BEHAVIORAL HEALTH SYSTEMS
ASSESSMENT REPORT AND TREATMENT PLAN
MEDICATION EVALUATION/MANAGEMENT

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☐ Withdrawn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

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

Previous Medications and Response:

C. Current Medications:

D. Current Risk Assessment:

☐ SI/HI ☐ Plan ☐ Means ☐ Attempt

Describe:_____

_____

☐ Prior Attempt(s)_____

Other Dangerous Behaviors:_____

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

	None	Minimal	Mild	Moderate	Severe	Profound	Describe
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	_____

F. DSM 5 Diagnoses:

_____

_____

_____

_____

G. Treatment Services Requested: **# Sessions / Frequency**

☐ Brief Visit (99212/13/14) _____
☐ Standard Visit (99213/14 +90833) _____
☐ Extended Visit (99215+90836) _____

H. Other Services Recommended:

☐ Individual ☐ Group ☐ Partial Hospitalization
☐ Family ☐ CD Assessment ☐ Intensive Outpatient Program
☐ Marital/Couples ☐ Inpatient Treatment ☐ Residential

I. Return to Work Recommendations (if applicable):

Provider Signature:_____ **Date:**_____

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