



BEHAVIORAL HEALTH SYSTEMS ASSESSMENT REPORT AND TREATMENT PLAN THERAPY

Check One: Initial Assessment Continuing Care Today's Date: _____

Patient Name: _____ Date of Birth: ____-____-____ Age: ____ Male Female

Insured Employer: _____ Provider Name, Licensure: _____

A. Current Problems (Check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Sleep disturbance: ____ ↑ ____ ↓ | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Anhedonia | <input type="checkbox"/> Delusions |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Paranoia |
| <input type="checkbox"/> Decreased energy | <input type="checkbox"/> Hallucinations: ____ AH ____ VH |
| <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Agitation |
| <input type="checkbox"/> Appetite disturbance | <input type="checkbox"/> Withdrawn |
| <input type="checkbox"/> Helplessness | <input type="checkbox"/> Memory loss |
| <input type="checkbox"/> Worthlessness | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Delirium |
| <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Binging |
| <input type="checkbox"/> Obsessions/Compulsions | <input type="checkbox"/> Purging |
| <input type="checkbox"/> Dissociative state | <input type="checkbox"/> Weight change: ____ ↑ ____ ↓ |
| <input type="checkbox"/> Elevated mood | <input type="checkbox"/> Somatic complaints |
| <input type="checkbox"/> Impaired judgment | <input type="checkbox"/> Grief |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Oppositional |
| <input type="checkbox"/> Impulsiveness | <input type="checkbox"/> Physical fighting |
| <input type="checkbox"/> Grandiosity | <input type="checkbox"/> Learning disability |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Marital conflict |
| <input type="checkbox"/> Fears | <input type="checkbox"/> Family conflict |

Symptoms have been present for:
 < 1 Mo 1-6 Mos 7-12 Mos > 1 Yr
 Physical/Sexual Trauma Victim At What Age: _____
 Physical/Sexual Trauma Perpetrator
 Legal problems: _____
 Substance Abuse (including substance, amount, and frequency):

B. Psychiatric Treatment History:

- | | |
|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Inpatient |
| <input type="checkbox"/> Outpatient | <input type="checkbox"/> w/in past 12 mos |
| <input type="checkbox"/> Intensive Outpatient Program | <input type="checkbox"/> 2 or more admissions |
| <input type="checkbox"/> Partial Hospitalization Program | |

C. Current Medications:

Is patient prescribed psychotropic medication? Yes No

If Yes, indicate problems/conditions treated:

List all current psychotropic medications, dosage and frequency.

Is patient compliant with medication? Yes No

Prescribing provider: Psychiatrist PCP Pediatrician Other

D. Other Pertinent Medical Information:

E. Current Risk Assessment (Check all that apply):

Suicidality: Not present Ideation Plan Means Prior attempt
 Describe: _____

Homicidality: Not present Ideation Plan Means Prior attempt
 Describe: _____

Other dangerous or self-injurious behaviors: _____

F. Current Level of Functioning (Please rate level of impairment in each area):

	None	Minimal	Mild	Moderate	Severe	Profound	Comments
Marriage/family	0	1	2	3	4	5	_____
Work/school performance	0	1	2	3	4	5	_____
Social	0	1	2	3	4	5	_____
Activities of daily living	0	1	2	3	4	5	_____

Other Factors / Pertinent Information Impacting Treatment:

Patient Name: _____

G. Treatment Plan (Must be behaviorally measurable and have an expected time frame for achievement):

Goal #1 _____

Objectives:

- 1
- 2
- 3

Goal #2 _____

Objectives:

- 1
- 2
- 3

Goal #3 _____

Objectives:

- 1
- 2
- 3

Alternate plan should the patient fail to progress as expected:

H. DSM 5 Diagnoses:

I. Treatment Services Requested At This Time:

Sessions / Frequency

- Individual Therapy (90834/37) _____
- Brief Individual Therapy (90832) _____
- Family Therapy (90846/47) _____
- Marital / Couples Therapy (90847) _____
- Group Therapy (90853) _____
- Other/CPT Code: _____

Estimated **TOTAL** number of sessions to complete treatment: _____

J. Other Services Recommended:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Group | <input type="checkbox"/> Psychological Testing | <input type="checkbox"/> Intensive Outpatient Program |
| <input type="checkbox"/> Family | <input type="checkbox"/> AA / NA | <input type="checkbox"/> Substance Abuse Assessment | <input type="checkbox"/> Partial Hospitalization |
| <input type="checkbox"/> Marital / Couples | <input type="checkbox"/> Other Support Group:
_____ | <input type="checkbox"/> Medication Evaluation | <input type="checkbox"/> Inpatient Treatment |
| | | | <input type="checkbox"/> Other:
_____ |

Provider Name: _____

Date: _____