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):

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	Symptom	Severity	Duration	Symptom	Severity	Duration	Symptom
____	____	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 Behavior	____	____	Violent Behavior
____	____	Dissociation						
____	____	Elevated Mood	____	____	Panic Attacks			

9. DSM DIAGNOSIS ________ . ______________________________

________ . ______________________________

MEDICAL CONDITIONS: ______________________________

10. PATIENT'S CHALLENGES: ______________________________

____

11. STRENGTHS: ______________________________

____

Clinical Assessment Client Name: ____________________

12. ASSESSMENT AND CONCLUSION: ____________________

____

____

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

Symptom/Functional	Goal	Intervention/Plan for Achieving Goal	Progress	Target Date

Treatment Plan discussed with client: Yes ☐ No ☐

14. 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:** ____________________