Clinical Assessment

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 ☐ Current Ideation: Yes ☐ No ☐ Intent: Yes ☐ No ☐ Plan: Yes ☐ No ☐

Means: Yes ☐ No ☐ Past Attempts: Yes ☐ No ☐ Current safety contract: Yes ☐ No ☐

B. HOMICIDALITY: ☐ None ☐ Current Ideation Intent: Yes ☐ No ☐ Plan: Yes ☐ No ☐

C. CURRENT/PAST PHYSICAL/SEXUAL ABUSE, or CHILD/ELDER NEGLECT (check): 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	Number 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 or Psychiatrist): _____

7. 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: _____

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	☐ 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	

9. 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

Severity	Duration		Severity	Duration		Severity	Duration	
____	____	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			

10. ICD-10: _____ . _____

_____ . _____

MEDICAL CONDITIONS: _____

11. PATIENT'S CHALLENGES: _____

_____

12. STRENGTHS: _____

_____

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Clinical Assessment Client Name: _____

13. ASSESSMENT AND CONCLUSION: _____

_____

_____

14. TREATMENT PLAN (Including management of identified risk factors - Ques. 4):

Symptom/Functional Impairment	Goal	Intervention/Plan for Achieving Goal	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 ☐

☐ 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:** _____

Holman Care Manager: _____ **Date:** _____

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