The Holman Group
Managed Behavioral Health Care Services

Clinical Assessment

1. IDENTIFYING INFORMATION					
Client Name:			Date of First Appointment:		
If date seen was more than 5-days from date assigned to Provider, please explain:					
Client Address:			Client Phone:		
Client Date of Birth:		Client Gender:	Provider Name:		
Insured's SSN or ID:			Provider Phone:	Lic.#	
Insured's Employer:			Is Patient on Disability?:	☐Yes ☐No	
Client was referred by:	☐County ☐PCP ☐Member ☐Holman				

2. PRESENTING PROBLEM *(including precipitating events/ current stressors/ relevant history)*

3. DESIRED OUTCOME OF TREATMENT

4. CURRENT RISK FACTORS

A. Suicidality:	☐None	Current Ideation: ☐Yes ☐No	Intent: ☐Yes ☐No
	Means: ☐Yes ☐No	Past Attempts: ☐Yes ☐No	Current Safety Plan: ☐Yes ☐No
B. Homicidality:	☐None	Current Ideation: ☐Yes ☐No	Intent: ☐Yes ☐No
	Plan: ☐Yes ☐No		

C. Current/ Past Physical/ Sexual Abuse, or Child/ Elder Neglect: ☐Yes ☐No

If "yes", patient is:	☐Perpetrator	☐Victim	Has the abuse been legally reported? ☐Yes ☐No
If "yes" to any of the above, please explain:			

D. Current Drug and Alcohol Use: ☐None ☐Use ☐Abuse ☐Dependence

Substance	Quantity	Frequency	Last Used	Duration of Use	# of Attempts at Sobriety	Type of CD Txmt

5. PREVIOUS MEDICAL, AND PSYCHIATRIC TREATMENT *(Please check all that apply)*

☐Inpatient Psychiatric (date):	☐Outpatient Psychiatric (date):	☐Self-Help Support Group:
☐Psychotropic Medication Management	☐Significant Medical (type & date)	☐Other:
Date of Last Physical Exam:	Name of Primary Care Physician:	

6. CURRENT MEDICATIONS

Name of Medication	Current Dosage/ Frequency	Start Date

Prescribing physician (indicate if Primary Care Provider of Psychiatrist):

7. RELEVANT SOCIAL HISTORY

Ethnic/ Religious ID:		Do cultural, ethnic or religious factors affect treatment?	☐Yes ☐No
If "yes", please explain:			

The Holman Group
Managed Behavioral Health Care Services

Clinical Assessment

Client Name: _____

8. MENTAL STATUS EXAM *(Please check appropriate box for each category)*						
Affect:	☐Appropriate	☐Labile	☐Expansive	☐Constricted	☐Blunted	
Mood:	☐Normal	☐Depressed	☐Anxious	☐Euphoric		
Appearance:	☐Well-groomed	☐Disheveled	☐Bizarre	☐Inappropriate		
Motor Activity:	☐Calm	☐Hyperactive	☐Agitated	☐Tremors/Tics	☐Muscle Spasms	
Thought Process:	☐Intact	☐Tangential	☐Circumstantial	☐Flight of Ideas	☐Loose Associations	☐Confused
Hallucinations:	☐None	☐Auditory	☐Visual	☐Olfactory	☐Command	
Delusions:	☐None	☐Persecutory	☐Grandiose			
Memory:	☐Intact	☐Impaired	☐Immediate	☐Recent	☐Remote	
Judgment:	☐Intact	☐Impaired	☐Mild	☐Moderate	☐Severe	
Orientation:	☐Intact	☐Impaired	☐Date	☐Place	☐Time	☐Situation
Speech:	☐Normal	☐Slowed	☐Pressured	☐Slurred	☐Stuttering	

9. DIAGNOSIS	_____ . _____	_____ . _____
	Medical Conditions:	
10. PATIENT'S CHALLENGES		
11. STRENGTHS		
12. ASSESSMENT AND CONCLUSION		

13. TREATMENT GOALS

14. REQUEST FOR TREATMENT AUTHORIZATION

☐Problem Resolved – No further sessions needed.

Number of sessions used:						
This is a request for:	☐Individual Tx	☐Group Tx	☐Other: *(Explain)*			
Medication Mgt.:	☐EM99213/EM99214		☐EM+90833 (20-30 min)		☐EM+90836 (45-50 min)	☐Other:
Treatment Frequency:	Times Per Week:		Month:		Other:	

To request referrals covered under the patient's Holman mental health benefits, please call (800) 321-2843.

☐ **I certify that the above is true and correct. The treatment plan has been reviewed and agreed upon by the patient.**

Provider Signature:		**Date:**	

FOR HOLMAN USE ONLY

# of Sessions/ Service/ Frequency	
# of Sessions/ Service/ Frequency	
Date Span:	
Note:	
Signature:	**Date:**