Assessment and Treatment Plan

Client Name_____________________________________ **Case Number**______________________

Date of Birth______________________________ **Assessment Date**___________________

Presenting Problem (Note symptoms: behavioral and functioning problems; precipitating factors; indicate referral source and reason for referral; client/family description of the problem and expectations):

Current Living Situation:

Homeless on street or in shelter

Specialized Residential Home

Private residence with family members

General AFC

Private Residence: alone or with friends

Other: _________________________________

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Comments on Current Living Situation (include client's satisfaction with current living situation and quality of relationships of other household members):

Support System (primary/family/marital/significant other/friendships/peer supports/Community support groups/etc.):

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Pertinent Family History (include family mental health and substance abuse history):

Outpatient Mental Health/Substance Abuse Treatment History None Reported

Name of Agency: ____ Dates: ______________
Clinician Name: ____

Outpatient Mental Health/Substance Abuse Treatment History None Reported

Name of Agency: ____ Dates: ______________
Clinician Name: ____

Outpatient Mental Health/Substance Abuse Treatment History None Reported

Name of Agency: ____ Dates: ______________
Clinician Name: ____

Outpatient Mental Health/Substance Abuse Treatment History None Reported

Name of Agency: ____ Dates: ______________
Clinician Name: ____

Outpatient Mental Health/Substance Abuse Treatment History None Reported

Name of Agency: ____ Dates: ______________
Clinician Name: ____

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Psychiatric Hospitalizations/Substance Abuse Treatment None Reported

Name of Hospital/Residential Program: _________________________ Dates: ______________
Clinician Name: ____

Psychiatric Hospitalizations/Substance Abuse Treatment None Reported

Name of Hospital/Residential Program: _________________________ Dates: ______________
Clinician Name: ____

Psychiatric Hospitalizations/Substance Abuse Treatment None Reported

Name of Hospital/Residential Program: _________________________ Dates: ______________
Clinician Name: ____

Psychiatric Hospitalizations/Substance Abuse Treatment None Reported

Name of Hospital/Residential Program: _________________________ Dates: ______________
Clinician Name: ____

Previous or Current Diagnoses (if known)

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Substance Use History: **Not Applicable**

Drug/Substance			Age of First Use	Date of Last Use	Amount	Frequency
Alcohol	Yes	No	______	_______	______________	______________
Marijuana/Hashish	Yes	No	______	_______	______________	______________
Amphetamines/Speed	Yes	No	______	_______	______________	______________
Hallucinogens (LSD, Ecstasy, Mescaline)	Yes	No	______	_______	______________	______________
Inhalants (gas, glue, rush, propane)	Yes	No	______	_______	______________	______________
PCP/Angel Dust/Phencyclidine	Yes	No	______	_______	______________	______________
Cocaine/Crack	Yes	No	______	_______	______________	______________
Sedative/Hypnotic (Quaaludes, Doriden)	Yes	No	______	_______	______________	______________
Barbiturates/Downers	Yes	No	______	_______	______________	______________
Heroin/Methadone	Yes	No	______	_______	______________	______________
Opiates (Codeine, Morphine, Demerol)	Yes	No	______	_______	______________	______________
Caffeine	Yes	No	______	_______	______________	______________
Nicotine	Yes	No	______	_______	______________	______________
Other: _________________	Yes	No	______	_______	______________	______________

Additional Notation:

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Have you ever experienced?

Withdrawal SX Describe:

Blackouts Employer Concern Family Concern Financial Stress

Friend Concern Increased Tolerance Seizures Irresponsible Behavior

Loss of Control Physical Problem Unable to abstain

History of Overdose

Motivation for Abstinence:

Precontemplative Contemplative Preparation Action Maintenance

Current Medication Information (include psychiatric, medical and OTC/Herbal):

Medication	Rationale/Purpose	Dosage/Route/Frequency

If there are additional medications, please attach a separate sheet.

Client Name_______________________________________ Case Number________________

Past Psychotropic Medications

Medication	Reason for Discontinuation

Current Health Needs:

Primary Care Physician: _____________________________________ **Phone:** _________________________

Other Prescribing Physicians

Name	Address	Phone	Fax

Client Name______________________________________ **Case Number**________________

Health History (include all health conditions):

Religion/Spirituality:

Cultural/Ethnic Issues/Information/Concerns:

Primary/Preferred Language of the Client:

Developmental Issues:

Client Name______________________________________ **Case Number**________________

Sexual History/Concerns:

Education History (Include highest grade completed, learning difficulties, barriers to learning, literacy level):

Assistive Technology in the provision of services needs:

Employment History:

Military History (include branch of service, any pertinent duties, and any trauma experienced during service as applicable, type of discharge):

Client Name______________________________________ **Case Number**________________

Current Legal Problems (include parole or probation officer name, address, pending lawsuits, court ordered treatment and ATOs)

History of Legal Problems:

Abuse History:

No self-reported history of abuse/violence

Domestic Violence/Abuse

Physical Abuse

Community Violence

Physical Neglect

Emotional Abuse

Elder Abuse

Sexual Abuse/Molestation

Other Trauma (i.e. witnessing violence, traumatic losses, etc.) __________________________________

Abuse Comments (describe each element checked above; identify if client was/is a victim or a perpetrator or both):

Client Name______________________________________ **Case Number**________________

Other Health and Safety Risk Factors:

Unsafe sex practices	Impulsivity
Pregnancy	Residential Safety
Chronic Health Problems	Diet/Nutrition
Hygiene	Self-harm
Household Management	Aggression toward others
Medication interaction	Physical Disability
Medication Management	Psychosis
Stress related to parenting	Risk taking
Recent loss (parent, child, spouse, job, relationship)	Anxiety
Sleep problems	Mood swings

Other____

Explanation of Health and Safety Risk Factors:

Past Attempts to Harm Self or Others:

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Current Risk of Harm to Self or Others:

Diagnosis:

	Code	Narrative Description
Primary		
Secondary		
Tertiary		
Quaternary		
Quinary		
Senary		

Describe the clients:

Strengths (include assets, resources, and natural positives)

Client Name______________________________________ **Case Number**________________

Needs (include liabilities, weaknesses, and what the client needs to recover):

Abilities (include interests, skills, aptitudes, capabilities, talents and competencies):

Preferences (things the client feels will enhance their treatment experience):

Client Name_______________________________________ **Case Number**________________

Narrative Summary (summarize the global picture of the client, the severity of problem, clinical impressions, client's current stage of change)

Client Name______________________________________ **Case Number**________________

Recommendations (include all health and safety risks and how they will be addressed in treatment):

Treatment Plan

Client Name______________________________________ **Case Number**________________

Desired Goal in Client's Words:

(Goal and objectives must be understandable, measurable, achievable, time specific)

Goal #1: ____

Objective #1: By: ____

Objective #2: By: ____

Objective #3: By: ____

Objective #4: By: ____

Goal #2: ____

Objective #1: By: ____

Objective #2: By: ____

Objective #3: By: ____

Objective #4: By: ____

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Goal #3: ____

Objective #1: By: ____

Objective #2: By: ____

Objective #3: By: ____

Objective #4: By: ____

Interventions:

Service____________ **Frequency of Service**____________ **Duration of service**____________

Frequency at which this plan will be review: Monthly Every 3 months

Additional Referrals/Identified Needs:

None Indicated
Psychiatric

Psychological
Medical/PCP

Educational
Vocational

Visual
Auditory

Substance Abuse
Dental

Other: ____

If the client is a child under the age of 18 years old, complete the Child/Adolescent Assessment Attachment to the Assessment and Treatment Plan.

Treatment Agreement

Client Name____ **Case Number**________________

Client's Responsibilities to achieve outcomes (please have client/guardian initial):

_______ I was asked if I had any special considerations to be successful with my treatment such as cultural, spiritual, physical needs, handicap accessibility, age, gender, sexual orientation, socioeconomic status, language, etc.

_______ I agree to allow Recovery Technology to contact me 30 days following discharge to check on my progress.

_______ I understand that early withdrawal from services could be detrimental to my treatment and it is necessary to attend and participate in services on a regular basis.

_______ I am aware that if I am unhappy or have concerns with any portion of my treatment, I may share those concerns through the informal complaint Resolution Process with: ________________________________

Client Signature____ Date_______________________

Parent/Guardian Signature_______________________________________ Date_______________________

Staff Signature/Credentials_______________________________________ Date_______________________

Supervisor Signature/Credentials_________________________________ Date_______________________

Other Signature____ Date_______________________

Other Signature____ Date_______________________