmental history Yes No

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Family history and supports:

Family Structure and Relationship History: _____

Social History: *(Describe social development and significant cultural and religious background.)* _____

FAMILY/SIGNIFICANT OTHERS/SOCIAL (Current):

Describe the following:

Religious/Cultural Factors: *(i.e. country, city, drug, gang, ethnic, etc.) as they relate to current service needs, support systems, stressors, strengths, and consumer preferences:*

Social/Family Supports: *(to include family, friends, other community supports)*

Psycho-educational needs: *(i.e., problem solving skills, anger management, interpersonal communication skills, understanding illness and medications)*

3. Cognitive Functioning including strengths and weaknesses:

4. Employment, vocational, and educational background: *Describe employment/educational/vocational history and current:*

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5. Previous Interventions and Outcomes

6. Financial resources and benefits *Describe current resources and benefits/income.:*

7. Health history and current medical care needs:

a. Allergies

Physical and Medical Status:

b. Current (i.e. physical health, dental and recent physical complaints) (For each condition, in the last 8 columns, check all categories that apply)

List current medical diseases & conditions	Name of Treating Physician	Onset	Duration	Stable with tx	Unstable with tx	Not treated /unmet need	Refuses tx	Compliant with tx	Self-managing

c. Nutritional needs:

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d. Chronic conditions

List Below	Treatment Dates <i>(Onset Duration)</i>	Treating Provider <i>(name, address and phone number if known)</i>	Current Status <i>(i.e. treated yes/no, active condition, in remission)</i>

e. Communicable diseases

List below (e.g. TB, HIV/AIDS, HBV, STD, etc.)	Treatment Dates <i>(Onset Duration)</i>	Treating Provider <i>(name, address and phone number if known)</i>	Current Status <i>(i.e. treated yes/no, active condition, in remission)</i>	Chronic Y/N

f. Restrictions on physical activities if any:

g. Restrictive Protocols or Special Supervision Requirements:

h.

Serious illnesses, serious injuries and medical hospitalizations	Onset & Duration <i>(Treatment Dates)</i>	Treating Provider <i>(name, address and phone number if known)</i>	Status And Impact On Functioning	Chronic Y/N

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i.

FAMILY/SIGNIFICANT OTHERS/SOCIAL (History):

Medical update of consumer's parents, siblings and significant others in the household:

Relationship to Consumer	In Household? (yes or no)	Serious Illnesses, Chronic Conditions, and/or Substance Abuse (Onset and Duration)

j. Current and past substance use including alcohol, prescription and nonprescription medications, and illicit drugs:

SUBSTANCE ABUSE TREATMENT (History and Current):

(alcohol, prescription and non-prescription medications and illicit drugs)

Treatment Dates	Treating Provider <i>(name, address and phone number if known)</i>	Currently Using? Yes/No

Extent and effect of drug or alcohol use:

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Current presenting problem(s):

8. Psychiatric and substance use issues including current mental health or substance use needs, presence of co-occurring disorders, history of substance use or abuse, and circumstances that increase the individual's risk for mental health or substance use issues-

9. History of abuse, neglect, sexual, or domestic violence, or trauma including psychological trauma-

10. Legal status including authorized representative, commitment, and representative payee status-

11. Relevant criminal charges or convictions and probation or parole status-

12. Daily living skills

	<i>Independent Skills</i>	<i>Needs and has support</i>	<i>Unmet need, need support</i>	<i>Health/safety signif. jeopardized if no support</i>	<i>Give "as evidenced by" (AEB) examples (required)</i>
<i>Bathing</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Dressing</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Toileting</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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<i>Eating</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Meal Prep</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Housekeeping</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Laundry</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Money Management</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Transportation Use</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Shopping</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Using Phone</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Home Maintenance</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Medication Mgt/Nursing.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Medical Mgt.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Dental/Optical/Other</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Ambulation</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

13. Housing arrangements *Describe current arrangement, recent or potential changes, (i.e., type of residence; degree of harmony/conflicts; composition of household; impact of mental illness/behaviors on housing stability; consumer housing preference)*

14. Ability to access services including transportation needs

15. Fall risk (Is the individual at risk for falls):

Communication Methods and Needs *(Is the individual verbal? If the individual is not verbal, how do they communicate?)*

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Mobility and adaptive equipment needs

Name and Title of the QDDP: _____

Signature and Title of the QDDP completing the form: _____

Date: _____