MANHATTAN
MENTAL HEALTH COUNSELING

INTAKE AND TREATMENT PLANNING FORM

Informant(s): Patient: ***Others: specify***

1. CONTACT/DEMOGRAPHIC INFORMATION

NAME: **DATE OF BIRTH:** **AGE:**

DATE/NATURE OF FIRST TELEPHONE CONTACT:

DATE OF INITIAL INTERVIEW:

REFERRAL SOURCE/CONSENT TO CONTACT:

HOME ADDRESS:

TELEPHONE NUMBERS: HOME: BUSINESS: CELL:

SEX: **RACE:** **EDUCATION:**

OCCUPATION:

ETHNIC/RELIGIOUS BACKGROUND:

LIVING ARRANGEMENTS:

MARITAL STATUS:_____SINGLE ____MARRIED ____DIVORCED____WIDOWED ____SEPARATED

IMMEDIATE FAMILY RELATIONSHIPS (SPOUSE, CHILDREN, SIBLINGS, PARENTS):

NAME	RELATIONSHIP	AGE	LOCATION

SEXUAL ORIENTATION (IF RELEVANT)

EMERGENCY CONTACT:
NAME: RELATIONSHIP: TELEPHONE NUMBER(S):

INSURANCE INFORMATION (COMPANY, INSURED, ID #, GROUP #, DEDUCTIBLE/COPAY, PHONE, *OBTAIN COPY OF INSURANCE CARD IF AVAILABLE*):

2. HEALTH HISTORY

PSYCHIATRIC/PSYCHOTHERAPEUTIC HISTORY (INCLUDING PSYCHOTROPIC MEDICATION)**:**

RELEVANT MEDICAL HISTORY (INCLUDING ALL CURRENT MEDICATIONS, PRESCRIBED, OTC AND COMPLEMENTARY; ALLERGIES; TOBACCO; CAFFEINE)**:**

NAME/ADDRESS OF PERSONAL PHYSICIAN AND DATE OF LAST EXAM:

ALCOHOL/SUBSTANCE USE, ABUSE AND DEPENDENCE HISTORY:

HISTORY OF PHYSICAL/SEXUAL ABUSE:

HISTORY OF DOMESTIC VIOLENCE:

FAMILY HISTORY OF MENTAL/EMOTIONAL DISTURBANCE (INCLUDING SUICIDE, ALCOHOL/ SUBSTANCE ABUSE, PHYSICAL/ SEXUAL ABUSE AND DOMESTIC VIOLENCE):

3. CURRENT ASSESSMENT

CHIEF COMPLAINT (AS STATED BY PATIENT**):**

PRESENT ILLNESS (PATIENT DESCRIPTION OF SYMPTOMS):

CURRENT RELEVANT HISTORY/PRECIPITANTS (CHILDHOOD/DEVELOPMENTAL, MARITAL AND SEXUAL, EDUCATIONAL, WORK, SOCIOECONOMIC, LEGAL/CRIMINAL):

PATIENT'S STATED GOALS FOR THERAPY:

PRESENTING PROBLEMS (CLINICAL SUMMARY)
_____MENTAL HEALTH/SYMPTOMS:
_____INTERPERSONAL/SOCIAL:
_____MARITAL/FAMILY:
_____ADDICTIONS:
_____PHYSICAL/HEALTH:
_____WORK:
_____SCHOOL:
_____OTHER:

RISK ASSESSMENT:
ANY RISK FACTORS PRESENT? NO YES
IF YES, SPECIFY:
CURRENT RISK FACTORS:
POTENTIAL FOR VIOLENCE:
HOSTILE/ABUSIVE BEHAVIOR:
MAJOR DEPRESSION:
SUICIDAL IDEATION/INTENT/PLAN:
PAST RISK FACTORS:
SUICIDE ATTEMPTS:
VIOLENT BEHAVIOR:
INPATIENT HOSPITALIZATION:
HOSTILE/ABUSIVE BEHAVIOR:
MAJOR DEPRESSION:
SUICIDAL IDEATION/INTENT/PLAN:
RISK ASSESSMENT (TYPE AND DEGREE OF RISK):

CASE FORMULATION (INCLUDE ETIOLOGY OF PROBLEMS SUCH AS INTERNALIZED CONFLICT, OBJECT RELATIONS DISTURBANCE, SELF/NARCISSISTIC DISORDER, DEFICITS IN EGO FUNCTIONING, FAMILY SYSTEM DYSFUNCTIONS, NEGATIVE THINKING PATTERNS, PROBLEM BEHAVIORS, COGNITIVE/NEUROPSYCHOLOGICAL IMPAIRMENT, ETC.)

4. MENTAL STATUS EXAM

DATE:________________

APPEARANCE AND ATTITUDE (POSSIBLE DESCRIPTIONS: NEAT, UNKEMPT, BIZARRE, INAPPROPRIATE, EYE CONTACT, COOPERATIVE, GUARDED, SUBMISSIVE, UNCOOPERATIVE, PROVOCATIVE):

MOTOR ACTIVITY (NORMAL, HYPERACTIVE, AGITATED, RETARDED):

SPEECH (NORMAL, LOUD, SLURRED, STUTTERING, UNDERPRODUCTIVE):

AFFECT (APPROPRIATE, LABILE, EXPANSIVE, FULL RANGE, INAPPROPRIATE, CONSTRICTED, BLUNTED, FLAT):

MOOD (EUTHYMIC, DEPRESSED, ANXIOUS, EUPHORIC, ANGRY; *INCLUDE PATIENT'S SELF-REPORT ALSO*):

SLEEP DISTURBANCE (NONE, DIFFICULTY FALLING ASLEEP, EARLY AM AWAKENING, NIGHTMARES, HOURS SLEEP/NIGHT {CURRENT AND NORMAL}):

EATING DISTURBANCE (NONE, DECREASED APPETITE, WEIGHT LOSS {SPECIFY}, INCREASED APPETITE, WEIGHT GAIN {SPECIFY}:

SOMATIC COMPLAINTS (NONE, SEXUAL, MENSTRUAL, HEADACHES, FATIGUE, DIZZINESS, GASTROINTESTINAL/EXCRETORY):

SUICIDAL IDEATION: (NONE, CURRENT/PAST, PASSIVE WISHES TO DIE, IDEATION, INTENT, PLAN, COMMAND HALLUCINATIONS, PATIENT CONCERN ABOUT, *DESCRIBE IN DETAIL):*

HOMICIDAL IDEATION (NONE, CURRENT/PAST, IDEATION, INTENT, PLAN, VICTIM(S), PATIENT CONCERN ABOUT, *DESCRIBE IN DETAIL*):

THOUGHT PROCESS: (GOAL DIRECTED, CIRCUMSTANTIAL, FLIGHT OF IDEAS, LOOSENING OF ASSOCIATIONS, OBSESSIONAL):

PERCEPTUAL ABNORMALITY (NONE, DEPERSONALIZATION, DEREALIZATION, DEJA VU, ILLUSIONS, HALLUCINATIONS {AUDITORY, VISUAL, OLFACTORY},):

THOUGHT CONTENT ABNORMALITY: (NONE, OBSESSIONS, COMPULSIONS, PHOBIAS, MAGICAL THINKING, DELUSIONS {PERSECUTORY, GRANDIOSE, SOMATIC, BEING CONTROLLED, RELIGIOUS, THOUGHT INSERTION/DELETION, BIZARRE):

ORIENTATION (FULLY ORIENTED, DISORIENTED {ALWAYS, SOMETIMES: TIME, PLACE, PERSON}):

CONCENTRATION: (INTACT, IMPAIRED, E.G., SERIAL 7'S):

ATTENTION: (ALERT, DULL, VARIABLE):

MEMORY (INTACT, IMPAIRED {RECENT, PAST, REMOTE})

ESTIMATE OF INTELLIGENCE (BELOW AVERAGE, AVERAGE, ABOVE AVERAGE, SUPERIOR):

JUDGEMENT (INTACT, IMPAIRED {DAILY LIVING, INTERPERSONAL, DECISION-MAKING, IMPULSE CONTROL}, *SPECIFY DEGREE OF IMPAIRMENT {*MILD, MODERATE, SEVERE}):

INSIGHT: (INTACT, IMPAIRED {DOES NOT ADMIT PROBLEMS, BLAMES OTHERS} *DEGREE* {MILD, MODERATE, SEVERE}):

ADDITIONAL REMARKS ON MSE:

5. TREATMENT PLAN/CONSENT

DATE:______________________

DIAGNOSIS (DSM 5):

THERAPEUTIC GOALS (RESOLUTION OF PROBLEMS AND/OR SYMPTOMS, SHORT AND LONG TERM**)**:

THERAPEUTIC TREATMENT PLAN:

MODALITY: FREQUENCY: ESTIMATED LENGTH OF TREATMENT:

TYPES OF INTERVENTIONS: COLLATERALS INVOLVED:

REFERRALS:

____ PSYCHIATRIC/PHARMACOTHERAPY:
____ MEDICAL (SPECIFY):
____ COLLATERAL PROGRAM (E.G., AA, NA):
____ ADJUNCTIVE THERAPY (E.G., GROUP, FAMILY):
____ PSYCHOLOGICAL TESTING/ REFERRAL QUESTION(S):

PLANNED CONSULTATION/SUPERVISION:

THERAPY CONTRACT/INFORMED CONSENT DISCUSSION: (DATE, ANY PATIENT REACTION, COMMENTS)

____ HIPAA PRIVACY NOTICE/MEANS OF COMMUNICATION FORMS (DATE)

____ HIPAA AUTHORIZATIONS (FOR PLANNED REFERRALS/CONSULTATIONS) (DATES)

____ DIAGNOSIS

____ TREATMENT GOALS/PLAN

____ BENEFITS AND RISKS:

____ ALTERNATIVES:

____ CONFIDENTIALITY AND ITS LIMITS (CHILD ABUSE/DUTY TO PROTECT/SAFE ACT):

____ FEE/FINANCIAL MATTERS (SPECIFY ARRANGEMENTS):

____ MANAGED CARE ISSUES:

____ CANCELLATION POLICY/SCHEDULING ISSUES (SPECIFY):

____ EMERGENCY AVAILABILITY (SPECIFY):

____ INDIVIDUAL CONCERNS OF PATIENT:

____ PROFESSIONAL QUALIFICATIONS/COMPLAINTS: