BEHAVIORAL HEALTH SYSTEMS
CLINICAL ASSESSMENT REPORT AND TREATMENT PLAN

Check One: ☐ Initial Assessment ☐ Continuing Care (Only Sections E-J) Today's Date: _____

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

Insured Employer: _____ Provider Name, Licensure: _____

A. Presenting Problems (Check all that apply):

- ☐ Anger
- ☐ Impaired judgment
- ☐ Elevated mood
- ☐ Guilt
- ☐ Helplessness
- ☐ Hyperactivity
- ☐ Impulsiveness
- ☐ Obsessions
- ☐ Panic attacks
- ☐ Somatic complaints
- ☐ Appetite disturbance
  - ☐ Weight loss
  - ☐ Weight gain
- ☐ Withdrawn
- ☐ Sleep disturbance
  - ☐ Increased sleep
  - ☐ Decreased sleep
- ☐ Delusional
- ☐ Anxiety
- ☐ Compulsions
- ☐ Poor concentration
- ☐ Decreased energy
- ☐ Depressed mood
- ☐ Dissociative state
- ☐ Fears
- ☐ Grief
- ☐ Hallucinations
  - ☐ Auditory
  - ☐ Visual
- ☐ Irritability
- ☐ Memory loss
- ☐ Oppositional
- ☐ Paranoia
- ☐ Worthlessness
- ☐ Binging
- ☐ Purging
- ☐ Marital conflict
- ☐ Family conflict
- ☐ Physical fighting
- ☐ Learning disability
- ☐ Grandiosity
- ☐ Distractibility

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. Previous Treatment History:

Psychiatric	Substance Abuse
☐ None	☐ None
☐ Outpatient	☐ Outpatient
☐ Inpatient	☐ Inpatient
☐ w/in past 12 mos	☐ w/in past 12 mos
☐ 2 or more admissions	☐ 2 or more admissions

Medication History:

Has patient been treated with psychotropic medication? ☐ Yes ☐ No

Is the patient compliant with medication regimen? ☐ Yes ☐ No

Prescribing provider: ☐ Psychiatrist ☐ PCP ☐ Pediatrician ☐ Other

C. List psychotropic medications, dosage and frequency:

D. Other pertinent medical information:

E. 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 (e.g., family/social history, test results, lab values, comorbid issues):

_____

_____

G. DSM-IV-TR Diagnoses:

Axis I: _____ _____ _____

Axis II: _____ _____ _____

Axis III: _____

_____

Axis IV: _____

Axis V: Current ____ Highest in past year ____ Anticipated at discharge ____

GAF Scale:

91-100	Superior function
81-90	Minimal symptoms
71-80	Mild/transient symptoms
61-70	Mild symptoms
51-60	Moderate symptoms
41-50	Serious symptoms
31-40	Impaired reality testing
21-30	Inability to function in many areas
11-20	Some danger
0-10	Serious danger of hurting self or others/ Inability to maintain minimal self care

H. Treatment Approach:

☐ Crisis stabilization ☐ Symptom reduction ☐ Cognitive-behavioral ☐ Behavior modification

☐ Solution focused ☐ Insight oriented ☐ Supportive ☐ Other

I. 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:

J. Treatment Services Requested:

	# Sessions / Frequency
☐ Medication Management	_____
☐ Individual Therapy with physician	_____
☐ Individual Therapy w/ master's or PhD	_____
☐ Family Therapy with patient	_____
☐ Marital / Couples Therapy	_____
☐ Group Therapy	_____
☐ Other _____	_____

Estimated total number of sessions to complete episode of treatment:

☐ <4 ☐ 4-8 ☐ 9-12 ☐ Other

Other Services Recommended:

☐ None ☐ Individual

☐ Family ☐ Group

☐ Marital / Couples ☐ Psychological testing

☐ Medication evaluation ☐ CD assessment

☐ AA / NA

☐ Other support group _____

☐ Intensive outpatient program

☐ Partial hospitalization

☐ Inpatient treatment

☐ Other _____

* Please note, BHS may authorize a maximum of 8 visits based on this treatment request. A new treatment request should be submitted if continued treatment is necessary.

Provider Name: _____

Patient Name: _____ Date: _____