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)
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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].)

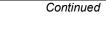
3. Symptoms (List consumer's symptoms in support of given DSM / DC:0-3 diagnoses.)

Severity of Symptoms D Mild D Moderate D 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?





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SECTION I — INITIAL ASSESSMENT / REASSESSMENT (Continued)				
 7. Has there been a consultation to clarify diagnosis / treatment? If so, by whom? Psychiatrist Ph.D. Psychologist Master's-Level Ps Advanced Practice Nurse Prescriber-Psych / Mental Health S Substance Abuse Counselor Date of latest consultation (MM/DD/CCYY) Provide results of consultation or attach report, if available. 	ychotherapist 🏾 Other (Specify)			

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
- Appetite Disruption
- Decreased Energy
- Delusions
- Depressed Mood
- Disruption of Thoughts

Other

- Dissociation
- Elevated Mood
- Guilt
- Hallucinations

- Hopelessness
- Hyperactivity

Homicidal

- Impaired Concentration
- Impaired Memory
- □ Impulsiveness
- □ Irritability
- Manic
- Obsessions / Compulsions
- Occupational Problems

- Oppositional
- Panic Attacks
- Paranoia
- Phobias
- Police Contact
- Poor Judgment
- □ School / Home / Community Issues □ Worthlessness
- □ Self-Injury
- □ Sexual Issues
- □ Sleeplessness

- Somatic Complaints
- Substance Use
- Suicidal
- Tangential
- □ Tearful
- □ Violence

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			

	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.		
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? Date of last medication check (MM/DD/CCYY)		I Yes			I No	o 	
	List psychoactive medications and dosages.							
	Medication and Dosages				Та	rge	t Symptoms	
	Medication and Dosages				Та	rge	et Symptoms	
	Medication and Dosages		Yes 🗖		Та	arget Sym	et Symptoms	
	Is informed consent current for all medications?	Ye		🗆 No	No			
	CTION IV — SIGNATURES							 14 Data Signad
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, Wis. Admin. Code § DHS 36.16(3), will be met if this form is signed by the consumer/legal guardian for children.