SAMPLE INITIAL EVALUATION TEMPLATE

I. Demographic Information
Date: ________________
Name: _____________________________________________________________
Address: ___________________________________________________________
Phone (Home/Cell): ______________________ Phone (Work): __________
Date of Birth: _______________________
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:

<table>
<thead>
<tr>
<th>Symptom #1:</th>
<th>Frequency/Duration</th>
<th>Degree of Impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptom #2:</td>
<td>______________________</td>
<td>______________________</td>
</tr>
<tr>
<td>Symptom #3:</td>
<td>______________________</td>
<td>______________________</td>
</tr>
<tr>
<td>Symptom #4:</td>
<td>______________________</td>
<td>______________________</td>
</tr>
</tbody>
</table>
**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 Illogical 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

<table>
<thead>
<tr>
<th>None noted</th>
<th>Thoughts (only)</th>
<th>Frequency of thoughts</th>
<th>Plan</th>
<th>Intent</th>
<th>Means</th>
<th>Attempt</th>
<th>Active or passive</th>
<th>Chronic or acute</th>
</tr>
</thead>
</table>

Comments

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

Homicidal Ideation - check (X) all relevant and describe in comments section

<table>
<thead>
<tr>
<th>None noted</th>
<th>Thoughts only</th>
<th>Frequency of thoughts</th>
<th>Plan</th>
<th>Intent</th>
<th>Means</th>
<th>Attempt</th>
<th>Active or passive</th>
<th>Chronic or acute</th>
</tr>
</thead>
</table>

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:
_______________________________________________________________________________________

VII. Psychosocial Information
Support Systems:

School/Work Life:

Legal History:
_______________________________________________________________________________________
_______________________________________________________________________________________

VIII. Substance Abuse History (complete for all patients age 12 and over)

<table>
<thead>
<tr>
<th>Substance</th>
<th>Amount</th>
<th>Frequency</th>
<th>Duration</th>
<th>First Use</th>
<th>Last Use</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caffeine</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco</td>
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<td></td>
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<tr>
<td>Alcohol</td>
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<td></td>
<td></td>
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<tr>
<td>Marijuana</td>
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<tr>
<td>Opioids/Narcotics</td>
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<tr>
<td>Amphetamines</td>
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<tr>
<td>Cocaine</td>
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<tr>
<td>Hallucinogens</td>
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<tr>
<td>Others:</td>
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</tbody>
</table>

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

Risk Factors:

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

Axis I: ____________________________

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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 developed with the patient, and the patient’s understanding of the treatment plan is 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 ___ Problem Solving Skills Training
___ Anger Management ___ Solution Focused Techniques
___ Affect Identification and Expression ___ Stress Management
___ Cognitive Restructuring ___ Supportive Therapy
___ Communication Training ___ Self/Other Boundaries Training
___ Grief Work ___ Decision Option Exploration
___ Imagery/Relaxation Training ___ Pattern Identification and Interruption
___ Parent Training ___ 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

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   Axis I: ________________________________

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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