



MENTAL HEALTH TREATMENT REPORT OUTPATIENT

Patient Name: _____

Date of Birth: _____ Sex: () MALE () FEMALE

Address: _____

Name of Insured: _____ Relationship to Insured: _____

Marital Status: _____

Please answer the following questions:

Date: _____

Duration of Sessions: 15 (); 30 (); 45 (); Other ()

Date Treatment Began: _____ CONTINUING () YES () NO

Termination Date: _____

DIAGNOSIS (use D.S.M. IIR):

1. _____
2. _____
3. _____

Please respond to all items. Use additional pages as necessary.

I. State the patient's initial reasons for seeking treatment. Describe how and when the condition was first manifested. Summarize previous treatment efforts, if any.

II. Describe the patient's current condition. Include the duration and severity of functional impairments and stress factors.

III. Mental Status

IV. If applicable give the date and describe the significant results of physical and psychological examinations. Include pertinent laboratory tests, abnormal findings and dates of tests. (If diagnosis is alcoholism, provide results of neurological examination, liver function and chemical screen)

V. Current treatment goals and estimated duration of treatment to achieve stated goals. If treatment has been terminated give date and fill out form, answering all questions.

VI. Components of Treatment Plan:

- A) Psychotherapy: Specific types, frequency, and length of sessions. (If group psychotherapy, also give number of patients in the group) _____

- B) Medication: Name each drug, dosage and dates begun and ended since last MHTR or during this episode of illness. _____

- C) Collateral contacts (i.e., visits or sessions with a significant person in the patient's life) Specify type frequency, duration and purpose. _____

- D) Adjunctive therapies (i.e., physical or occupational therapy, art therapy etc.) Specify type, frequency and duration. _____

VII. Other remarks or additional detail (such as consultations) that would assist professional reviewer in understanding this case)

(Type or Print)

Provider Name	Degree	Tax ID#
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Address	Telephone #	
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Signature	Date	