WA-PACT Comprehensive Assessment Template

Overview
Given the local variation and regional authority in oversight of public mental health services in Washington State through the Regional Support Network (RSN) structure, the Washington State PACT (WA-PACT) Standards specify only those topic areas to be covered by the Comprehensive Assessments (vs. specifying specific forms and questions to ask). According to the Standards, the WA-PACT Comprehensive Assessment shall cover the following eight areas: (1) Psychiatric History, Mental Status, and Diagnosis; (2) Physical Health; (3) Use of Drugs and Alcohol; (4) Education and Employment; (5) Social Development and Functioning; (6) Activities of Daily Living; (7) Family Structure and Relationships; and (8) Strengths and Resources.

In recognition of this regional variation, the Washington Institute continues to develop and improve upon a template that may be used by PACT teams for completion of their Comprehensive Assessments. Please note that use of this template is NOT REQUIRED, as long as each team is assessing across the eight core areas specified within the WA-PACT Standards. While some teams have chosen to use the existing template, others have adapted the assessment forms within their agencies or are using new forms that still address these eight core areas.

This updated template continues to follow the eight required areas of assessment, but with a more person-centered, recovery-oriented format. The new format was developed based on input from our ten WA-PACT teams and in consultation from Janis Tondora, Psy.D., a national expert on person-centered practices from the Yale Program on Recovery and Community Health.

General Guidelines & Considerations for Completion of the Comprehensive Assessment:

• While the WA-PACT Standards currently require the completion of the comprehensive assessment within 30 days of enrollment, we recognize that assessment is an ongoing process. The collection of all of the information within each section (particularly Part 5) may take more time; a fuller picture of each consumer will become more evident as you get to know each consumer over time and build a therapeutic relationship.

• If engagement is an issue, you may want to prioritize the assessment areas that are most engaging to a consumer at enrollment, focusing on consumer-identified needs (e.g., Prioritize completion of Part 4 if the consumer talks about a desire to go back to school or get a job).

• Don’t be limited to completing the assessment in one or two sit-down sessions. You can glean much important information as you’re working with consumers in the community (e.g., assessment of independent living skills in their home, asking questions about interests and activities while running errands) and while providing services.

• Be comfortable but sensitive to consumer reactions to questions. Assessments may be open to change and/or new information over time.

• All specialists should be contributing assessment information and as such, team members should look across specialty areas.
• Utilize client voice in direct quotes whenever possible to reflect attempts to gather information. Example: “I don’t have mental illness.” This helps ensure accuracy of assessment within the first 30 days.

Considerations for Assessing Substance Use in Part 3:

• Use assessment principles and practices consistent with Integrated Dual Disorders Treatment and Motivational Interviewing to assess consumers’ use and abuse of substances.

• In particular, remember that the first goal of substance abuse assessment within a PACT team is to facilitate an environment in which the consumer feels it is safe to talk openly with the team about substance use. Toward this end, Motivational Interviewing methods are especially helpful (e.g., using open-ended questions, using empathic and reflective statements, conveying a neutral and nonjudgmental stance).

• Specific substance abuse assessment forms, such as the Functional Analysis form and the Payoff Matrix, can be completed collaboratively with the consumer or completed initially by staff.

We hope that you find this updated template more purposeful and engaging for new PACT consumers admitted to the program.

For further questions and/or consultation on completion of the WA-PACT Comprehensive Assessment or this template, please contact Maria Monroe-DeVita, Ph.D. (206-604-5669 or mmdv@u.washington.edu) or Shannon Blajeski, MSW (206-685-0331 or blajes@u.washington.edu).
WA-PACT Comprehensive Assessment
Part 1: Mental Health & Psychiatric Symptoms
Including Psychiatric History Timeline, Mental Status, and Diagnosis

A. Mental Health & Psychiatric Symptoms

What are your most troubling psychiatric symptoms? How much do they interfere with your life? Are they getting in the way of the things you’d like to do?

How do you cope with your symptoms? What do you do to stay well? How much are your medications helping you?

If you want to make changes, what are they? What are your goals for maintaining your mental health?

What are the barriers keeping you from being as psychiatrically healthy as possible (e.g. side effects of medications, etc.)? How could the PACT team help you?
### B. Mental Status Exam

<table>
<thead>
<tr>
<th>Presentation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Clothing</td>
<td></td>
</tr>
<tr>
<td>2. Other physical characteristics</td>
<td></td>
</tr>
<tr>
<td>3. Openness to assessment</td>
<td></td>
</tr>
<tr>
<td>4. Consciousness</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Posture</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Slumped</td>
<td></td>
</tr>
<tr>
<td>6. Rigid, tense</td>
<td></td>
</tr>
<tr>
<td>7. Other</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>General Body Movements</th>
<th></th>
</tr>
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<tbody>
<tr>
<td>8. Accelerated, increased</td>
<td></td>
</tr>
<tr>
<td>9. Decreased, slowed</td>
<td></td>
</tr>
<tr>
<td>10. Restless, fidgety</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Amplitude &amp; Quality of Speech</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>11. Increased, loud</td>
<td></td>
</tr>
<tr>
<td>12. Decreased, slowed</td>
<td></td>
</tr>
<tr>
<td>13. Slurred, stammering, etc.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emotional State</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>14. Different from thought content</td>
<td></td>
</tr>
<tr>
<td>15. Labile</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Predominate Mood</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>16. Lessened emotion, “feeling nothing”</td>
<td></td>
</tr>
<tr>
<td>17. Euphoria</td>
<td></td>
</tr>
<tr>
<td>18. Anger, hostility</td>
<td></td>
</tr>
<tr>
<td>19. Fear, anxiety, apprehension</td>
<td></td>
</tr>
<tr>
<td>20. Depression, sadness</td>
<td></td>
</tr>
<tr>
<td>21. Panic attacks or symptoms</td>
<td></td>
</tr>
<tr>
<td><strong>Facial Expression &amp; Overall Physical Behavior</strong></td>
<td>22. Anxiety, fear, apprehension</td>
</tr>
<tr>
<td></td>
<td>23. Depression, sadness</td>
</tr>
<tr>
<td></td>
<td>24. Anger, hostility, irritability</td>
</tr>
<tr>
<td></td>
<td>25. Decreased variability of expression, blunted, unvarying</td>
</tr>
<tr>
<td></td>
<td>26. Elated</td>
</tr>
<tr>
<td><strong>Perception</strong></td>
<td>27. Illusions</td>
</tr>
<tr>
<td></td>
<td>28. Hallucinations</td>
</tr>
<tr>
<td></td>
<td>A. Auditory hallucinations</td>
</tr>
<tr>
<td></td>
<td>B. Visual hallucinations</td>
</tr>
<tr>
<td></td>
<td>C. Other hallucinations</td>
</tr>
<tr>
<td><strong>Thought Content</strong></td>
<td>29. Obsessions</td>
</tr>
<tr>
<td></td>
<td>30. Compulsions</td>
</tr>
<tr>
<td></td>
<td>31. Phobias</td>
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<tr>
<td></td>
<td>32. Derealization</td>
</tr>
<tr>
<td></td>
<td>33. Depersonalization</td>
</tr>
<tr>
<td></td>
<td>34. Suicidal Ideation</td>
</tr>
<tr>
<td></td>
<td>35. Homicidal Ideation</td>
</tr>
<tr>
<td></td>
<td>36. Delusions</td>
</tr>
<tr>
<td></td>
<td>37. Ideas of reference</td>
</tr>
<tr>
<td></td>
<td>38. Ideas of influence</td>
</tr>
<tr>
<td><strong>Stream of Thought</strong></td>
<td>39. Associations</td>
</tr>
<tr>
<td></td>
<td>40. Thought flow decreased, slowed</td>
</tr>
<tr>
<td></td>
<td>41. Thought flow increased</td>
</tr>
<tr>
<td>Intellectual Functioning</td>
<td>42. Fund of common knowledge</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td></td>
<td>43. Abstract thinking</td>
</tr>
<tr>
<td></td>
<td>44. Calculations ability</td>
</tr>
<tr>
<td></td>
<td>45. Comprehension</td>
</tr>
<tr>
<td>Orientation</td>
<td>46. Person</td>
</tr>
<tr>
<td></td>
<td>47. Place</td>
</tr>
<tr>
<td></td>
<td>48. Time</td>
</tr>
<tr>
<td>Attention</td>
<td>49. Concentration on mental or practical tasks</td>
</tr>
<tr>
<td>Memory</td>
<td>50. Immediate recall</td>
</tr>
<tr>
<td></td>
<td>51. Recent memory</td>
</tr>
<tr>
<td></td>
<td>52. Remote memory</td>
</tr>
<tr>
<td>Insight</td>
<td></td>
</tr>
<tr>
<td>Judgment</td>
<td></td>
</tr>
</tbody>
</table>
Mental Status Summary:

C. DSM IV

Axis I ______________________________________________________________
____________________________________________________________
____________________________________________________________
____________________________________________________________

Axis II ______________________________________________________________
____________________________________________________________
____________________________________________________________

Axis III ______________________________________________________________
____________________________________________________________
____________________________________________________________

Axis IV  Primary Support          Occupational           Health Care
        Social Environment          Housing               Legal System/Crime
        Educational                Economic             Other _____________

Axis V __________

Assessment Summary

Strengths/Resources

Completed by: _______________________________        Date Completed: ____________
## Comprehensive Time Line

### Consumer Name

- **DOB**
- **Marital Status**
- **Education**

### Records Reviewed

### Records Needed

<table>
<thead>
<tr>
<th>Comprehensive Time Line</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admit/DC Dates</td>
</tr>
<tr>
<td>------------------</td>
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</tbody>
</table>
WA-PACT Comprehensive Assessment
Part 2: Physical Health

Do you have any specific medical problems or concerns about your health? Are you getting enough rest and exercise? If you smoke, are you interested in trying to quit?

If you want to make changes, what are they? What are your goals for staying healthy?

What are the barriers keeping you from being as healthy as possible? How could the PACT team help you with this area?
Current Doctor and Dentist:
1. General Physician: _____ Address: _____
2. Dentist: _____ Address: _____

3. Serious Illnesses and Disorders:

| ☐ Heart disease | ☐ Gallstones | ☐ Diabetes |
| ☐ High blood pressure | ☐ Kidney infections | ☐ Arthritis |
| ☐ Emphysema | ☐ Kidney stones | ☐ Glaucoma |
| ☐ Asthma | ☐ Stomach ulcers | ☐ Gout |
| ☐ Liver disease | ☐ Thyroid disorder | ☐ Cancer |
| ☐ Cirrhosis | ☐ Anemia | ☐ HIV / AIDS |
| ☐ Hepatitis | ☐ Rheumatic fever | ☐ Other: |

4. Seizure Activity:   Yes ☐   No ☐

Frequency: _____ Duration: _____
Last seizure: _____ Type: _____

5. Previous Medical Hospitalizations

<table>
<thead>
<tr>
<th>Hospital Name / Address</th>
<th>Date</th>
<th>Reason (e.g., injuries, surgery, tests and procedures)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Current Medications (non-psychiatric only)
6. List the medications taken NOW, dosage, frequency, reason for taking, when started, last date taken and prescribing physician.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
<th>Reason</th>
<th>Start Date</th>
<th>End Date</th>
<th>Prescriber</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Allergies
7. Do you have any known allergies?   Yes ☐   No ☐
8. If so, describe allergies to:
   Mediations _____   Hay Fever or Allergic Rhinitis _____
   Foods _____   Other _____

Family Health
9. Father: Living ☐   Deceased ☐   Age, or age at death _____
10. Mother: Living ☐   Deceased ☐   Age, or age at death _____
11. Sisters: Number Living   Number deceased   Causes if deceased _____
12. Brothers: Number living   Number deceased   Causes if deceased _____
13. Children (number, names, and dates of birth/ages) _____
   Number Deceased   Causes if Deceased _____
Name: ________________________________

**Disease in Your Family**

14. [ ] Heart Disease
15. [ ] Diabetes
16. [ ] Glaucoma
17. [ ] Cancer
18. [ ] Goiter
19. [ ] High Blood Pressure
20. [ ] Mental Illness
21. [ ] Substance Abuse
22. [ ] Other

**Most Recent Exam**

Date     Ordering Physician
23. Physical Exam
24. Chest X-Ray
25. Hearing Exam
26. Pelvic Exam/Pap Smear
27. Lab Work
   Blood Chemistry
   CBC
   Hepatitis Antibody Screen
   Urinalysis
   HIV Assay
   TB Skin Test _____  Reaction: Negative [ ] Positive [ ]

**Physical Information**

28. Ht. _____  Wt. _____  Usual Wt. _____  Normal Weight [ ]  Overweight [ ]  Underweight [ ]
29. T. _____  P. _____  reg [ ]  irreg [ ]  R. _____  BP. _____
30. Hair: Color _____  Condition _____
31. Hearing: Adequate [ ]  Impaired Partial [ ]  Impaired Complete [ ]
   Hearing Aid _____  Type _____
32. Eyes: Color _____
   Vision: Adequate [ ]  Impaired Partial [ ]  Impaired Complete [ ]
   Vision Corrected: Yes [ ]  No [ ]  Glasses [ ]  Contact Lenses [ ]
   Optician/Ophthalmologist: _____
   Address: _____
   Most recent vision exam: _____
   Glasses purchased at: _____
33. Teeth: Natural [ ]  Good Condition [ ]  Poor Condition [ ]
   Dentures: Upper [ ]  Lower [ ]  Partial [ ]  Orthodontic Appliance: _____
   Most recent dental exam: _____
34. Ambulation: Unassisted [ ]  Assisted [ ]  Specify _____  Prosthesis: Type _____
   Corrective Devices: Type _____
35. Skin: Condition _____
   Notable features (e.g., scars, bruises, tattoos, birthmarks) and location _____
36. Bowel Habits: Regular [ ]  Irregular [ ]
   Bowel Medication: _____
Questions for Women Only:
37. Are you having your menstrual periods? Yes ☐ No ☐
38. When was your last period? Month/Year ______
39. Are your periods regular? Yes ☐ No ☐
40. If yes, how many days do they last? ______
41. How many days between periods? ______
42. Do you examine your breasts regularly? Yes ☐ No ☐
43. Have you ever been pregnant? Yes ☐ No ☐
   Number of pregnancies: Births _____ Abortions _____ Miscarriages _____ Still Births _____
44. Do you presently have any noticeable vaginal discharge or discomfort? ______
45. Have you ever been treated for a yeast infection? ______

Sexual
46. Do you have any sexual concerns? ______
47. Which is most true?
   I have sex with people of a different sex. ☐
   I have sex with people of the same sex. ☐
   I have sex with both males and females. ☐
48. Where did you acquire your sex information? ______
49. Would you like information related to bodily function, performance, birth control? Yes ☐ No ☐
50. Are you using any birth control methods at the present time? Yes ☐ No ☐
   Partner ☐ Self ☐ Type _____ Length of time ______
51. If not, have you used any birth control methods in the past? Yes ☐ No ☐
   What kind? ______
   Why did you discontinue its use? ______
52. Did you plan on using any birth control in the future? ______
53. Are you aware of signs and symptoms of sexually transmitted diseases? ______
54. Have you ever suspected you have, had, or have you been treated for:
   Syphilis ☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ HIV Infection (ARC, AIDS) ☐
   Do you know and/or use measures (e.g., condoms) to prevent sexually transmitted diseases? ______
55. Have you ever been sexually assaulted or abused? ______
56. Have you ever been treated for injuries connected with the above? ______

Summary of Significant Physical Conditions
_____

Recommendations for Immediate Care & Diagnostic Treatment
_____

Strengths/Resources
_____

Completed by: ____________________________ Date: __________
WA-PACT Comprehensive Assessment
Part 3: Use of Drugs or Alcohol

Do drugs and/or alcohol influence your life right now? If so, how? (if person alludes to possible substance abuse or dependence, utilize assessment questions on page 2)

If you want to make changes, what are they? What are your goals for reducing or eliminating your use of drugs and alcohol and/or decreasing the harmful effect they have on your life?

What are the barriers to reaching these goals? (e.g. all my friends use, there are a lot of drugs in my building) How could the PACT team help you with your goals?)
Name: ________________________________

ASSESSMENT QUESTIONS

1. People use alcohol and street drugs for different reasons. What would you say are the reasons that you drink? That you use street drugs?

2. When you first started drinking/using, how much did you have to drink/use to feel drunk/high?

3. How much does it take for you to feel drunk/high now?

4. Do you find that using alcohol or drugs relieves tremors, shakes, sweating, anxiety, sleep problems, or hallucinations? Which ones?

5. Have you ever drank or used more than you originally planned?

6. Have you ever tried to cut down or quit drinking or using and found that you were unable to do so? Yes□ No□

7. How much of your day do you think about drinking/using/coming down from using?

8. What is the longest you have been able to stay clean and sober?

9. How did you do it? What was helpful to you?

10. Have you ever been in treatment for alcohol or drug use?

11. What are the situations or times in which you DON’T use?

12. What do you think about continuing to use (assess his/her motivations or intentions concerning usage):

13. Describe the client's “islands of health” (those dreams, goals, values, strengths, aspects of the persons life that might be discrepant with drinking or drugging or be used as levers for change)
Instructions: Circle the most appropriate number. This scale is for assessing a person’s stage of substance abuse treatment, not for determining diagnosis. The reporting interval is the last six months. If the person is in an institution, the reporting interval is the time period prior to institutionalization.

1. **Pre-engagement** The person does not have contact with a case manager, mental health counselor, or substance abuse counselor, and meets criteria for substance abuse or dependence.

2. **Engagement** The person has had only irregular contact with case manager or counselor, and meets criteria for substance abuse or dependence.

3. **Early Persuasion** The person has regular contacts with a case manager or counselor, continues to use the same amount of substances or has reduced substance use for less than 2 weeks, and meets criteria for substance abuse or dependence.

4. **Late Persuasion** The person has regular contacts with a case manager or counselor, shows evidence of reduction in use for the past 2-4 weeks (few substances, smaller quantities, or both), but still meets criteria for substance abuse or dependence.

5. **Early Active Treatment** The person is engaged in treatment and has reduced substance use for more than the past month, but still meets criteria for substance abuse or dependence during this period of reduction.

6. **Late Active Treatment** The person is engaged in treatment and has not met criteria for substance abuse or dependence for the past 1-5 months.

7. **Relapse Prevention** The person is engaged in treatment and has not met criteria for substance abuse or dependence for the past 6-12 months.

8. **In Remission or Recovery** The person has not met criteria for substance abuse or dependence for more than the past year.

9. **Not Applicable** No substance use disorder

Comments: ____________________________________________________________
CLINICAN’S RATING SCALES:
Alcohol Use Scale (AUS)

Initial rating will be based on self-report, records, and any other information gathered regarding client’s use over the previous six months. All other rating will be done on a quarterly basis.

Client ID:____________________      Rating Date:____________

1. **Abstinent**: no use of alcohol during this time period.

2. **Use without impairment**: use of alcohol during this time period but no evidence of persistent or recurrent problems related to use or dangerous use.

3. **Abuse**: use of alcohol and evidence of persistent or recurrent problems related to use or recurrent dangerous use.

4. **Dependence**: meets at least three of the following: greater amounts or intervals of use than intended, much of time used obtaining or using substance, frequent intoxication or withdrawal interferes with other activities, important activities given up because of alcohol use, continued use despite knowledge of alcohol or substance-related problems, marked tolerance, characteristic withdrawal symptoms.

5. **Dependence with Institutionalization**: Problems related to dependence are so severe that they make non-institutional living difficult.

**CLINICIAN ALCOHOL USE RATING:** __________
Initial rating will be based on client self-report, records, and any other information gathered regarding client’s use over the previous six months. All other rating will be done on a quarterly basis.

Client ID: ___________________  Rating Date: ____________

1. **Abstinent**: no use of drugs during this time period.

2. **Use without impairment**: use of drugs during this time period but no evidence of persistent or recurrent problems related to use or dangerous use.

3. **Abuse**: use of drugs and evidence of persistent or recurrent problems related to use or recurrent dangerous use.

4. **Dependence**: meets at least three of the following: greater amounts or intervals of use than intended, much of time used obtaining or using substance, frequent intoxication or withdrawal interferes with other activities, important activities given up because of drug use, continued use despite knowledge of alcohol or substance-related problems, marked tolerance, characteristic withdrawal symptoms.

5. **Dependence with Institutionalization**: Problems related to dependence are so severe that they make non-institutional living difficult.

**CLINICIAN DRUG USE RATING**: ____________

Identify drugs used: __________________________________________________
MY RELAPSE PREVENTION PLAN:

1. Relapse Risk Factors:

2. Lifestyle factors (e.g., high stress):

3. My external triggers: (people, places, things, times, dates, events):

4. Actions and decisions I make that set me up for relapse (e.g., hanging out with people who use, going to drinking parties, telling myself that drinking a little won’t hurt):

5. Slips/lapse contingencies:

6. The likely short-term, negative consequences of continuing my drinking are:

7. The likely long-term, negative consequences of continuing my drinking are:

8. Health lifestyle/wellness: What I can do to prevent relapse (daily meditation or prayer, regular exercise):

9. Ways I can prevent or avoid experiencing these triggers:

10. Skills I can use to cope with these triggers if I do experience them, i.e. what I can think, actions I can take:

11. Alternative choices and decisions I can make:

12. People I can ask for support:

13. Other supports I think I need:

14. Resources I can use (for instance, AA):

15. If I do slip or lapse, what do I need to think and do?

Strengths/Resources:

Completed by: ___________________________  Date:________

18 of 37 pages

WA-PACT 11-07
# Functional Analysis Form

<table>
<thead>
<tr>
<th>I. Triggers</th>
<th>II. Responses</th>
<th>III. Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Situations, places, times, etc</td>
<td>Thoughts, feelings, urges, moods, etc</td>
<td>(Choices, decisions, actions, etc.)</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Immediate</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Positive</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Positive</td>
</tr>
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</table>
# PAYOFF MATRIX

Name: ________________________________  
Date: ________________________________

<table>
<thead>
<tr>
<th>Using</th>
<th>Not Using</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate</td>
<td>Immediate</td>
</tr>
<tr>
<td>Delayed or Long Term</td>
<td>Delayed or Long Term</td>
</tr>
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**Advantages**

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**Disadvantages**

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WA-PACT Comprehensive Assessment
Part 4: Money, Employment & Education

A. Money/Finances

What are your sources of income? What do you usually spend your money on? Do you have enough money to do the things you would like to do?

How do you manage your money? Do you have a budget?

If you want to make changes, what are they? In terms of money, what would your ideal situation be (if different from what it is now)?

What are the barriers keeping you from being in the financial situation you want to be in? How could the PACT team help you?
B. Employment

Are you working right now? If so, where? Are you happy with this job? Where have you worked in the past? Are you interested in getting a new or different job now?

If you want to make changes, what are they? What kind of work situation would you like to be in (if different from where you are now)? What would be your ideal job?

What did you like about past jobs? What do you feel your best job skills are? Are you interested in getting a new or different job now?

What are the barriers keeping you from being in the work situation you want to be in? How could the PACT team help you with this?
C. Military History

Have you ever been in the military? If so, what branch?

Dates of Service: ____________________________
Combat action? Yes □ No □
Type of Discharge: Honorable □ General □ Dishonorable □

D. Education

Are you satisfied with your education? Do you feel you have the training you need to do the kind of work you want to do? Are there things you would just like to learn more about?

If you want to make changes, what are they? What are your goals for education/training?

What are the barriers keeping you from getting the education/training you want? How could the PACT team help you with this?
Name: ______________________________________

Strengths/Resources:

Completed by: ____________________________      Date:________
WA-PACT Comprehensive Assessment
Part 5: Social Development and Functioning

A. Social Development History

**Early Childhood**
How would you describe your childhood?  *Who raised you? Describe your friendships as a young child.*

**Adolescence**
What were your adolescent/high school years like?  *What did you do for fun during adolescence/high school? Did you drink or use drugs? Did your friends drink or use drugs? Describe your friendships during your teenage years. Did you date in high school?*

**Adulthood**
Who are the most important people in your life now? Tell me a little bit about these people. (*Who are the people you feel you can turn to or lean on? Who are the people who most believe in you? Are there people who depend on you? What kinds of qualities do you bring into a relationship?*)

Are you happy with your friendships right now? Are you happy with your dating life or romantic relationships? *What would help you to enjoy them more (e.g., spend more time with friends, feel more comfortable in social situations)?*
B. Culture

What is your family’s nationality or ethnic origin? Father? Mother? How long have you or your family lived in this country? When did your family immigrate? *Calculate immigrant generational status (e.g., first generation).*

What language do you speak at home? In the community? *Assess level of cultural assimilation* (Monocultural=new immigrant, Bicultural=balancing and integrating nondominant culture; Unicultural=assimilated to the point of no longer identifying with ethnic background).

What does your culture/family say about education? What do they say about work? *Family and child-rearing practices?*

What does your family/culture say about mental health needs? *How does your family respond to your mental health needs? Do you feel you or your family have ever been misunderstood or misinterpreted by mental health providers because of cultural or ethnic differences?*

Do you think you have experienced discrimination because of your culture or ethnic background? *If so, how?*
C. Spirituality

How important is faith/spirituality in your life? What are some of your spiritual practices? How satisfied are you with your opportunities to participate in your spiritual practice or attend the congregation of your choice right now? Do you belong to a spiritual community or would you like to?

If you want to make changes, what are they? What are your spiritual goals? How could the PACT team help you reach these goals?

E. Legal Involvement

Are you dealing with any legal issues right now? If your legal issues are bothering you, how can we help?
The following is a list of situations. Please read the situation and then rate how easy it is for you.

1 = very easy  
2 = sometimes easy  
3 = often difficult

____ 1. Walking down the street
____ 2. Being with your family
____ 3. Riding city bus
____ 4. Being with older people
____ 5. Going into bars
____ 6. Mixing with people at work
____ 7. Being in a crowd
____ 8. Expressing anger
____ 9. Making friends your own age
____ 10. Talking about your feelings
____ 11. Having someone over to your place
____ 12. Starting a conversation
____ 13. Going to social gatherings
____ 14. Meeting new people
____ 15. Asking for assistance
____ 16. Being alone
____ 17. Answering questions
____ 18. Spending time with men
____ 19. Spending time with women
____ 20. Going into stores
____ 21. Being criticized by someone
____ 22. Making a mistake
____ 23. Going on a date
____ 24. Saying “No” to a friend
____ 25. Talking to a work supervisor
____ 26. Keeping friends
Please check the things you would like to do during the next six months or at some time in the future.

I would like to:

| ☐ move to a new apartment | ☐ meet some women | ☐ get a job |
| ☐ study photography | ☐ live in a house | ☐ talk about feelings |
| ☐ save money | ☐ get off of welfare | ☐ go to bars |
| ☐ get my driver’s license | ☐ get along with my parents | ☐ be more assertive |
| ☐ buy a car | ☐ learn a skill | ☐ go to restaurants |

| ☐ meet some men | ☐ improve my grooming | ☐ go to movies |
| ☐ finish school | ☐ learn to job hunt | ☐ drink less coffee |
| ☐ play basketball | ☐ be less lonely | ☐ learn to manage stress |
| ☐ get special job training | ☐ maintain friendships | ☐ do woodworking |
| ☐ improve my cooking | ☐ communicate with parents | ☐ have more friends |

| ☐ go camping | ☐ go to church | ☐ take a vacation |
| ☐ play cards | ☐ drink less | ☐ get new clothes |
| ☐ have more money | ☐ go on dates | ☐ have a party |
| ☐ buy a TV | ☐ join a club | ☐ learn to sew |
| ☐ go bowling | ☐ be more active | ☐ open a bank account |

| ☐ go to see plays | ☐ stop smoking | ☐ get together with friends |
| ☐ learn relaxation | ☐ eat better | ☐ express my feelings |
| ☐ go to concerts | ☐ gain weight | ☐ go on picnics |
| ☐ play pool | ☐ call friends on the phone | ☐ go see a baseball game |
| ☐ get a roommate | ☐ learn to be less anxious | ☐ be assertive with friends |

| ☐ get a volunteer job | ☐ visit relatives | ☐ go to the library |
| ☐ enter a contest | ☐ do painting | ☐ other |
| ☐ write poetry | ☐ learn to knit | ☐ other |
| ☐ go fishing | ☐ play baseball | ☐ other |
| ☐ spend more time alone | ☐ lose weight | ☐ other |

**Strengths/Resources:**

Completed by: ___________________________  Date: ________
WA-PACT Comprehensive Assessment
Part 6: Activities of Daily Living

A. Living Situation

What is your current living situation? Do you live alone, with roommates? How do you feel about your place and your neighborhood?

If you want to make changes, what are they? What kind of living situation would you like to be in (if different from where you live now)?

What are the barriers keeping you from being in the living situation you want to be in? What kind of help would you like?
B. **Daily Living and Routine**

How do you spend your day? What does a “typical” day look like? Is this satisfying/enjoyable for you? Are there places in the community where you feel comfortable and safe?

If you want to make changes, what are they? What would your ideal day look like? How/where and with whom would you like to be spending your time? What kind of things do you like to do that you aren’t doing now?

What are the barriers keeping you from spending your time the way you would want? How could the PACT team help you with these?
C. **Housekeeping, Diet/Nutrition, Laundry, Transportation**

What housekeeping tasks do you enjoy the most? The least? Do you have access to laundry facilities?

What type of meals do you like? Where do you get your food currently?

How do you get to your appointments and activities?

If you'd like to change any of these areas (housekeeping, nutrition, laundry, transportation), what would they look like?

What are the major barriers to make these changes? How could the PACT team help you with these areas?

**Strengths/Resources:**

Completed by: ___________________________ Date: ________
WA-PACT Comprehensive Assessment
Part 7: Family and Relationships

Who are the most important people in your life right now? Are there people you can turn to when things get difficult? Are there people that depend on you?

How are your friendships going? How are your family relationships going? Do you have (or hope to have) a romantic or sexual relationship—how is this going?

If you want to make changes, what are they? Would you like to make new relationships or improve your current relationships?

What are the barriers to forming or improving relationships? How could the PACT team help you with this?
Name: ______________________________________

List all names of the members of the family of origin (i.e., parents and siblings) and of spouse or partner:

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<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Address and Telephone</th>
<th>Age</th>
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List the names of Children:

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<th>Name</th>
<th>Relationship</th>
<th>Birth Date and Age</th>
<th>Address and Telephone (if minor, whom are they living with)</th>
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Significant Others:

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Strengths/Resources:


Completed by:_________________________  Date: _________
WA-PACT Comprehensive Assessment
Part 8: Strengths and Resources

A. Hopes and Dreams

What are your hopes and dreams for the future? What are some of the most important things you want to have in your life?

If you could change anything in your life right now, what would it be?

B. Personal Strengths

To help you meet your goals, we need to think about what strengths you have. Sometimes people have a hard time remembering their strengths. The following statements may help you get ideas:

1. My best qualities as a person are…

2. Something I would NOT change about myself is…
3. The times I am most at peace are when…

4. People like that I am (people say they like my…)

5. I help other people out by… (Something I give to others that makes me feel good is…)

6. I admire people who are…

7. I notice my problems least when I am…

8. The kinds of things I’d like to change in my life are…
D. Other Issues

Are there other issues that are important in your recovery that we have not covered so far? Are there any other issues or areas in your life where you’d like to make changes?

If you want to make changes, what are they? What are your goals in this area?

What are the barriers for reaching this goal? How could the PACT team help you?

Completed by:_______________________      Date:______