



Behavioral Health Treatment Plan Form
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 Monterey, CA 93940
 Telephone: 831-657-2668 Fax: 831-657-2669

Patient Name (Last, First): _____	Age: _____	Date: _____
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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 provider: _____ Office # : _____

Have you contacted the prescribing provider to coordinate care? Yes No Mobile #: _____

If not, please explain: Patient refused coordination of care Attempt made, no response

Plan to initiate coordination by _____

<u>Name of Medication/s</u>	<u>Current Dosage</u>	<u>Current Frequency</u>	<u>Start Date</u>
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Print Provider Name: _____	Date: _____	Office #: _____
Provider Signature: _____	Fax #: _____	Mobile #: _____