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:

	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 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								
None noted	Thoughts (only)	Frequency of thoughts	Plan	Intent	Means	Attempt	Active or passive	Chronic or 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:

_____

_____

VII. Psychosocial Information

Support Systems:

School/Work Life:

Legal History:

_____

_____

_____

VIII. Substance Abuse History (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
____ History of multiple behavioral diagnosis
____ Suicidal/homicidal ideation
____ Sexual Abuse
____ Eating Disorder
____ Other (describe)

Diagnostic Impression

Axis I:_____

Please note: We created this document as a sample tool to help providers in documentation. We don't require the use of this document, nor are we collecting the information contained in it.

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
___ 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

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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