

HUMAN DEVELOPMENT COMPANY, INC.  
CLIENT ASSESSMENT FORM

COUNSELOR NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

CLIENT NAME: \_\_\_\_\_ SS \_\_\_\_\_ DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE: WORK: (\_\_\_\_) \_\_\_\_\_ EXT \_\_\_\_ HOME: (\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_\_

ETHNIC GROUP African American American Indian Asian Caucasian Hispanic Other

MARITAL STATUS: Married Single Divorced Widowed Estranged/Separated HIRE DATE \_\_\_\_\_

COVERED COMPANY: \_\_\_\_\_ JOB TITLE: \_\_\_\_\_

EMPLOYEE NAME: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_ RELATIONSHIP TO CLIENT: \_\_\_\_\_

INSURANCE CO: \_\_\_\_\_ GROUP #: \_\_\_\_\_ PLAN CODE: \_\_\_\_\_

PRESENTING PROBLEM: \_\_\_\_\_

CLINICAL IMPRESSIONS: \_\_\_\_\_

MEDICAL PROBLEMS? \_\_\_\_\_

ADHD/LD? \_\_\_\_\_

FINANCIAL PROBLEMS? \_\_\_\_\_

LEGAL PROBLEMS? \_\_\_\_\_

WORK PERFORMANCE ISSUES? \_\_\_\_\_

DISCIPLINARY ACTION (if any) \_\_\_\_\_

SOCIAL SUPPORT? \_\_\_\_\_

PHYSICAL ABUSE (Past or Present): \_\_\_\_\_

SEXUAL ABUSE (Past or Present): \_\_\_\_\_

CO-DEPENDENCY: \_\_\_\_\_

Is client in a relationship with someone who has a problem with alcohol or drugs? \_\_\_\_\_ If yes, what is their relation to you? \_\_\_\_\_

SUBSTANCE ABUSE SCREEN: \_\_\_\_\_

1. Has client or any significant other had concerns about client's drinking or drug use? \_\_\_\_\_ If yes, who and please explain: \_\_\_\_\_
2. Is client using more alcohol or drugs now than in the past? \_\_\_\_\_ If yes, how much: \_\_\_\_\_
3. Have there been times when client had memory problems after drinking? \_\_\_\_\_ If yes, how often: \_\_\_\_\_
4. Is there a family history of alcohol or drug problems? \_\_\_\_\_ If yes, who: \_\_\_\_\_

MENTAL STATUS: \_\_\_\_\_

1. Are there significant clinical signs of depression (energy, sleep, appetite changes)? \_\_\_\_\_
2. Does client have a history of psychiatric problems? \_\_\_\_\_ If yes, explain: \_\_\_\_\_
3. Is client a danger to self now? \_\_\_\_\_
4. Any history of suicidal or violent behavior? \_\_\_\_\_ If yes, explain: \_\_\_\_\_
5. Is there a family history of mental illness, suicide, depression or violence? \_\_\_\_\_ If yes, who: \_\_\_\_\_

COMMENTS:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

All sections must be filled out in full. Please call us if you have any questions.

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Intake Date: \_\_\_\_\_  
Covered Company: \_\_\_\_\_ SS #: \_\_\_\_\_

Initial Visit Summary: \_\_\_\_\_ Counselor's Name: \_\_\_\_\_

Other Visits Summary: \_\_\_\_\_ Dates: \_\_\_\_\_

- Primary Problem:**
- |                     |                   |                 |                  |
|---------------------|-------------------|-----------------|------------------|
| A. Alcohol          | F. Financial      | K. Job/Career   | W. Eating/Weight |
| B. Polydrug         | G. Gambling       | L. Legal        |                  |
| C. Codependency     | H. Child          | M. Medical      |                  |
| D. Other Drug Abuse | I. Job/Career     | N. Non-EAP      |                  |
| E. Eldercare        | J. Marital/Family | P. Psych/Emotio |                  |

- Client Action:**
- |                  |                         |                           |
|------------------|-------------------------|---------------------------|
| D. Declined Help | E. Affiliate Visit ONLY | X. Affiliate and Referral |
|------------------|-------------------------|---------------------------|

- Treatment:**
- |                       |               |                        |                      |
|-----------------------|---------------|------------------------|----------------------|
| C. CD Inpt Rehab      | G. Gambling   | N. Non-EAP             | U. Unneeded          |
| D. Detox              | J. Job/Career | P. Psych Inpatient     | Y. Self-Help         |
| I. CD Intensive Outpt | L. Legal      | O. Outpatient (non-CD) | Z. Family Counseling |
| X. CD Outpt Counselng | M. Medical    | S. Community Svcs      |                      |

Referred To: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

- Disposition:**
- |               |                        |             |             |
|---------------|------------------------|-------------|-------------|
| 1. Resolved   | 4. Worsened            | 7. Retired  | 10. Non-EAP |
| 2. Improved   | 5. Client Dropped Out  | 8. Laid Off |             |
| 3. Unimproved | 6. Employer Terminated | 9. Deceased |             |

Counselor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_