**FORWARDHEALTH**

# OUTPATIENT MENTAL HEALTH ASSESSMENT AND TREATMENT / RECOVERY PLAN

The use of this form is voluntary and optional and may be used in place of the consumer's assessment and treatment/recovery plan.

**SECTION I — INITIAL ASSESSMENT / REASSESSMENT**
Date of initial assessment / reassessment (MM/DD/CCYY) _____

1. Presenting Problem

2. Diagnosis (Use current *Diagnostic and Statistical Manual of Mental Disorders* [DSM] / *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* [DC: 0-3] code and description.)
   Axis I

   Axis II

   Axis III

   Axis IV (List psychosocial / environment problems.)

   Axis V (Current Global Assessment of Functioning [GAF].)

3. Symptoms (List consumer's symptoms in support of given DSM / DC:0-3 diagnoses.)

   Severity of Symptoms ❑ Mild ❑ Moderate ❑ Severe

4. Strength-Based Assessment (Include current and historical biopsychosocial data and how these factors will affect treatment. Also include mental status, developmental and intellectual functioning, school / vocational, cultural, social, spiritual, medical, past and current traumas, substance use / dependence and outcome of treatment, and past mental health treatments and outcomes.)

5. Describe the consumer's unique perspective and own words about how he or she views his or her recovery, experience, challenges, strengths, needs, recovery goals, priorities, preferences, values, and lifestyle of the consumer, areas of functional impairment, family and community support, and needs.

6. What do you anticipate as barriers / strengths toward progress and independent functioning?

*Continued*

## SECTION I — INITIAL ASSESSMENT / REASSESSMENT (Continued)

7. Has there been a consultation to clarify diagnosis / treatment? ❑ Yes ❑ No
   If so, by whom?
   ❑ Psychiatrist ❑ Ph.D. Psychologist ❑ Master's-Level Psychotherapist ❑ Other (Specify) _____
   ❑ Advanced Practice Nurse Prescriber-Psych / Mental Health Specialty
   ❑ Substance Abuse Counselor
   Date of latest consultation (MM/DD/CCYY)_____
   Provide results of consultation or attach report, if available.

## SECTION II — SUBSEQUENT ASSESSMENTS

Not required when Initial Assessment section is completed. This section must be completed for subsequent reviews.

8. Indicate any changes in Elements 1-7, including the current GAF, change in diagnoses (five axes), and symptoms in support of new diagnosis, including mental status.

9. Describe current symptoms / problems.

| | | | |
|---|---|---|---|
| ❑ Anxiousness | ❑ Homicidal | ❑ Oppositional | ❑ Somatic Complaints |
| ❑ Appetite Disruption | ❑ Hopelessness | ❑ Panic Attacks | ❑ Substance Use |
| ❑ Decreased Energy | ❑ Hyperactivity | ❑ Paranoia | ❑ Suicidal |
| ❑ Delusions | ❑ Impaired Concentration | ❑ Phobias | ❑ Tangential |
| ❑ Depressed Mood | ❑ Impaired Memory | ❑ Police Contact | ❑ Tearful |
| ❑ Disruption of Thoughts | ❑ Impulsiveness | ❑ Poor Judgment | ❑ Violence |
| ❑ Dissociation | ❑ Irritability | ❑ School / Home / Community Issues | ❑ Worthlessness |
| ❑ Elevated Mood | ❑ Manic | ❑ Self-Injury | |
| ❑ Guilt | ❑ Obsessions / Compulsions | ❑ Sexual Issues | |
| ❑ Hallucinations | ❑ Occupational Problems | ❑ Sleeplessness | |

❑ Other _____

## SECTION III — TREATMENT / RECOVERY PLAN

**Based on strength-based assessments.**

10. Treatment plan, as agreed upon with consumer.
    Short term (Three months) _____
    Long term (Within the next year) _____
    Specify objectives utilized to meet the goals.
    Indicate modality (Individual [I], group [G], family [F], other [O]) after each objective.

| | What are the therapist / consumer agreed-upon signs of improved functioning? As reported by _____ | Describe progress since last review as agreed-upon with consumer, or lack thereof, on each goal. For children, provide caregiver's report. | Changes in Goals / Objectives |
|---|---|---|---|
| 1 | | | |

*Continued*

**SECTION III — TREATMENT / RECOVERY PLAN (Continued)**

| | What are the therapist / consumer agreed-upon signs of improved functioning? As reported by _____ | Describe progress since last review as agreed-upon with consumer, or lack thereof, on each goal. For children, provide caregiver's report. | Identify changes in goals / objectives. |
|---|---|---|---|
| 2 | | | |
| 3 | | | |

11. How are consumer's strengths being utilized?

If little or no progress is reported, discuss why you believe further treatment is needed and how you plan to address the need for continued treatment. What strategies will you, as the therapist, use to assist the consumer in meeting his / her goals? If progress is reported, give rationale for continued services.

12. Is consumer taking any psychoactive medication? ❑ Yes ❑ No
Date of last medication check (MM/DD/CCYY) _____

List psychoactive medications and dosages.
Medication and Dosages _____ Target Symptoms _____
Medication and Dosages _____ Target Symptoms _____
Medication and Dosages _____ Target Symptoms _____

Is informed consent current for all medications? ❑ Yes ❑ No

**SECTION IV — SIGNATURES**

| 13. **SIGNATURE** — Rendering Provider | 14. Date Signed |
|---|---|
| 15. **SIGNATURE** — Consumer / Legal Guardian* | 16. Date Signed |

*The outpatient psychotherapy clinic certification standards requiring the consumer to approve and sign the treatment plan and agree with the clinician on a course of treatment (HFS 36.16[3], Wis. Admin. Code) will be met if this form is signed by the consumer/legal guardian for children.

Reset Form