CLINICAL RECORD FORM

ADMINISTRATIVE & SELF-REPORT INFORMATION **(*May Be Completed by Patient*)**

Patient: _____ Date of Birth: ___/___/___ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: Work (____) _____ Home: (____) _____ Cell: (___) _____

Health Plan ID#: _____ Subscriber S.S.#: _____-_____-_____

Employer/School: _____

Sex: □ Male □ Female Marital Status: □ Married □ Single □ Divorced □ Widowed

Emergency Contact: _____ Telephone: (____) _____

Parent/Guardian (if relevant): Name: _____

Address: _____ Telephone: (____) _____

Current Medical Conditions:_____

_____

_____

_____

_____

_____

Current Medications, Herbal Supplements & Vitamins (Daily Dose, Start Date, Name of Prescriber): _____

_____

_____

_____

_____

Allergies/Adverse Reactions to Treatment:_____

_____

_____

Primary Care Physician Name: _____

Address: _____ Telephone: (____) _____

Reason for Seeking Evaluation Today: _____

_____

_____

_____

_____

Patient Signature: _____ Date: _____

Clinician Name, Degree/License: _____ Date: _____

(*Pages 2-6 To Be Completed By Clinician*)

Presenting Problem: _____

Prior and Current Treatment for Mental Health, Alcohol or Other Drug Problems: _____

Past and Present Use of Cigarettes, Alcohol and Other Substances (Date of First Use, Most Recent Use, Use in Past 3 Months; Legal, Vocational and Family Consequences): _____

Psychosocial History (for children and adolescents, include pre-natal and post-natal events and developmental history):

Patient Name: _____ Date: _____

Clinician Name, Degree/License: _____ Date: _____

CURRENT MENTAL STATUS EVALUATION: (Please check all that apply)

APPEARANCE: [ ] Well-groomed [ ] Disheveled [ ] Bizarre [ ] Inappropriate

ATTITUDE: [ ] Cooperative [ ] Guarded [ ] Suspicious [ ] Uncooperative
[ ] Belligerent [ ] Other _____

MOTOR ACTIVITY: [ ] Calm [ ] Hyperactive [ ] Agitated [ ] Tremors/Tics
[ ] Muscle spasms [ ] Other _____

AFFECT: [ ] Appropriate [ ] Labile [ ] Expansive [ ] Constricted
[ ] Blunted [ ] Flat [ ] Worrisome [ ] Sad [ ] Apathetic

MOOD: [ ] Euthymic [ ] Depressed [ ] Anxious [ ] Euphoric [ ] Angry

SPEECH: [ ] Normal [ ] Delayed [ ] Soft [ ] Loud [ ] Slurred
[ ] Excessive [ ] Pressured [ ] Incoherent [ ] Persevering

THOUGHT PROCESS: [ ] Intact [ ] Circumstantial [ ] Tangential [ ] Flight of ideas
[ ] Loose associations
[ ] Other_____

THOUGHT CONTENT:

Hallucinations: [ ] Not present [ ] Present
If Present, describe: _____

Delusions: [ ] Not present [ ] Present
If Present, describe: _____

SUICIDE/HOMICIDE: *See Next Page*

ORIENTATION: [ ] Fully oriented [ ] Disoriented
If Disoriented, describe:_____

MEMORY: Long-Term [ ] Intact [ ] Impaired
Short-Term [ ] Intact [ ] Impaired
If Impaired, describe: _____

COGNITIVE FUNCTION:

General Knowledge: [ ] Intact [ ] Somewhat intact [ ] Not intact
Serial Sevens/Calculations: [ ] Intact [ ] Somewhat intact [ ] Not intact
Abstract Thinking: [ ] Intact [ ] Somewhat intact [ ] Not intact

JUDGEMENT: [ ] Intact [ ] Impaired – [ ] Mild [ ] Moderate [ ] Severe

INSIGHT: [ ] Intact [ ] Impaired – [ ] Mild [ ] Moderate [ ] Severe

Patient Name: _____ Date: _____

Clinician Name, Degree/License: _____ Date: _____

Suicidal Risk:

Suicidal Ideation?	[ ] Yes	[ ] No
Current plan/intent to harm himself/herself?	[ ] Yes	[ ] No
Hx of any previous attempts?	[ ] Yes	[ ] No

Homicidal Risk:

Homicidal Ideation?	[ ] Yes	[ ] No
Current plan/intent to harm others?	[ ] Yes	[ ] No
Hx of any previous attempts to harm others?	[ ] Yes	[ ] No

Legal Issues (Current and Past): _____

Other Risk Issues: _____

Mental Status Comments: _____

Patient Name: _____ Date: _____

Clinician Name, Degree/License: _____ Date: _____

Structured Rating Scale Results:

If you use any standardized instruments as part of your assessment, put your findings here. We suggest using instruments to complement your clinical assessment for depression (such as the PHQ-9: http://www.pfizer.com/pfizer/phq-9/index.jsp), Alcohol Disorders (such as the AUDIT: see www.niaaa.nih.gov and search on AUDIT for info), and Anxiety Disorders (such as Panic Disorder and Generalized Anxiety Disorder).

Depression Findings _____

Anxiety Findings _____

Alcohol Abuse/Dependence Findings _____

DSM-5 Diagnosis: Code Description

Insight Specifier (Good, Poor, Absent)

Diagnosis Specific Severity Scale (DSM-5 pgs. 733-738)

Differential Diagnosis

Patient Name: _____ Date: _____

Clinician Name, Degree/License: _____ Date: _____

Treatment Plan

Specific Target Sx/Behaviors: Interventions (Related to Goals): Estimated Time for resolution:

Does patient understand and consent to proposed treatment plan? Yes □ No □ :
If "no," explanation:

Were referrals to other services (i.e., medication evaluation) or patient education provided? Yes □ No □
If so, description (including preventive services):

If patient was prescribed psychotropic medication, was informed consent obtained? Yes □ No □

Provide date of initial prescription, name and dosage, instructions and if applicable, dates of refill.

Date	Medication Name	Dosage	Instructions (e.g. one BID)	Refills

Patient Name: _____ Date: _____

Clinician Name, Degree/License: _____ Date: _____

BEHAVIORAL HEALTHCARE COORDINATION FORM

Responsible practice requires coordination of care with other treating professionals and healthcare delivery systems as clinically appropriate. Consider using this form (or one with comparable information) to send to your client's Primary Care Physician or other healthcare provider (not to MHN) if he or she *meets any of the following criteria*:

_ Is taking prescribed psychotropic medications
_ Has reported a concurrent medical condition
_ Has a substance use disorder
_ Has a significant mental illness (condition other than an adjustment disorder)
_ Was referred to you by a PCP or other medical practitioner, or
_ If a PCP will be following the patient for psychotropic medications
_ Was referred to you following a psychiatric admission or ER service

Name of Patient: _____ Patient ID Number: _____

Information exchanged for purposes of treatment, payment and healthcare operations is permitted under the Health Insurance Portability and Accountability Act (HIPAA) even without a member's authorization to do so. A member's authorization is required only before behavioral health practitioners share psychotherapy notes (session notes kept separate from the medical record consisting of the contents of conversation during a private, group, joint, or family counseling session) which are not included in this form.

PCP or Other Healthcare Professional Who Is Also Providing Care

Name_____ Fax #_____

Address_____ Phone #_____

****

Dear Doctor: Today's Date: _____

The above named patient is receiving behavioral health services. Date of First Session: _____

Current Diagnosis: _____

Current Psychotropic Medications

MEDICATION	DOSAGE	START DATE	PRESCRIBED BY

Coordination of Care Issues

_____

_____

_____

Behavioral Health Practitioner

Name _____ **Fax #** _____

Address _____ **Phone #** _____

This information has been disclosed to you from records whose confidentiality is protected by confidentiality provisions of most states' law and applicable federal law. Under such law, you are prohibited from making any further disclosure of these records without the specific written consent of the person to whom they pertain or as otherwise specifically required or permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal regulations under 42 CFR Part 2 restrict any use of the confidential information to criminally investigate or prosecute any alcohol or drug abuse patients.

PROGRESS NOTES *[COPY AND USE ONE PROGRESS NOTE PAGE FOR EACH SESSION]*

Session #: ____

Patient progress towards goals (including patient's strengths/limitations):

Interventions and patient's response:

Revised goals or interventions:

Check any of the following that apply and explain actions taken (i.e., list any referrals made):

Suicide Risk □ Homicide Risk □ Diminished Activities of Daily Living □ Judgment Risk □

Document **all** of the following (if applicable):

- Laboratory test results
- Mandated reports
- Prevention/Referrals to community services
- Coordination of care with other clinicians, consultants, healthcare institutions or programs
- Discharge plan (For final session, document tx summary, discharge plan and patient status)

Follow-up appointment date:

Clinician Signature, Degree/License: _____ Date:_____

Patient Name or ID Number: _____