

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



DT-PA068-068

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.

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

Medication and Dosages _____

Medication and Dosages _____

Target Symptoms _____

Target Symptoms _____

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, Wis. Admin. Code § DHS 36.16(3), will be met if this form is signed by the consumer/legal guardian for children.