THE WASHINGTON INSTITUTE
FOR MENTAL ILLNESS RESEARCH & TRAINING

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).

Name:_____ Chart #: _____

Date:_____

WA-PACT Comprehensive Assessment
Part 1: Mental Health & Psychiatric Symptoms
Including Psychiatric History Timeline, Mental Status, and Diagnosis

A. <u>Mental Health & Psychiatric Symptoms</u>

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

Presentation	1. Clothing	
	2. Other physical characteristics	
	3. Openness to assessment	
	4. Consciousness (awareness, responsiveness, attentiveness)	
Posture	5. Slumped	
	6. Rigid, tense	
	7. Other	
General Body Movements	8. Accelerated, increased	
	9. Decreased, slowed	
	10. Restless, fidgety	
Amplitude & Quality of Speech	11. Increased, loud	
	12. Decreased, slowed	
	13. Slurred, stammering, etc.	
Emotional State	14. Different from thought content	
	15. Labile	
Predominate Mood	16. Lessened emotion, "feeling nothing"	
	17. Euphoria	
	18. Anger, hostility	
	19. Fear, anxiety, apprehension	
	20. Depression, sadness	
	21. Panic attacks or symptoms	

Facial Expression & Overall Physical Behavior	22. Anxiety, fear, apprehension	
	23. Depression, sadness	
	24. Anger, hostility, irritability	
	25. Decreased variability of expression, blunted, unvarying	
	26. Elated	
Perception	27. Illusions	
	28. Hallucinations	
	A. Auditory hallucinations	
	B. Visual hallucinations	
	C. Other hallucinations	
Thought Content	29. Obsessions	
	30. Compulsions	
	31. Phobias	
	32. Derealization	
	33. Depersonalization	
	34. Suicidal Ideation	
	35. Homicidal Ideation	
	36. Delusions	
	37. Ideas of reference	
	38. Ideas of influence	
Stream of Thought	39. Associations	
	40. Thought flow decreased, slowed	
	41. Thought flow increased	

Intellectual Functioning	42. Fund of common knowledge	
	43. Abstract thinking	
	44. Calculations ability	
	45. Comprehension	
Orientation	46. Person	
	47. Place	
	48. Time	
Attention	49. Concentration on mental or practical tasks	
Memory	50. Immediate recall	
	51. Recent memory	
	52. Remote memory	
Insight		
Judgment		

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

Comprehensive Time Line									
Admit/ DC Dates	**Treatment Provider**	**Presenting Problems/ Legal Status**	**Diagnosis**	**Medications**	**Services Received**	**Reasons for DC/ Recommendations**	**Living Situation**	**Employment**	**Other Comments**

Name:_____ Chart #: _____
Date:_____

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?

Name: _____

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

Hospital Name / Address	Date	Reason (e.g., injuries, surgery, tests and procedures)

Current Medications (non-psychiatric only)

6. List the medications taken NOW, dosage, frequency, reason for taking, when started, last date taken and prescribing physician.

Medication	Dose	Frequency	Reason	Start Date	End Date	Prescriber

Allergies

7. **Do you have any known allergies?** Yes☐ No☐
8. **If so, describe allergies to**:
   Medications _____ 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	Relation of Family Member
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: _____

Name: _____

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: _____

Name: _____

Name: _____ Chart #:_____
Date: _____

WA-PACT Comprehensive Assessment
Part 3: <u>Use of Drugs or Alcohol</u>

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)**

Name: _____

CLINICIAN RATING SCALES:
SUBSTANCE ABUSE TREATMENT SCALE (SATS)

Client ID:_____ Rating Date:_____

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: _____

Name: _____

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: _____

Name: _____

CLINICAN'S RATING SCALES:
Drug Use Scale (DUS)

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:_____

Name: _____

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:_____

Functional Analysis Form

I. Triggers		II. Responses	III. Consequences	
Situations, places, times, etc	***Thoughts, feelings, urges, moods, etc***	***(Choices, decisions, actions, etc.)***	***Immediate*** ***Positive*** ***Negative***	***Delayed or long-term*** ***Positive*** ***Negative***

Name: _____

PAYOFF MATRIX

Name:

Date:

	Using		**Not Using**	
	Immediate	Delayed or Long Term	Immediate	Delayed or Long Term
Advantages				
Disadvantages				

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

A. <u>Money/Finances</u>

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 mange 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?

Name: _____

B. <u>Employment</u>

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?

Name: _____

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)?***

Name: _____

B. <u>Culture</u>

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?***

Name: _____

C. <u>Spirituality</u>

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. <u>Legal Involvement</u>

Are you dealing with any legal issues right now? If your legal issues are bothering you, how can we help?

Name: _____

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

Name: _____

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

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

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

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

- ☐ get a volunteer job
- ☐ enter a contest
- ☐ visit relatives
- ☐ do painting
- ☐ go to the library
- ☐ 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?

Name: _____

B. <u>Daily Living and Routine</u>

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?

Name: _____

C. <u>Housekeeping, Diet/Nutrition, Laundry, Transportation</u>

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: _____

Name: _____

Name: _____ Chart #: _____
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:

Name	Relationship	Address and Telephone	Age

List the names of Children:

Name	Relationship	Birth Date and Age	Address and Telephone (if minor, whom are they living with)

Significant Others:

Name	Relationship	Age

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…**

Name: _____

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…**

Name: _____

D. <u>Other Issues</u>

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:_____