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):

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☐ Withdrawn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

☐ None
☐ Outpatient
☐ Intensive Outpatient Program
☐ Partial Hospitalization Program
☐ Inpatient
  ☐ w/in past 12 mos
  ☐ 2 or more admissions

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 <u>TOTAL</u> number of sessions to complete treatment: _____

J. Other Services Recommended:

☐ None
☐ Family
☐ Marital / Couples
☐ Group
☐ AA / NA
☐ Other Support Group: _____
☐ Psychological Testing
☐ Substance Abuse Assessment
☐ Medication Evaluation
☐ Intensive Outpatient Program
☐ Partial Hospitalization
☐ Inpatient Treatment
☐ Other: _____

Provider Name: _____ **Date:**_____