

Clinical Assessment

(Claims will not be processed until completed form is submitted)

1. IDENTIFYING INFORMATION:

Client Name: _____ Date of First Appointment: _____ Date Patient Seen, If Different: _____

If Date Seen was more than 5 days from Date Assigned to Provider, please explain: _____

Client Date of Birth: _____ Provider Name: _____

Insured's Soc. Sec. #: _____ Provider Phone: _____ Lic #: _____

Insured's Employer: _____ Is Patient on Disability?: Yes ___ No ___

2. PRESENTING PROBLEM (include precipitating events/current stressors/relevant history):

3. CLIENT SUBJECTIVE GOALS:

A. Desired Goals/Outcome of treatment: _____

4. CURRENT RISK FACTORS:

A. Suicidality: None Ideation Plan Intent without means Intent with means, how _____ Prior attempts, how _____

B. Homicidality: None Ideation Plan Intent without means Intent with means, how _____ Prior attempts, how _____

C. If Risk Exists - Client has contracted not to harm: Self Others

D. Impulse Control: Sufficient Moderate Minimal Inconsistent Explosive

E. Medical Risks: Yes No If "yes," please explain: _____

F. Current/Past Physical/Sexual Abuse, or Child/Elder Neglect (circle): Yes No If "yes", patient is: Perpetrator Victim

Has the abuse been legally reported?: Yes No Is there any current risk of further abuse by perpetrator?: Yes No If "yes" to any of the above, please explain: _____

G. Risk History — Please explain risk factors that may affect the client's level of functioning: _____

5. DRUG AND ALCOHOL ABUSE HISTORY:

None Abuse Dependence Inpatient treatment _____ Outpatient treatment _____ 12 Step _____

Substance(s)	quantity	frequency	date of last use	duration of use	number of attempts at sobriety	type CD treatment

6. 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: _____

7. CURRENT MEDICATIONS:

Name of Medication	Current Dosage / Frequency	Start Date

Prescribing physician (indicate if Primary Care Provider or Psychiatrist): _____

8. RELEVANT FAMILY/SOCIAL HISTORY:

Substance abuse/dependence Suicide attempt Divorce Psychiatric problems Abuse

If "yes" to any, please explain: _____

Ethnic/Religious ID: _____ Do cultural, ethnic or religious factors affect treatment? Yes No

If "yes", please explain: _____



9. 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 Circumstantial Tangential Flight of Ideas Loose Associations Confused
- Hallucinations: None Auditory Visual Olfactory Command
- Delusions: None Persecutory Grandiose
- Memory: Intact Impaired: Immediate Recent Remote
- Judgement: Intact Impaired: Mild Moderate Severe
- Orientation: Intact Impaired: Date Place Time Situation
- Speech: Normal Slowed Pressured Slurred Stuttering

10. SYMPTOM CHECKLIST (Please rate severity & duration for each applicable symptom):

Severity Rating: 1 = Mild 2 = Moderate 3 = Severe **Duration Rating:** 1 = < 1 Mo. 2 = 1-6 Mos. 3 = 7-12 Mos. 4 = > 1 Year

<u>Severity</u>	<u>Duration</u>		<u>Severity</u>	<u>Duration</u>		<u>Severity</u>	<u>Duration</u>	
----	----	Agitated Behavior	----	----	Fatigue	----	----	Paranoid Ideation
----	----	Anger	----	----	Gender Issues	----	----	Poor Self-Care
----	----	Anxiety	----	----	Helplessness	----	----	Poor Concentration
----	----	Appetite Disturbance	----	----	Homicidal Ideation	----	----	Poor Insight
----	----	Attention Problems	----	----	Hopelessness	----	----	Ruminating
----	----	Bizarre Behavior	----	----	Impaired Reasoning	----	----	Sexual Dysfunction
----	----	Compulsive Behavior	----	----	Irritability	----	----	Sleep Disturbance
----	----	Conduct Problems	----	----	Malingering	----	----	Social Isolation
----	----	Denial	----	----	Mood Swings	----	----	Suicidal Ideation
----	----	Depression	----	----	Obsessive-Compulsive	----	----	Violent Behavior
----	----	Dissociation			Behavior			
----	----	Elevated Mood	----	----	Panic Attacks			

11. PATIENT'S CHALLENGES: _____

12. DSM-IV DIAGNOSIS (PLEASE INCLUDE ALL AXES):

- Axis I. Primary: _____ Description: _____
- Axis I. Secondary: _____ Description: _____
- Axis II. _____ Description: _____
- Axis III. Medical Problems: _____
- Axis IV. Problems with (check all that apply): Access to Health Care Housing Primary Support Group Economic
- Education Occupational Social Environment Other Psychosocial or Environmental Legal System/Crime
- Axis V. GAF (1-100) Current: _____ Highest GAF over Past Year: _____

13. STRENGTHS: _____

14. TREATMENT PLAN:

Symptom Group	Behavioral Goal	Intervention/Methods for Achieving Goals	Progress	Target Date

Treatment Plan discussed with client: Yes No

15. OTHER INFORMATION:

- Problem resolved - no further sessions needed. Number of sessions used: _____
- Did you discuss the client's option to continue treatment with an alternative provider? Yes No If yes, what decision was made?:
- Client will continue with you Estimated # of sessions: _____ Client has opted to request alternative provider
- Client was referred to self-help group/agency/other provider (i.e. PCP). If "yes" please list name(s) of referrals: _____

TO REQUEST REFERRALS COVERED UNDER THE PATIENT'S HOLMAN MENTAL HEALTH BENEFITS, PLEASE CALL (800) 321-2843.

Provider Signature: _____ **Date:** _____

Care Manager: _____ **Date:** _____