

<b>Patient Name (Last, First):</b> _____	<b>Age:</b> _____	<b>Date:</b> _____
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**Diagnosis:**

Primary focus of treatment is:     Psychiatric     Substance Abuse

**Specify Code:**

Axis I: \_\_\_\_\_                      Axis II: \_\_\_\_\_                      Axis III: \_\_\_\_\_

Axis IV: (Check below those which *currently* apply):

- Problems with primary support group     Educational problems     Occupational problems     Problems related to social environment  
 Housing problems     Economic problems     Problems related to interaction with legal system / crime     SED /2726  
 Other (describe): \_\_\_\_\_

Axis V Current: \_\_\_\_\_                      Highest past year: \_\_\_\_\_

**Risk Assessment** (Check those which *currently* apply):

- Risk of Suicide:     Ideation                       Plan                       Means                       History of prior attempts  
 Risk of Violence:     Ideation                       Plan                       Means                       History of prior attempts

Risk of Grave Disability – Child Adolescents (Check those that apply):

- Minor is at risk for removal from the home or has already been removed from the home  
 Minor cannot use food, clothing, or shelter as provided by others

**Treatment History** (Check all that apply):     None                       Psychiatric                       Substance Abuse

- Outpatient Treatment within:     6 months                       1 year                       2-5 years                       more than 5 years ago  
 Partial Hospitalization or Day Care within:     6 months                       1 year                       2-5 years  
 Residential Treatment within:     6 months                       1 year                       2-5 years  
 Inpatient Treatment within:     6 months                       1 year                       2-5 years

**Treatment Progress:**

- Number of sessions for current calendar year to date: \_\_\_\_\_                      Expected session frequency: \_\_\_\_\_  
 Number of sessions to complete entire episode of treatment: \_\_\_\_\_  
 Has termination and/or discharge been discussed with client?     Yes                       No  
 Is the patient actively participating in treatment on a regular basis?     Yes                       No

**Treatment Approach** (Check all that apply):

- Modality used:     Individual psychotherapy                       Conjoint psychotherapy                       Family therapy  
                           Group therapy                       Medication management  
 Are there other forms of treatment or community services being utilized:     Yes                       No    If yes, please specify: \_\_\_\_\_

**Symptoms:**

Check below all that *currently* apply:

- Anxiousness     Appetite disturbance     Decreased energy     Delusions                       Depressed moods                       Dissociation  
 Elevated mood     Hallucinations     Hyperactivity     Hopelessness                       Impaired memory / concentration  
 Impulsivity     Irritability     Mania     Mood lability                       Obsessions/compulsions     Oppositionality  
 Panic attacks     Paranoia     Self-injurious bx     Sleep dist.                       Somatic complaints                       Worthlessness

Substance Use / Abuse     Active                       In Remission

- Without treatment symptoms would likely persist for:     0-6 months     6-12 months     More than 12 months  
 Symptoms have been present for as long as:     0-6 months     6-12 months     More than 12 months

**Medications:**

- Has patient been evaluated for medication?     Yes     No                      Is patient on medication?     Yes     No     Client refuses  
 If yes, is the patient compliant with medication?     Yes     No                      Prescribing physician:     PCP     Psychiatrist     Other  
 Name of prescribing psychiatrist or physician: \_\_\_\_\_                      Telephone Number: \_\_\_\_\_  
 Have you contacted the prescribing provider to coordinate care?     Yes     No  
 If not, please explain:     Patient refused coordination of care     Attempt made, no response  
 Plan to initiate coordination by \_\_\_\_\_

Name of Medication	Current Dosage	Current Frequency	Start Date

<b>Print Provider Name:</b> _____	<b>Date:</b> _____
<b>Provider Signature:</b> _____	<b>Telephone:</b> _____