Diagnostic Interview

-To be completed upon admission to services and every year thereafter.

*If Client has Medicaid, BHSN or Self Pay: Schedule Diagnostic Service with Master's Level Therapist

*If Client has Commercial Insurance, Medicare or TriWest: Schedule service with Med Provider (even if client is only seeking therapy services, client must see Med Provider to enter services- **UNLESS** your office has a Licensed Therapist / Licensed Clinical Social Worker who is able to see these clients for Diagnostic interview).

Referral Information

DI-Referral Information*Copy*

Attendees:	☐ Client ☐ Guardian ☐ OCH Staff ☐ Spouse/Partner ☐ Foster/Step-parent ☐ Friend ☐ Mother ☐ Sibling(s) ☐ DCS ☐ Father ☐ Extended Family ☐ Other
What brought you in for this appointment today?	(In Client's own words) Max: 2000 characters.
Reason for Referral:	(Indicate reason cited by client, as well as reason cited by referral source- goals and expectations of services) Max: 2000 characters.

-Attendees: Indicate who is present during session

-Quote Client's own words to explain why client is seeking services

-Cite reason for referral according to client, as well as any referral source (if applicable)

Presenting Problems

DI- Presenting Problem Checklist*Copy*

Indicate any issues client is reporting

Include Frequency, Intensity, Duration and Onset for all areas checked "Yes"

Abandonment / Separation Issues:	Select Abandonment / Separation Issues
Anxiety:	Select Anxiety
Authority Defiance:	Select Authority Defiance
Behavioral Outbursts:	Select Behavioral Outbursts
Cult / Gang Involvement:	Select Cult / Gang Involvement
Depression:	Select Depression
Destruction of Property:	Select Destruction of Property
Eating Disorder:	Select Eating Disorder
Enuresis / Encopresis:	Select Enuresis / Encopresis
Exposure to Violence, Trauma or Natural Disaster:	Select Exposure to Violence, Trauma or Natural Disaster
Fire Setting:	Select Fire Setting
Grief / Loss:	Select Grief / Loss
Harm to Animals:	Select Harm to Animals
Hygiene Problems:	Select Hygiene Problems
Hyperactive / Impulsive / Inattentive Behaviors:	Select Hyperactive / Impulsive / Inattentive Behaviors
Low Self Esteem:	Select Low Self Esteem
Lying / Manipulative Behaviors:	Select Lying / Manipulative Behaviors
Mania:	Select Mania
Mood Disruption:	Select Mood Disruption
Obsessions / Compulsions:	Select Obsessions / Compulsions
Physical / Verbal Aggression:	Select Physical / Verbal Aggression
Psychosis:	Select Psychosis
Self Mutilation / Self Harming:	Select Self Mutilation / Self Harming
Sexual Aggression:	Select Sexual Aggression
Stealing / Theft:	Select Stealing / Theft
Additional Problems- Any difficulties not addressed:	Select Additional Problems- Any difficulties not addressed

NOTE- Questions answered with a “yes” answer will produce a drop-down text area, requesting additional information. Please provide as much information as possible.

Family History

DI- Family History*Copy*

Relationship History

How many times have you been married?	Select How many times have you been married?
How many kids do you have?	Select How many kids do you have?
Number of divorces?	Select Number of divorces?
If divorced, how long since you were last married?	(number of years)
Detail Relationship/ Marital / Divorce History:	(Include number, length, quality) Max: 2000 characters.
Have you recently experienced any significant change in your living environment / situation?	(removal from family, divorce, adoption, school suspension, family death, loss of job/ income, etc...) ○ Yes ○ No
Do you have any family history of mental illness / substance abuse?	○ Yes ○ No
Family history of abuse (physical, emotional, sexual, exploitation, neglect)?	○ Yes ○ No
Family history of medical problems?	○ Yes ○ No
Are there any ongoing conflicts in your family that have an effect on you?	○ Yes ○ No
Anticipated family involvement in your treatment:	Max: 2000 characters.

NOTE- Questions answered with a “yes” answer will produce a drop-down text area, requesting additional information. Please provide as much information as possible.

Living Environment

DI-Living Environment*Copy*

Household Members

Number of household members, including client:	Select Number of household members, including client
Additional Household Member- Relationship- Age:	
Additional Household Member- Relationship- Age:	
Additional Household Member- Relationship- Age:	
Additional Household Member- Relationship- Age:	
Additional Household Member- Relationship- Age:	
Additional Household Member- Relationship- Age:	
Additional Household Member- Relationship- Age:	
Type of dwelling:	Select Type of dwelling
Number of Bedrooms:	Select Number of Bedrooms

-Enter name, age, and relationship of **each** member of household.

Financial Review

DI- Financial Review

Income Source:
- ☐ Employed
- ☐ Retirement
- ☐ Parental / Caregiver Support
- ☐ Family Support
- ☐ Social Security Disability (SSDI)
- ☐ Spouse/ Sig. Other Support
- ☐ Friend Support
- ☐ Social Security Insurance (SSI)
- ☐ Other__
- ☐ Personal Savings
- ☐ Women, Infants and Children (WIC)

How well does Income meet client/family needs? Select How well does Income meet client/family needs?

Financial Stressors:

Max: 1000 characters.

Resources

Resources being currently utilized:
- ☐ Academic Advocacy
- ☐ Food Assistance
- ☐ Social Service Agency Advocacy
- ☐ Caregiver Training
- ☐ Housing Stability
- ☐ Social Supports
- ☐ Clothing Assistance
- ☐ Legal Advocacy

Needed Resources:
- ☐ Academic Advocacy
- ☐ Food Assistance
- ☐ Social Service Agency Advocacy
- ☐ Caregiver Training
- ☐ Housing Stability
- ☐ Social Supports
- ☐ Clothing Assistance
- ☐ Legal Advocacy

Additional resource information:

Max: 1000 characters.

NOTE- Complete income source, financial stressors, utilized resources and needed resources. Check all areas that apply.

Spiritual / Cultural / Ethnic Assessment

DI- Spiritual / Cultural / Ethnic Assessment

Race: Select Race

Ethnicity: Select Ethnicity

Are there any customs and /or practices related to your culture /ethnicity we should be aware of? Describe alternative healing practices, beliefs or any other information that would be important to know in relation to providing services.
○ Yes ○ No

Do you ever feel down on yourself or others due to your (or other's) racial or ethnic group?
○ Yes ○ No

Do you have a religious affiliation you would like to make us aware of? Describe any religious or spiritual beliefs that might be important to know about in providing services.
○ Yes ○ No

NOTE- If you answer “yes” to any of these questions, a free text area will appear. Please use this area to fill in details in Client’s own words.

Developmental History

NOTE Different history questions will appear if client is an adult or a child**

Adult

DI- Developmental History

Age of Client: ☑ Adult ☐ School Age

Timing of Developmental Events

Other Developmental Issues:
☐ 1) Had difficulties with speech ☐ 4) Difficulty gaining weight ☐ 6) Bed wetting / soiling clothes
☐ 2) Had unusual sensitivity to touch ☐ 5) Difficulty with coordination ☐ 7) None of the above
☐ 3) Received developmental evaluations

Please provide any additional info that might be helpful:
Issues or Significant events (major illnesses, injuries, head trauma, accidents, etc...)

Max: 2000 characters.

Has / Is the client receiving services from the Division of Developmental Disabilities? ☐ no ☐ yes

Has client ever received genetic testing? ○ Yes ○ No

Does the client need any assistive technology? ○ Yes ○ No

Youth

DI- Developmental History

Age of Client: ☐ Adult ☑ School Age

During pregnancy, did this client's mother:
☐ 1) Receive health care ☐ 4) Use illicit drugs ☐ 7) Give birth prematurely
☐ 2) Drink alcohol ☐ 5) Use any medications ☐ 8) Have complications during delivery
☐ 3) Use tobacco ☐ 6) Have any medical or emotional problems

Timing of Developmental Events

By 0-1 year of age, this client: ☐ 1) Sat up ☐ 2) Crawled

Did not sit up- please specify:

Max: 1000 characters.

Did not crawl- please specify:

Max: 1000 characters.

By 1-3 years of age, this client: ☐ 1) Walked alone ☐ 2) Used first words ☐ 3) Fed self with spoon

Did not walk alone- please specify:

Max: 1000 characters.

Did not use first words- please specify:	Max: 1000 characters.
Did not feed self with a spoon- please specify:	Max: 1000 characters.
By 3-5 years of age, this client:	☐ 1) Was toilet trained ☐ 2) Used first sentences ☐ 3) Learned to ride a tricycle
Did not toilet train- please specify:	Max: 1000 characters.
Did not use first sentences- please specify:	Max: 1000 characters.
Did not learn to ride a tricycle- please specify:	Max: 1000 characters.

NOTE- Ask if client hit developmental milestones at appropriate age. If client hit milestones on time, without issues, click the box next to the milestone. When you do this, you will notice the associated text box will disappear, as no further information is required. If client did NOT hit a particular milestone on time, or if there were issues achieving the milestone, do not put a checkmark next to the milestone and enter the details in the associated text box.

Educational History

DI- Educational History

Current Student?	○ Yes ○ No
Do / Did you participate in extra-curricular activities?	○ Yes ○ No
Do you currently or have you ever qualified for special education?	○ Yes ○ No
Were you ever held back a grade level?	○ Yes ○ No
What kind of grades do / did you make?	
Educational strengths:	
Educational weaknesses:	
Literacy Level:	Select Literacy Level
Any reported handicaps or disabilities?	○ Yes ○ No
Have any evaluations ever been performed? :	◉ Yes ○ No
If yes- please specify:	(Educational, Developmental, Behavioral, Psychological, IQ, COE- Indicate where and when) Max: 1000 characters.
Have you obtained an ROI for a records request for previous evaluations?	○ Yes ○ No
History of behavior problems / School difficulties?	○ Yes ○ No
Interpersonal / Socialization Issues:	○ Yes ○ No
Specify any other details related to educational history if needed:	Max: 1000 characters.

NOTE- A “Yes” answer to any of the above questions will create a drop-down text field, requesting additional information. Follow prompts located above the text field.

Employment / Vocational History

NOTE Each answer to “Are you currently working?” will produce additional fields, according to that response.

DI- Employment / Vocational History

Are you currently working?	☐ 1) Yes ☐ 2) No ☐ 3) NA- School Age
Describe your work and / or military history.	Max: 1000 characters.
How has your work and / or military history impacted your life?	Max: 1000 characters.
Describe strengths and barriers that have influenced your ability to work.	Max: 1000 characters.

Answering “YES” will produce the following fields.

If yes, describe your current job.	(type of work, work environment, length of employment, attitude toward work) Max: 1000 characters.
How does this work affect your life?	(family, leisure, health, relationships) Max: 1000 characters.

Answering “NO” will produce the following fields.

If no, when was the last time you worked?	(date, reason for leaving) Max: 1000 characters.
Are you currently interested in finding employment?	(What are your occupational / vocational interests?) Max: 1000 characters.
Are there any supports or resources you need in order to work?	Max: 1000 characters.

Answering “NA-School Age” will produce the following field and questions around military experience will hide.

If school age- What are you interested in doing when you finish school?	Max: 1000 characters.

Judiciary / Legal History

Answering “No” will produce no further fields.

DI- Judiciary / Legal History

Do you have a history of involvement with the legal system?	○ Yes ◉ No

Answering “Yes” will produce the following fields.

Do you have a history of involvement with the legal system?	◉ Yes ○ No
If yes- please specify:	Max: 1000 characters.
Are you currently on probation?	◉ Yes ○ No
Name of probation officer, phone number:	
Did you ask for a Release of Information?	◉ Yes ○ No
Do you have an upcoming court date?	◉ Yes ○ No
If yes- date :	

Medical History

DI- Medical History

Allergies:	(Include environmental and medication allergies- specify type of reaction- specify onset age) Max: 1000 characters.
Current Medications:	(Specify Medication Name, Dosage, Frequency, Reason Taken, Efficacy, Prescribing Provider) Max: 1000 characters.
Past Medication Trials:	(Include all past Rx meds, dosage, reason med was taken, when med was last taken. reason for stopping) Max: 1000 characters.

NOTE- If client reports an allergy, forward this information to medical staff in your office so this information can be added as an allergy alert in the client’s chart.

Medical History Continued

Physical Health Status

Overall, how do you rate your health?	(In Client's own words) Max: 1000 characters.
Are you up to date on all immunizations?	○ Yes ◉ No
If no- please specify:	(barriers to access, religious/ personal preference) Max: 1000 characters.
Do you use tobacco products?	○ Yes ◉ No
Do you consume caffeine?	○ Yes ◉ No
Do you have any medical problems you are receiving treatment for?	○ Yes ◉ No
Have you had any serious health issues in the past?	○ Yes ◉ No
Have you had any serious injuries or surgeries?	○ Yes ◉ No
Do you have any history of head injury, concussion, loss of consciousness?	○ Yes ◉ No
Are you experiencing chronic pain?	◉ Yes ○ No
Pain Assessment:	Select Pain Assessment
If yes- please specify:	(Specify location, onset, Dx, treatment, outcome, treating provider's name) Max: 1000 characters.
Have you been hospitalized in the past 6 months?	○ Yes ◉ No
Is the client 21 years of age or younger?	◉ Yes ○ No
If yes, has there been a Wellness (EPSDT) Checkup within the past 12 months?	◉ Yes ○ No

NOTE- Additional fields may populate, requesting more detailed information, according to your answer to the above questions. Follow prompts to assist with details.

Name of your Primary Care Provider:	
Date Last Seen:	
What was the purpose of that visit?	Max: 1000 characters.
Has a Release of Information been obtained for PCP?	○ Yes ○ No
Date of last Dental Visit:	

NOTE- If client has a Primary Care Provider, ensure that a Release of Information has been obtained.

Medical History Continued

Tell me about your sleep:	Check all that apply		
	☐ 1) Slept 5hrs or less in past 24 hrs	☐ 4) Difficulty falling asleep	☐ 6) Nightmares/ Bad Dreams
	☐ 2) Slept 6hrs to 9hrs in past 24 hrs	☐ 5) Difficulty staying asleep	☐ 7) Require medications (Rx, OTC, Illicit) to assist with sleep
	☐ 3) Slept 9+ hrs is past 24 hrs		
Tell me about your eating patterns:	Check all that apply		
	☐ 1) I eat 3 meals/ day with appropriate snacks	☐ 4) I eat to make myself feel better	☐ 7) I have had surgical procedure(s) to control weight / appearance
	☐ 2) I eat less than 3 meals / day with appropriate snacks	☐ 5) I limit eating due to concerns for how I look / feel	☐ 8) I have bowel / digestive problems
	☐ 3) I eat more than 3 meals / day with appropriate snacks	☐ 6) I take meds / substances to control my weight / appearance	
Are you currently pregnant?	○ Yes ○ No		
Are you sexually active?	○ Yes ○ No		
Sexual orientation:	☐ Lesbian, gay or homosexual	☐ Bisexual	☐ Don't know.
	☐ Straight or heterosexual	☐ Something else, please describe.	☐ Choose not to disclose.
Gender expression:	☐ Identifies as Male	☐ Male-to-Female (MTF)/Transgender Female/Trans Woman	☐ Choose not to disclose
	☐ Identifies as Female	☐ Genderqueer, neither exclusively male nor female.	☐ Female
	☐ Female-to-Male (FTM)/Transgender Male/Trans Man	☐ Additional gender category or other, please specify.	☐ Male
Do you have a pronoun preference?	○ Yes ○ No		

NOTE- On the above questions, check all that apply or the most appropriate answer.

Behavioral Health History

DI- Behavioral Health History

Have you had a behavioral health hospitalization in the past?	(●) Yes ( ) No
If yes- specify when, where and why:	Max: 1000 characters.
Have you received out patient behavioral health treatment in the past?	(●) Yes ( ) No
If yes- specify type of treatment, provider, response, dates:	Max: 1000 characters.
List any previous mental health diagnoses given:	Include name of provider who gave the diagnosis (if known) and age of diagnosis Max: 1000 characters.

Do you now, or have you ever had a problem with alcohol or substance use?	(●) Yes ( ) No
Do you have a past medical condition, hospitalization or ER treatment due to substance use?	(●) Yes ( ) No
If yes- Specify:	Max: 1000 characters.
Have you ever felt you ought to cut down on your drinking or use of drugs?	(●) Yes ( ) No
Have people annoyed you by criticizing your drinking or use of drugs?	(●) Yes ( ) No
Have you ever felt bad or guilty about your drinking or use of drugs?	(●) Yes ( ) No
Have you ever had a drink or taken drugs first thing in the morning:	(●) Yes ( ) No
Have you ever had blackouts from drinking or use of drugs?	(●) Yes ( ) No
Substances used in the past and / or substances currently used:	Specify substance(s) used, Quantity used, Age first used Max: 2000 characters.

NOTE- Only if you answer “Yes” to “Do you now, or have you ever had a problem with alcohol or substance use?” will the follow up questions appear.

Mental Status Exam

MM- Mental Status Exam

Coding Tips

Problem Focused	1-5 elements
Expanded Problem Focused	At least 6 elements
Detailed	At least 9 elements
Comprehensive	ALL elements PLUS 3 Vital Signs

Appearance and Attitude:
- ☐ 1) Calm and Cooperative
- ☐ 2) Adequate Grooming and Hygiene, Appropriate Dress
- ☐ 3) Other
- ☐ 4) Unusual Behavior

Musculoskeletal :
- ☐ 1) Normal Gait/Station, Normal Strength/Tone
- ☐ 2) Psycho-Motor Agitation
- ☐ 3) Psycho-Motor Retardation
- ☐ 4) Tremor
- ☐ 5) Cogwheeling
- ☐ 6) Assisted Gait
- ☐ 7) Broad Based Gait
- ☐ 8) Limp
- ☐ 9) Other

For Comprehensive Exam
Must address BOTH Gait/Station and Strength/Tone

Orientation:
- ☐ 1) Oriented to Time, Place, Person, Situation
- ☐ 2) Other

Memory:
- ☐ 1) Intact Long Term
- ☐ 2) Intact Short Term
- ☐ 3) Other

Attention/Concentration:
- ☐ 1) Alert
- ☐ 2) Attentive
- ☐ 3) Distractable
- ☐ 4) Inattentive
- ☐ 5) Other

Speech:
- ☐ 1) Normal Rate, Tone, Volume, Articulation
- ☐ 2) Other

Language:
- ☐ 1) Consistent with Level of Education
- ☐ 2) Spontaneous
- ☐ 3) Pressured
- ☐ 4) Paucity
- ☐ 5) Poverty
- ☐ 6) Other

Knowledge:
- ☐ 1) Consistent with Level of Education
- ☐ 2) Other

Affect and Mood:
- ☐ 1) Reactive and Mood Congruent
- ☐ 2) Euthymic
- ☐ 3) Anxious
- ☐ 4) Depressed
- ☐ 5) Blunted
- ☐ 6) Elevated
- ☐ 7) Irritable
- ☐ 8) Fearful
- ☐ 9) Other

Thought Process:
- ☐ 1) Able to Abstract
- ☐ 2) Concrete
- ☐ 3) Logical
- ☐ 4) Illogical
- ☐ 5) Racing
- ☐ 6) Other

Thought Associations:
- ☐ 1) Goal Directed, Linear
- ☐ 2) Circumstantial
- ☐ 3) Perseverative
- ☐ 4) Tangential
- ☐ 5) Other

Thought Content:
- ☐ 1) Within Normal Limits
- ☐ 2) Hallucinations
- ☐ 3) Obsessions
- ☐ 4) Compultions
- ☐ 5) Delusions
- ☐ 6) Phobias
- ☐ 7) Other

Suicidal Ideation:
- ☐ 1) Passive
- ☐ 2) Active
- ☐ 3) Plan
- ☐ 4) Means
- ☐ 5) Intent
- ☐ 6) None

Homicidal Ideation:
- ☐ 1) Passive
- ☐ 2) Active
- ☐ 3) Plan
- ☐ 4) Means
- ☐ 5) Intent
- ☐ 6) None

Insight/ Judgement:
- ☐ 1) Good
- ☐ 2) Fair
- ☐ 3) Poor
- ☐ 4) Other

NOTE- For each area, check all answers that apply

Clinical Summary and Recommendations

DI- Clinical Summary & Recommendations

Interactive Complexity

Barriers to Treatment: Are there life circumstances, special needs or handicaps that may create barriers to treatment?
○ Yes ○ No

Additonal Information: Is there anything else we should talk about that could provide Important Information?
○ Yes ◉ No

Summary of Risk Factors

Summary of Risk Factors identified during this session:

Max: 1000 characters.

Report any Interventions needed to address these Risk Factors: Safety Plan, Mobile Crisis, Referral for In Patient

Max: 1000 characters.

Which service was completed for this Diagnostic Interview? ◉ Psychiatric Service ○ Therapeutic Service

Please complete the Medical Evaluation Form.

NOTE- If you are performing this diagnostic interview as part of a psychiatric service, you will be prompted to enter your Summary on the Medical Evaluation Form, located in the service document group. By doing this, your information will copy forward onto future Medication Management Progress Notes.

Which service was completed for this Diagnostic Interview? ○ Psychiatric Service ◉ Therapeutic Service

Clinical Summary/Recommendations: Summarize collected information justifying diagnostic decisions

Max: 4000 characters.

NOTE- If you are performing this diagnostic interview as part of a therapeutic service, you will enter your Clinical Summary here.

Recommended Services

Choose all that apply:

☐ Case Management	☐ Group Therapy	☐ Outpatient Therapy
☐ CCFT	☐ Healthlink	☐ Peer Support Services
☐ CTT	☐ In-Home Therapeutic Services	☐ Primary Care
☐ EAP	☐ IOP	☐ PSG
☐ FITT	☐ Medication Management	☐ Psychological Testing Services

NOTE- Choose all services you feel client may benefit from.

Clinical Summary and Recommendations

	Interactive Complexity
	The need to manage maladaptive communication (related to, e.g. high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care.
Communication Complexity:	○ Yes ○ No
	Caregiver emotions or behaviors that interfere with implementation of the treatment plan.
Behavior / Emotion Complexity:	○ Yes ○ No
	Evidence or disclosure of a sentinel event and mandated report to a third party with initiation of discussion of the sentinel event and / or report with patient and other visit participants.
Sentinel Event Complexity:	○ Yes ○ No
	Use of play equipment, physical devices, interpreter or translator to overcome barriers to diagnostic or therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.
Use of Device/ Translator:	○ Yes ○ No

NOTE: If you answer "Yes" to any of tha above questions, you qualify to bill for Interactive Complexity. You will do this by going to the Additional Services Module, entering the TOTAL amount of time spent on Psychotherapy and hitting "Yes" for Interactive Complexity.