SAMPLE INITIAL EVALUATION TEMPLATE

I. Demographic Information

Date: _________________

Name: ____

Address: ____
Phone (Home/Cell): _______________________ Phone (Work): __________________________________
Date of Birth: ________________________ Social Security #: ______________________________________
Guardianship (for children and adults when applicable): ____
Marital Status: _________________________

Family Members

Name Age Gender Relationship

____
____

Employer: ______________________________Occupation:____
School (for children, and adults when applicable): ____

II. Emergency Contact Information

Name of Emergency Contact

Name:___________________________ Phone: 1._________________________2.________________________
Relationship to Patient: ____

Current Providers

Primary Medical Practitioner: _______________________________ Phone: ____________________________
Patient does____ /does not____ give permission to contact provider. (If patient does give permission, please ensure a copy of the release form in the medical record.)

Other Behavior Health Specialists or Consultants

Specialist: ____
Phone: ________________________________
Patient does____ /does not____ give permission to contact provider. (If patient does give permission, please ensure a copy of the release form in the medical record.)

III. Presenting Problem (include onset, duration, intensity)

____
____
____

Precipitating Event (why treatment now):

____

____

Target Symptoms:

Frequency/Duration **Degree of Impairment**

Symptom #1: ____

Symptom #2: ____

Symptom #3: ____

Symptom #4: ____

IV. Mental Status (circle appropriate items)

Orientation: Person Place Time

Affect: Appropriate Inappropriate Sad Angry Anxious Restricted Labile Flat Expansive

Mood: Normal Euthymic Depressed Irritable Angry Euphoric (describe details below)

Thought Content:

Obsessions - describe:

____

Delusions (specify and comment):

____

Hallucinations (specify and comment):

____

Thought Processes: Logical Coherent Goal-directed Detailed Tangential Circumstantial lllogical Looseness of Associations Disorganized Flight of Ideas Perseveration Blocking

Patient name: ____

Speech: Normal Slurred Slow Rapid Pressured Loud

Motor: Normal Excessive Slow Other_________

Intellect: Average Above Below

Insight: Present Partially Present Impaired

Judgment: Intact Impaired

Impulse Control: Adequate Impaired

Memory: Immediate Recent Remote

Concentration: Intact Impaired

Attention: Intact Impaired

Behavior: Appropriate Inappropriate (describe____

Details/additional comments:

____

____

V. Risk Assessment

Suicidal Ideation - check (X) all relevant and describe all checked items in comments section								
None	Thoughts	Frequency	Plan	Intent	Means	Attempt	Active or	Chronic or

noted	(only)	of thoughts					passive	acute

Comments

____
____
____
____
____

Homicidal Ideation - check (X) all relevant and describe in comments section								
None noted	Thoughts only	Frequency of thoughts	Plan	Intent	Means	Attempt	Active or passive	Chronic or acute

Comments

____
____
____
____
____

VI. Medical/Behavioral Health History

____
____

Allergies (adverse reactions to medications/food/etc.)

____
____

Medications

Is the member currently prescribed BH medication (s)? ___Yes __ No *(If yes please indicate below)*

A. Current BH Medications prescribed

(Include prescribed dosages, dates of initial prescription and refills, and name of doctor prescribing medication and check to indicate if member is adherent with each medication):

____
____
____
____

Were the risks and benefits of BH medication adherence discussed with the patient?

____
____

B. Is member taking other medications (prescribed or over the counter) or supplements? Yes___ No__ (if yes please list and indicate why).

____
____
____

Past Psychiatric History (Mental Health and Chemical Dependency):

____
____

Psychiatric Hospitalizations:

____
____
____
____

Prior Outpatient Therapy (include previous practitioners, dates of treatment, previous treatment interventions, response to treatment interventions (including responses to medications), and the source(s) of clinical data collected):

____
____
____

Patient name: ____

Results of recent lab tests and consultation reports (For physicians only and only where applicable):

____
____

Family Mental Health or Chemical Dependency History:

____
____

<u>VII. Psychosocial Information</u>

Support Systems:

School/Work Life:

Legal History:
____
____

<u>VIII. Substance Abuse History</u> (complete for all patients age 12 and over)

Substance	Amount	Frequency	Duration	First Use	Last Use	Comments
Caffeine						
Tobacco						
Alcohol						
Marijuana						
Opioids/ Narcotics						
Amphetamines						
Cocaine						
Hallucinogens						
Others:						

FOR CHILDREN AND ADOLESCENTS:
Developmental History (developmental milestones met early, late, normal):________________________
____
____

Risk Factors:

- ♦ _____ Domestic Violence
- ♦ _____ Child Abuse
- ♦ _____ Prior behavioral health inpatient admissions _____ Sexual Abuse
- ♦ _____ History of multiple behavioral diagnosis _____ Eating Disorder
- ♦ _____ Suicidal/homicidal ideation _____ Other (describe)

<u>Diagnostic Impression:</u>

Axis I:____
Axis II:____
Axis III:____
Axis IV: _________Mild _________Moderate ________Severe
♦ Nature of Stressors: __ Family ____School ___ Work ___Health___ Other
Axis V:____
Current GAF: ____________
Highest GAF: ____________

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SAMPLE TREATMENT PLAN TEMPLATE

Patient's name**:** ____

All treatment goals must be objective and measurable, with estimated time frames for completion. The treatment plan is to be developed with the patient, and the patient's understanding of the treatment plan is to be documented in the medical record.

Treatment Goals [after each item selected, indicate outcome measures (i.e. "as evidenced by")]

____ Reduce Risk Factors: ____
____ Reduce Major Symptoms: ____
____ Decrease Functional Impairments: ___________________________________
____ Develop Coping Strategies to Deal with Stress: ________________________
____ Stabilize (short term) Crisis: _____________________________________
____ Maintain (long term) Stabilization of Symptoms: _________________________
____ Medication referral to: ____

Planned Interventions-Patient Participation (must be consistent with treatment goals):

___ Assertiveness Training
___ Anger Management
___ Affect Identification and Expression
___ Cognitive Restructuring
___ Communication Training
___ Grief Work
___ Imagery/Relaxation Training
___ Parent Training
___ Problem Solving Skills Training
___ Solution Focused Techniques
___ Stress Management
___ Supportive Therapy
___ Self/Other Boundaries Training
___ Decision Option Exploration
___ Pattern Identification and Interruption
____Medication Management
___ Engage Significant Others in Treatment: ____
___ Facilitate Decision Making Regarding: ____
___ Monitor: ____
___ Teach Skills of: ____
___ Educate regarding: ____
___ Assign Readings: ____
___ Assign Tasks of: ____
___ Referrals Planned: ____
___ Preventive Strategies: ____
___ Obstacles to change: ____

My therapist and I have developed this plan together, and I am in agreement to working on these issues and goals. I understand the treatment goals that were developed for my treatment.

Patient's Signature____ Date_____________

Provider's Signature____ Date_____________

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SAMPLE DISCHARGE SUMMARY TEMPLATE

Must be completed within 60 days from last visit

Patient's name: ____

Date of Discharge: _________________; date of last contact**:** ______________ **(telephonic or visit?)**

Reason for Termination **(***was patient in agreement with termination at this time?):*

____

____

____

If patient did not return for scheduled appointment, list attempt(s) made to contact patient to reschedule?

____

____

Patient Condition at Termination (were all treatment goals reached?):

____

____

____

Discharge Medications:

____

Final DSM IV Axis I: _______________________________

Axis II: _______________________________

Axis III: ______________________________

Axis IV: ______________________________

Axis V: _______________________________

Referral Options Given (if treatment goals were not met, appropriate referrals must be made)

1) ____

2) ____

Treatment Record Documents Preventive Services as appropriate (for example):

- ♦ _____ Relapse Prevention ♦ _____Stress Management ________________
- ♦ _____ Other (list): ____

If patient became homicidal, suicidal, or unable to conduct activities of daily living during course of treatment, was patient referred to appropriate level of care? (Explain): __________________________

____

____

Signature: ____Date:__________________

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