



Safe Haven Counseling, PLLC

Mental Health | Domestic Violence | Addictions | Grief | Career

Stéphanie Gimenez, MA, NCC, LCMHC, LCAS-A

163 Stratford Court, Suite 225 | Winston-Salem, NC 27103

Office: (336) 396-7834 | **Crisis:** (336) 986-2720 | **Fax:** (336) 217-8708

Stephanie.G@SafeHavenCounselingPLLC.com | www.SafeHavenCounselingPLLC.com

Comprehensive Clinical Assessment (CCA)

Name:	DOB:	MRN:	Ins. #:
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Demographic & Insurance Information

Name:	MRN:	Date:
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DOB:	Age:	Phone:
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Address:	Email:
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Primary Ins.: _____	Policy#: _____	Group#: _____
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Two-Way Consent(s) Needed for Continuity of Care:

Preferred Hospital: _____ | Emergency Contact: _____

Insurance Co.: _____ | Primary Care Physician: _____

Specialist(s): _____ Concerned Third Party: _____

Referral Source: _____ Other: _____

Referral Source (Person/Organization's Name, Ph.#, Email/Mailing Address):

Emergency Contact (Name; Relation to Client; Email/Ph.#):

Presenting Concerns

1) _____

2) _____

3) _____

Environmental / Psychosocial Stressors

<input type="checkbox"/> Legal Issues: _____	<input type="checkbox"/> Single / Co-Parenting: _____	<input type="checkbox"/> Medical: _____
<input type="checkbox"/> Relationships Issues: _____	<input type="checkbox"/> Job-Related Stress: _____	<input type="checkbox"/> Mental Health: _____
<input type="checkbox"/> DV/Crime Victim: _____	<input type="checkbox"/> Financial Stress: _____	<input type="checkbox"/> Addiction: _____
<input type="checkbox"/> Grief/Loss: _____	<input type="checkbox"/> Transportation: _____	<input type="checkbox"/> Life Transition: _____
<input type="checkbox"/> Separation / Divorce: _____	<input type="checkbox"/> Housing: _____	<input type="checkbox"/> Other: _____

Notes:





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(FOR OFFICE USE ONLY) Treatment (Tx) Goals

(Perceptions, Expectations, Readiness to Change)

- 1) Deepen insight into domestic abuse history & safety plan to reduce & prevent future risks of abuse (i.e. phys., emo., psych., fin....) & begin the recovery process.
- 2) Deepen insight into, learn to effectively manage & reduce _____ & _____ Sx, related psychosocial impairments (i.e. interpersonal; occupational; emotional; financial; parenting...) & psychological distress.
- 3) Deepen insight into, learn to effectively manage & reduce problematic use, misuse, abuse &/or dependence of _____ &/or _____ so as to learn to moderate & prevent harm to self (i.e. health problems; serious injuries; mental health issues...), others (i.e. interpersonal conflicts) or other negative consequences (i.e. reduced job / school performance...); or to prevent relapse.
- 4) Advance through grieving process.

Mental Health:

- Pre-Contemplation
- Contemplation
- Preparation
- Action
- Maintenance/Sobriety (#: _____)
- Recycling/Relapse (#: _____)

Addiction:

- Pre-Contemplation
- Contemplation
- Preparation
- Action
- Maintenance/Sobriety (#: _____)
- Recycling/Relapse (#: _____)

- 5) Improve overall psychosocial (i.e. intrapersonal; interpersonal; occ. / acad.; emo.; fin.; co-parenting...) functioning (i.e. effective communication; healthy boundaries; conflict resolution; career exploration / job search / applying / interviewing...) across life domains (i.e. at home; at school / work) & improve quality of important relationships (i.e. _____; _____; _____), expand / strengthen / better utilize natural support systems, &/or advance through career development.
- 6) Identify root causes of _____ & _____ issues, work through & resolve traumatic incidents &/or attachment (i.e. codependent / excessively detached / apathetic) / relationship style issues, learn to meet own physical (i.e. food, shelter, safety...) & mental health needs (i.e. love, acceptance, approval, respect, care, attention, guidance...) more effectively & consistently so as to rebuild confidence & assertiveness (i.e. self-advocacy...) &/or establish more positive, healthy & helpful self-care routines (i.e. sleep hygiene; exercise; diet; coping...) & improve overall health.

Values, Strengths, Skills, Talents & Interests

Career Interests / Skills

- Realistic
- Investigative
- Artistic
- Social
- Enterprising
- Conventional
- Other: _____

Personality:

- Introvert
- Extrovert
- Flexible
- Planner
- Thinker
- Feeler
- Intuitive
- Practical

_____ | _____ | _____
Pessimistic **Realistic** **Optimistic**

Values:

What Is Going Well / Helpful:





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Personal / Professional Strengths, Skills, Natural Talents / What You Do Well:

Sleep Hygiene: Restful Sleep Fall Asleep Quickly Heavy Sleep Light Sleep
 Chronic / Episodic Decreased Increased Need for / Sleep Insomnia
 Hypersomnia Fatigue Nightmares Sleepwalking Wake Up Often
 I Work Night Shifts Breathing Issues | **Sleep Schedule:** _____

Notes:

Diet (#Meals/Day): _____ Diversified Vegan Vegetarian Pescatarian
 Water (Amount/Day): _____ Dairy Protein Carbs Fiber Fat
 Sugars (i.e. Soda Candy/Deserts Junk Food Other: _____)
 Past Chronic / Episodic Decreased Appetite / Fasting (duration): _____
 Past Chronic / Episodic Increased Appetite / Binge Eating Purging: _____

Notes:

Physical Activity / Exercise: Walking Swimming Biking Hiking Yoga
 Combat Sports Team Sports Gym Dance Other: _____

Amount & Frequency: _____

Self-Care Activities/Routines:

Social & Occupational Functioning

Marital Status: Single Married Separated Divorced Widowed Dating
 Casual Serious / Committed Monogamous Polyamorous Open Domestic
 Partnership **Gender Identity:** _____ **Sexual Orientation:** _____ **Racial/Ethnic Identity:**
 _____ **Religion/Spirituality:** _____

Current Intimate Relationship(s): Fulfilling Harmonious Unsatisfying Distant
 Severed Conflictual Enmeshed/Overbearing Controlling Abusive →
 Verbal /Emotional Financial Physical Sexual Other:

Dependents (Names; Ages):

Custody Status:

P C CPS involvement (Explain):

Parenting Issues:

Behavior Concerns:

Other Important Relationships & Support System(s) (i.e. status/quality, satisfaction level...):

Employment Status: Employed (FT/ PT) Unemployed (Not Seeking) Retired
 Homemaker Disabled (Perm./ Temp.) Furloughed Student (FT/ PT)





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Income: \$ _____ / Hr. Wk. Mo. Yr. | **Job Title:** _____
Satisfaction Level: Very Somewhat Not At All | **Education:** _____
Career Goals / Dream Job: _____

Medical Status

Primary Care Provider (Practice & Provider Name; Address, Ph.#):

Past & Current Diagnoses (Dx) (Past / Current):

P C

P C

Allergies:

Last PCP Visit:

Last Dental Visit:

Pharmacy (Name; Address, Ph.#):

Barriers to Medical Tx & Recovery:

Current Rx/OTC	Dosage / Day	Purpose	Prescriber	Start/Stop Date

Specialist(s) (Practice & Provider Name; Address, Ph.#):

Developmental Concerns: Cognitive Speech Motor Physical Emotional Social

Mental Health (MH) / Substance Abuse (SA) / Addiction History (Hx)

Family Hx: MH SA DV Legal (Persons Involved, Sx & Dx, Charges...):

MH / SA Dx (Past / Current): P C

P C

P C

P C

P C

Rx / OTC	Dosage / Day	Purpose	Prescriber	Start/Stop Date





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Psychiatric / MH Care Provider (Name, Practice, Address, Ph.#):

Suicidal Ideations (SI) / Homicidal Ideations (HI) (Past / Current)

P C SI | P C Threats | P C Plan/Intent | Access to Means | Attempts
 (#; Dates; Means Used...): _____

P C HI | P C Threats | P C Plan/Intent | Access to Means | Attempts
 (#; Dates; Means Used...): _____

Hospitalization(s) (Dates, Purpose...): _____

Trauma Hx (Dates & Persons Involved)

Verbal / Emotional / Psychological Abuse:

Physical Abuse:

Sexual Abuse:

Harassment: Sexual | Workplace | Ex-Partner | Stranger | Other:

Stalking/Cyberstalking:

Childhood Neglect (Caregivers):

→ **Basic Needs Unmet:** Food Housing Safety Medical/Psychiatric Care Love / Attention / Affection / Guidance Social / Leisure / Free Time & Space Other:

Exposure to Violence/Trafficking/Criminal Activities: Parental DV Substance Use

Trafficking Criminal Activity School Workplace Community (i.e. Gangs...)

Bullying:

Serious or Life-threatening Accident / Medical Issue(s):

Natural Disaster: Flood Fire Tornado/Hurricane Earthquake Other:

Homelessness:

Unexpected or Violent Death / Loss of Loved One(s):

Discrimination: Racial/Ethnic Religious Socio-Economic Sexual orientation

Gender Identity Other:

Immigration:

(FOR OFFICE USE ONLY) Mental Health Status

Orientation: All 4X | People Place Time Situation | None

Eye Contact: Excessive / Intense Good

Avoidant None Other:

Judgement: Good Fair Poor

Appearance: Neat Unremarkable

Sloppy Disheveled Other: _____

Hygiene: Good Fair Poor





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Attitude / Affect / Mood: <input type="checkbox"/> Attentive <input type="checkbox"/> Engaged <input type="checkbox"/> Motivated <input type="checkbox"/> Eager <input type="checkbox"/> Enthusiastic <input type="checkbox"/> Positive <input type="checkbox"/> Bright <input type="checkbox"/> Elevated <input type="checkbox"/> Euphoric <input type="checkbox"/> Cooperative <input type="checkbox"/> Humorous <input type="checkbox"/> Other: _____	
<input type="checkbox"/> Unremarkable <input type="checkbox"/> Flat <input type="checkbox"/> Indifferent / Nonchalant <input type="checkbox"/> Careless <input type="checkbox"/> Distractible / Preoccupied / Absent-minded <input type="checkbox"/> Confused <input type="checkbox"/> Passive <input type="checkbox"/> Evasive <input type="checkbox"/> Reluctant / Apprehensive / Excessively Shy <input type="checkbox"/> Guarded <input type="checkbox"/> Anxious <input type="checkbox"/> Fearful <input type="checkbox"/> Other: _____	
<input type="checkbox"/> Pessimistic <input type="checkbox"/> Depressed <input type="checkbox"/> Defeatist <input type="checkbox"/> Fatalist <input type="checkbox"/> Remorseful <input type="checkbox"/> Disempowered / Hopeless <input type="checkbox"/> Over-compromising <input type="checkbox"/> Severely Distressed <input type="checkbox"/> Persecuted / Helpless	
<input type="checkbox"/> Attention-Seeking <input type="checkbox"/> Codependent <input type="checkbox"/> Compulsive <input type="checkbox"/> Pushy / Demanding <input type="checkbox"/> Flirtatious <input type="checkbox"/> Inappropriate <input type="checkbox"/> Manipulative <input type="checkbox"/> Deceitful <input type="checkbox"/> Controlling <input type="checkbox"/> Uncompromising / Rigid <input type="checkbox"/> Irritable <input type="checkbox"/> Argumentative <input type="checkbox"/> Resistant <input type="checkbox"/> Frustrated / Angry <input type="checkbox"/> Disdainful / Arrogant <input type="checkbox"/> Apathetic <input type="checkbox"/> Antagonistic <input type="checkbox"/> Intimidating <input type="checkbox"/> Aggressive <input type="checkbox"/> Oppressive / Abusive <input type="checkbox"/> Explosive <input type="checkbox"/> Unremorseful <input type="checkbox"/> Cruel / Sadistic <input type="checkbox"/> Other: _____	
Motor: <input type="checkbox"/> Unremarkable <input type="checkbox"/> Calm <input type="checkbox"/> Sluggish <input type="checkbox"/> Lethargic <input type="checkbox"/> Tense <input type="checkbox"/> Agitated <input type="checkbox"/> Fidgety <input type="checkbox"/> Hyperactive <input type="checkbox"/> Pacing <input type="checkbox"/> Tics <input type="checkbox"/> Tremors / Shakes <input type="checkbox"/> Constricted <input type="checkbox"/> Awkward <input type="checkbox"/> _____	Memory: <input type="checkbox"/> Long-Term <input type="checkbox"/> Short-Term <input type="checkbox"/> Lapsed / Blocked <input type="checkbox"/> Repressed <input type="checkbox"/> <input type="checkbox"/> Selective <input type="checkbox"/> Vague <input type="checkbox"/> Disorganized <input type="checkbox"/> <input type="checkbox"/> Confused <input type="checkbox"/> Other: _____
Tone of Speech: <input type="checkbox"/> Unremarkable <input type="checkbox"/> Inaudible <input type="checkbox"/> Soft <input type="checkbox"/> Normal <input type="checkbox"/> Loud <input type="checkbox"/> Obnoxious <input type="checkbox"/> Stringent <input type="checkbox"/> Mute <input type="checkbox"/> Melodious <input type="checkbox"/> Incongruent <input type="checkbox"/> Other: _____	
Enunciation: <input type="checkbox"/> Unremarkable <input type="checkbox"/> Clear <input type="checkbox"/> Eloquent <input type="checkbox"/> Mumbled <input type="checkbox"/> Slurred <input type="checkbox"/> Stuttered <input type="checkbox"/> Rhyming / Rapping <input type="checkbox"/> Other: _____	
Pace of Speech: <input type="checkbox"/> Delayed <input type="checkbox"/> Normal <input type="checkbox"/> Rapid <input type="checkbox"/> Monotone <input type="checkbox"/> Spontaneous <input type="checkbox"/> Pressured <input type="checkbox"/> Rhythmic <input type="checkbox"/> Other: _____	
Intellect: <input type="checkbox"/> Average <input type="checkbox"/> Above Average <input type="checkbox"/> Below Average <input type="checkbox"/> Delayed <input type="checkbox"/> Disabled	
Thought Pattern: <input type="checkbox"/> Unremarkable <input type="checkbox"/> Logical <input type="checkbox"/> Goal-Oriented <input type="checkbox"/> Aimless <input type="checkbox"/> Irrelevant <input type="checkbox"/> Disorganized <input type="checkbox"/> Confused/Confusing <input type="checkbox"/> Loosely Associated <input type="checkbox"/> Incoherent / Incomprehensible <input type="checkbox"/> Word Salad <input type="checkbox"/> Avoidant / Indirect <input type="checkbox"/> Long-winded / Tangential	
Thought Content: <input type="checkbox"/> Insightful <input type="checkbox"/> Relevant <input type="checkbox"/> Concrete <input type="checkbox"/> Relational <input type="checkbox"/> Abstract <input type="checkbox"/> Logical <input type="checkbox"/> Reasonable <input type="checkbox"/> Past-Oriented <input type="checkbox"/> Present-Oriented <input type="checkbox"/> Future-Oriented <input type="checkbox"/> Optimistic <input type="checkbox"/> Realistic <input type="checkbox"/> Pessimistic <input type="checkbox"/> Obsessive <input type="checkbox"/> Fatalist <input type="checkbox"/> Unrealistic <input type="checkbox"/> Irrational <input type="checkbox"/> Tangential <input type="checkbox"/> Delusional <input type="checkbox"/> Paranoid <input type="checkbox"/> Fearful <input type="checkbox"/> Incongruent <input type="checkbox"/> Deceitful/Manipulative <input type="checkbox"/> Morbid <input type="checkbox"/> Intimidating <input type="checkbox"/> Threatening <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Other: _____	





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Mental Health Hx

Past (12+ months) & Current (Past 12 months) Sx

Neuro-Cognitive: P <input type="checkbox"/> C <input type="checkbox"/> Inattentiveness P <input type="checkbox"/> C <input type="checkbox"/> Forgetfulness P <input type="checkbox"/> C <input type="checkbox"/> Distractibility P <input type="checkbox"/> C <input type="checkbox"/> Concentration Issue P <input type="checkbox"/> C <input type="checkbox"/> Absent-Mindedness P <input type="checkbox"/> C <input type="checkbox"/> Disorganization (i.e.	Prioritizing; Time Mgt / Punctuality; Home / Work Spaces) P <input type="checkbox"/> C <input type="checkbox"/> Procrastination P <input type="checkbox"/> C <input type="checkbox"/> Careless Mistakes P <input type="checkbox"/> C <input type="checkbox"/> Fidgety / Squirmy P <input type="checkbox"/> C <input type="checkbox"/> Restless / Wound Up P <input type="checkbox"/> C <input type="checkbox"/> Hyperactive	<input type="checkbox"/> Goal-Oriented <input type="checkbox"/> Aimless P <input type="checkbox"/> C <input type="checkbox"/> Easily Bored P <input type="checkbox"/> C <input type="checkbox"/> Impatience P <input type="checkbox"/> C <input type="checkbox"/> Irritability P <input type="checkbox"/> C <input type="checkbox"/> Impulsivity P <input type="checkbox"/> C <input type="checkbox"/> Interruptive Bx P <input type="checkbox"/> C <input type="checkbox"/> Disruptive Bx
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Notes:

Depressive Sx (Past/Current): P <input type="checkbox"/> C <input type="checkbox"/> Depressed Mood / Melancholy P <input type="checkbox"/> C <input type="checkbox"/> Chronic <input type="checkbox"/> Episodic Unhappiness P <input type="checkbox"/> C <input type="checkbox"/> Crying Spells P <input type="checkbox"/> C <input type="checkbox"/> Chronic <input type="checkbox"/> Episodic Fatigue P <input type="checkbox"/> C <input type="checkbox"/> Hypersomnia P <input type="checkbox"/> C <input type="checkbox"/> Insomnia P <input type="checkbox"/> C <input type="checkbox"/> Physical Pains / Aches P <input type="checkbox"/> C <input type="checkbox"/> Low Motivation	P <input type="checkbox"/> C <input type="checkbox"/> Loss of Interest / Enjoyment P <input type="checkbox"/> C <input type="checkbox"/> Self-esteem Issues P <input type="checkbox"/> C <input type="checkbox"/> Excessive Guilt P <input type="checkbox"/> C <input type="checkbox"/> Hopelessness P <input type="checkbox"/> C <input type="checkbox"/> Worthlessness / Uselessness P <input type="checkbox"/> C <input type="checkbox"/> Dwelling / Wallowing Thoughts P <input type="checkbox"/> C <input type="checkbox"/> SI / Threats / Attempts P <input type="checkbox"/> C <input type="checkbox"/>
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Notes:

Anxious Sx (Past/Current): P <input type="checkbox"/> C <input type="checkbox"/> Anxiety P <input type="checkbox"/> C <input type="checkbox"/> Nervousness P <input type="checkbox"/> C <input type="checkbox"/> Easily Stressed P <input type="checkbox"/> C <input type="checkbox"/> Stress Headaches P <input type="checkbox"/> C <input type="checkbox"/> Trouble Relaxing P <input type="checkbox"/> C <input type="checkbox"/> Dizziness P <input type="checkbox"/> C <input type="checkbox"/> Digestive issues	P <input type="checkbox"/> C <input type="checkbox"/> Blurry Vision P <input type="checkbox"/> C <input type="checkbox"/> Pacing P <input type="checkbox"/> C <input type="checkbox"/> Muscle Weakness P <input type="checkbox"/> C <input type="checkbox"/> Muscle Tension P <input type="checkbox"/> C <input type="checkbox"/> Racing Thoughts P <input type="checkbox"/> C <input type="checkbox"/> Obsessive Thinking P <input type="checkbox"/> C <input type="checkbox"/> Social anxiety P <input type="checkbox"/> C <input type="checkbox"/> Indecisiveness	P <input type="checkbox"/> C <input type="checkbox"/> Impaired Reasoning P <input type="checkbox"/> C <input type="checkbox"/> Excessive Worrying P <input type="checkbox"/> C <input type="checkbox"/> Panic Attacks: <input type="checkbox"/> Sweating <input type="checkbox"/> Flushing <input type="checkbox"/> Rapid Heart Rate <input type="checkbox"/> Chest Pains/Pressure <input type="checkbox"/> Dizziness <input type="checkbox"/> Hyperventilating <input type="checkbox"/> _____ P <input type="checkbox"/> C <input type="checkbox"/> Fears/Phobias:
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Notes:

Posttraumatic Sx: <input type="checkbox"/> Fight <input type="checkbox"/> Flight <input type="checkbox"/> Freeze P <input type="checkbox"/> C <input type="checkbox"/> Intrusive Memories P <input type="checkbox"/> C <input type="checkbox"/> Flashbacks P <input type="checkbox"/> C <input type="checkbox"/> Nightmares P <input type="checkbox"/> C <input type="checkbox"/> Re-Experiencing P <input type="checkbox"/> C <input type="checkbox"/> Dissociating P <input type="checkbox"/> C <input type="checkbox"/> Emo. Numb / Shock	P <input type="checkbox"/> C <input type="checkbox"/> Internal Triggers (i.e. Thoughts; Feelings...) P <input type="checkbox"/> C <input type="checkbox"/> External Reminders (i.e. People; Places; Situations...): P <input type="checkbox"/> C <input type="checkbox"/> Severe Distress <u>Intensity (0-10):</u> <u>Duration:</u> P <input type="checkbox"/> C <input type="checkbox"/> Physiological Reaction/Sensations: P <input type="checkbox"/> C <input type="checkbox"/> Avoidant Bx	P <input type="checkbox"/> C <input type="checkbox"/> Trust issues P <input type="checkbox"/> C <input type="checkbox"/> Hypersensitivity P <input type="checkbox"/> C <input type="checkbox"/> Defensiveness P <input type="checkbox"/> C <input type="checkbox"/> Self-Critical P <input type="checkbox"/> C <input type="checkbox"/> Self-Doubt / Blame P <input type="checkbox"/> C <input type="checkbox"/> Shame / Regret P <input type="checkbox"/> C <input type="checkbox"/> Self-Destructive P <input type="checkbox"/> C <input type="checkbox"/> Self-Sabotaging P <input type="checkbox"/> C <input type="checkbox"/> Risky / Reckless Bx
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P <input type="checkbox"/> C <input type="checkbox"/> Memory Issues (i.e. Lapses; Blocks; Repressed; Disorganized; Faint/Blurred)	P <input type="checkbox"/> C <input type="checkbox"/> Social Isolation P <input type="checkbox"/> C <input type="checkbox"/> Activities W/D P <input type="checkbox"/> C <input type="checkbox"/> Persistent Fear P <input type="checkbox"/> C <input type="checkbox"/> Hypervigilance P <input type="checkbox"/> C <input type="checkbox"/> Easily Startled	P <input type="checkbox"/> C <input type="checkbox"/> Moodiness P <input type="checkbox"/> C <input type="checkbox"/> Short-Tempered P <input type="checkbox"/> C <input type="checkbox"/> Emo. Reactive P <input type="checkbox"/> C <input type="checkbox"/> Argumentative
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Traumatic Event(s) (TEs) (Persons involved; Dates...):

Emotional Management: P <input type="checkbox"/> C <input type="checkbox"/> Frequent Yelling P <input type="checkbox"/> C <input type="checkbox"/> Anger Outbursts P <input type="checkbox"/> C <input type="checkbox"/> Rebellious Bx P <input type="checkbox"/> C <input type="checkbox"/> Defiant Bx P <input type="checkbox"/> C <input type="checkbox"/> Road Rage P <input type="checkbox"/> C <input type="checkbox"/> Fits of Rage P <input type="checkbox"/> C <input type="checkbox"/> Adapting to Change P <input type="checkbox"/> C <input type="checkbox"/> Unyielding / Rigid	P <input type="checkbox"/> C <input type="checkbox"/> Stubborn P <input type="checkbox"/> C <input type="checkbox"/> Verbally Aggressive P <input type="checkbox"/> C <input type="checkbox"/> Intimidating Bx P <input type="checkbox"/> C <input type="checkbox"/> Controlling Bx P <input type="checkbox"/> C <input type="checkbox"/> Violent / Abusive Bx <input type="checkbox"/> Verbally <input type="checkbox"/> Emo. <input type="checkbox"/> Psych. <input type="checkbox"/> Phys. <input type="checkbox"/> Fin. <input type="checkbox"/> Sex. P <input type="checkbox"/> C <input type="checkbox"/> Hero / Savior Cplx	P <input type="checkbox"/> C <input type="checkbox"/> Superiority Complex P <input type="checkbox"/> C <input type="checkbox"/> Judgmental P <input type="checkbox"/> C <input type="checkbox"/> Hyper-Critical P <input type="checkbox"/> C <input type="checkbox"/> Prosecutory Bx P <input type="checkbox"/> C <input type="checkbox"/> Cruel / Sadist Bx P <input type="checkbox"/> C <input type="checkbox"/> Uncompassionate P <input type="checkbox"/> C <input type="checkbox"/> Selfish/-Centered P <input type="checkbox"/> C <input type="checkbox"/> Apathetic / Hateful P <input type="checkbox"/> C <input type="checkbox"/> Soc./Emo. Indifferent
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Triggers: People Women Elderly Children Animals/Pets Other:

Disordered Personality Sx: P <input type="checkbox"/> C <input type="checkbox"/> Loneliness P <input type="checkbox"/> C <input type="checkbox"/> Emptiness P <input type="checkbox"/> C <input type="checkbox"/> Hypersensitivity P <input type="checkbox"/> C <input type="checkbox"/> Extreme Emotions P <input type="checkbox"/> C <input type="checkbox"/> Emo. Reasoning	P <input type="checkbox"/> C <input type="checkbox"/> Out-Of-Control P <input type="checkbox"/> C <input type="checkbox"/> Self-Harming Bx P <input type="checkbox"/> C <input type="checkbox"/> Inferiority Complex P <input type="checkbox"/> C <input type="checkbox"/> Self-Critical P <input type="checkbox"/> C <input type="checkbox"/> Abandonment Issue P <input type="checkbox"/> C <input type="checkbox"/> Co-Dependence	P <input type="checkbox"/> C <input type="checkbox"/> Easily Influenced P <input type="checkbox"/> C <input type="checkbox"/> Manipulative P <input type="checkbox"/> C <input type="checkbox"/> Feeling Persecuted P <input type="checkbox"/> C <input type="checkbox"/> Needy / Overbearing P <input type="checkbox"/> C <input type="checkbox"/> Pushy / Controlling P <input type="checkbox"/> C <input type="checkbox"/> Bitter / Resentful
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Notes:

Manic Sx (Episodic 1+ week): P <input type="checkbox"/> C <input type="checkbox"/> Elevated Mood P <input type="checkbox"/> C <input type="checkbox"/> Euphoric Mood P <input type="checkbox"/> C <input type="checkbox"/> Grandiosity P <input type="checkbox"/> C <input type="checkbox"/> Lesser Need to Sleep Duration / Frequency:	P <input type="checkbox"/> C <input type="checkbox"/> Flight of Ideas / Racing Thoughts / Mind P <input type="checkbox"/> C <input type="checkbox"/> Agitated / Impatient / Impulsive / Hyperactive P <input type="checkbox"/> C <input type="checkbox"/> High-Risk / Extreme / Excessive / Grandiose Bx: <input type="checkbox"/> Hypersexual <input type="checkbox"/> Hyperverbal <input type="checkbox"/> Excessive Spending P <input type="checkbox"/> C <input type="checkbox"/> Unrealistic / Unsustainable <input type="checkbox"/> Thoughts <input type="checkbox"/> Moods <input type="checkbox"/> Ambitions <input type="checkbox"/> Projects <input type="checkbox"/> Decisions <input type="checkbox"/> Bx <input type="checkbox"/> Other: _____
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Notes:

Psychotic Sx: P <input type="checkbox"/> C <input type="checkbox"/> Auditory Hallucinations: <input type="checkbox"/> Voices <input type="checkbox"/> Noises <input type="checkbox"/> Music <input type="checkbox"/> Other: _____ P <input type="checkbox"/> C <input type="checkbox"/> Visual Hallucinations: <input type="checkbox"/> Visions (i.e. People; Spirits...) <input type="checkbox"/> Reflections <input type="checkbox"/> Symbols
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Safe Haven Counseling, PLLC

Mental Health | Domestic Violence | Addictions | Grief | Career

Stéphanie Gimenez, MA, NCC, LCMHC, LCAS-A

163 Stratford Court, Suite 225 | Winston-Salem, NC 27103

Office: (336) 396-7834 | **Crisis:** (336) 986-2720 | **Fax:** (336) 217-8708

Stephanie.G@SafeHavenCounselingPLLC.com | www.SafeHavenCounselingPLLC.com

Comprehensive Clinical Assessment (CCA)

Name:	DOB:	MRN:	Ins. #:
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- P** **C** Olfactory Hallucinations (Describe Smells): _____
P **C** Tactile Hallucinations: Touched Hit Other Sensations: _____
P **C** Cognitive Impairments (i.e. Disorganized Speech; Memory/Concentration Issues...)
P **C** Disorganized Psychomotor Activity: Tremors Delayed movement Jerks
P **C** Negative Sx: Flat Affect Catatonia Stupor Mutism Other: _____
P **C** Delusions: Somatic Grandiose Persecutory Paranoid Erotomaniac
P **C** Disorganized / Loosely Associated Thinking → Tangential

Notes:

CALOCUS Score: _____ (OFFICE USE)	1	2	3	4	5
Dimension I (Risk of Harm):					
Dimension II (Functional Status):					
Dimension III (Co-Morbidity):					
Dimension IV-A (Environmental Stress):					
Dimension IV-B (Environmental Support):					
Dimension V (Resilience & Treatment Hx):					
Dimension VI (Acceptance & Engagement):					

Recommended Level of Care (LOC): 1-OPT (1-2x/mo.) 2-I-OPT (1-2x/wk.) 3-IOP (3-4x/wk.) 4-PHP (5x/wk.) 5-IPT (24/7) | **Rationale:**

Substance Abuse & Addiction Hx

Past (12+ months) & Current (Past 12 months)

Process Addiction(s): Food Sex Emotional / Relationship (Co-)Dependence
 Gambling Shopping Exercise Gaming / Social Media Fetish: _____
 Other Obsessive/Compulsive Bx (i.e. Lying; Stealing...): _____

Substance Use Screening: **P** **C** Nicotine **P** **C** Caffeine **P** **C** Cannabis
P **C** Alcohol: Use Misuse Abuse Dependence Intoxication W/D
P **C** Stimulants: Use Misuse Abuse Dependence Intoxication W/D
P **C** Sedatives: Use Misuse Abuse Dependence Intoxication W/D
P **C** Benzos: Use Misuse Abuse Dependence Intoxication W/D
P **C** Opioids: Use Misuse Abuse Dependence Intoxication W/D
P **C** Hallucinogens **P** **C** Inhalants **P** **C** Designer Drugs

Age At:	1 st Use	Last Use	Amount & Frequency	Method
Nicotine				
Caffeine				
Cannabis				





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Alcohol					
Stimulants					
Sedatives / Benzos					
Opioids					
Hallucinogens					
Inhalants					
Designer Drugs					
Timeline:	Quit Attempts: ____ Relapses: ____				
Reasons To Use:	Cravings (Frequency/Intensity):				
Reasons Not To:	Triggers (Locations; People; Situations...):				
Sobriety Tools / Coping Strategies			Un-/Helpful Scale		
<input type="checkbox"/> Mutual Support Group:			0 5 10		
<input type="checkbox"/> Accountability Buddy / Sponsor:			0 5 10		
<input type="checkbox"/> Friend(s) / Family Allies:			0 5 10		
<input type="checkbox"/> Positive Self-Talk:			0 5 10		
<input type="checkbox"/> School / Work:			0 5 10		
<input type="checkbox"/> (Neglected) Child-/ Self-Care (Exercise; Diet)			0 5 10		
<input type="checkbox"/> Hobbies (Reading; Art; Music; Cooking; Crafts; Events...):			0 5 10		
<input type="checkbox"/> Other:			0 5 10		
ASAM Criteria & Score: _____ (OFFICE USE ONLY)			1	2	3
Dimension 1 (Acute Intoxication & Withdrawal Potential):					
Dimension 2 (Bio-Medical Conditions & Complications):					
Dimension 3 (Cognitive, Behavioral & Emotional Complications):					
Dimension 4 (Readiness to Change):					
Dimension 5 (Relapse, Continued Use & Relapse Potential):					
Dimension 6 (Recovery Environment):					
Placement: <input type="checkbox"/> 1-OPT (1-2x/mo.) <input type="checkbox"/> 2-SIOP (1-3x/wk.)/ PHP (4-5x/wk.) <input type="checkbox"/> 3-IPT / OMT (24/7)					
Rationale:					
Functioning & Distress Levels					





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Life Domains Affected by MH Sx / Addiction(s): None Social / Emotional (i.e. Support Systems) | Occupational / Academic Basic needs (Own &/or Dependents) (Food | Housing | Bills | Healthcare | Financial Transportation) Other:

Distress Level

0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DSM-V	ICD-10	Diagnoses & Specifiers	(FOR OFFICE USE ONLY)
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Rationale & Case Conceptualization:

Level of Care: OPT

Tx Frequency:

Tx Length:

Prognosis: Poor Fair Good Excellent

Services Requests & Recommendations

Risk Assessment: <input type="checkbox"/> None <input type="checkbox"/> Low <input type="checkbox"/> High	<input type="checkbox"/> S/H Prevention Plan	<input type="checkbox"/> DV Safety Plan
<input type="checkbox"/> Relapse Prevention	<input type="checkbox"/> Harm Prevention	<input type="checkbox"/> Detox (Alcohol/Opioid)
<input type="checkbox"/> DV CM / Advocacy	<input type="checkbox"/> Individual OPT	<input type="checkbox"/> Couple/Family OPT
<input type="checkbox"/> DV Anonymous	<input type="checkbox"/> DBT Trauma Grp	<input type="checkbox"/> Complex Grief Grp
<input type="checkbox"/> Process Addiction	<input type="checkbox"/> Rethinking Your Drinking Group	<input type="checkbox"/> Single Parents Grp
		<input type="checkbox"/> CNS 4 Counselors

REFERRALS

Legal Services Dept. Social Services Nutritional Services Primary Care Physician
 OBGYN Dentistry Psychiatry Sleep Study Optometrist Personal Trainer
 Financial Advisor Massage Therapist Neurological Testing (i.e. ADHD; DD; Autism...)
 Adjunct Services: _____





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Client's Name: _____ Client's Signature: _____

Clinician's Signature: Stéphanie Gimenez, MA, LCMHC Date: _____

