



SAMPLE CLINICAL DOCUMENTATION

Initial Assessment - Adult



Info

Service Provided	<i>Initial Assessment - Individual</i>
Present at session	<i>Client</i>
Location of service	<input checked="" type="checkbox"/> <i>Telehealth</i> <input type="checkbox"/> <i>Office (in person)</i>
The client agreed for this visit to occur via telehealth. The client's full name and address of present location has been confirmed at the start of the session:	<input checked="" type="checkbox"/> <i>Yes – client at home</i> <input type="checkbox"/> <i>Yes – client in another location, which has been confirmed</i> <input type="checkbox"/> <i>No</i>
Client is appropriate for Telehealth	<input checked="" type="checkbox"/> <i>Yes</i> <input type="checkbox"/> <i>No</i> <input type="checkbox"/> <i>N/A</i>

Demographics

Race (select all that apply, or write in)	<input type="checkbox"/> <i>African-American/Black</i> <input type="checkbox"/> <i>American Indian /Alaska Native</i> <input type="checkbox"/> <i>Asian</i> <input checked="" type="checkbox"/> <i>Caucasian/White</i> <input type="checkbox"/> <i>Native Hawaiian / Pacific Islander</i>
Ethnicity:	<input checked="" type="checkbox"/> <i>Hispanic</i> <input type="checkbox"/> <i>Not Hispanic</i>
Client's preferred language	<input checked="" type="checkbox"/> <i>English</i> <input type="checkbox"/> <i>Spanish</i> <input type="checkbox"/> <i>Other (list)</i>
If needed, was the client offered an interpreter?	<input type="checkbox"/> <i>Yes</i> <input type="checkbox"/> <i>No</i> <input checked="" type="checkbox"/> <i>N/A</i>
(If yes) Client's response to offer	<input type="checkbox"/> <i>Accepted</i> <input type="checkbox"/> <i>Declined</i>

	<input type="checkbox"/> <i>Requested additional information</i>
Gender Identity (optional)	<input type="checkbox"/> <i>Female</i> <input type="checkbox"/> <i>Male</i> <input checked="" type="checkbox"/> <i>Non-Binary</i> <input type="checkbox"/> <i>Transgender FTM</i> <input type="checkbox"/> <i>Transgender MTF</i> <input type="checkbox"/> <i>Other</i> <input type="checkbox"/> <i>Unknown</i>
Pronouns (multi-select) (optional)	<input type="checkbox"/> <i>She/Her</i> <input type="checkbox"/> <i>He/Him</i> <input checked="" type="checkbox"/> <i>They/Their</i> <input type="checkbox"/> <i>Xe</i> <input type="checkbox"/> <i>If other, please list:</i>
Marital Status	<input type="checkbox"/> <i>Single/never married</i> <input checked="" type="checkbox"/> <i>Married or in a domestic partnership</i> <input type="checkbox"/> <i>Separated</i> <input type="checkbox"/> <i>Divorced</i> <input type="checkbox"/> <i>Widowed</i>
Sexual Orientation (multi-select)	<input type="checkbox"/> <i>Heterosexual</i> <input type="checkbox"/> <i>Gay/Lesbian</i> <input type="checkbox"/> <i>Bisexual</i> <input type="checkbox"/> <i>Asexual</i> <input type="checkbox"/> <i>Questioning</i> <input type="checkbox"/> <i>Pansexual</i> <input checked="" type="checkbox"/> <i>Queer</i> <input type="checkbox"/> <i>Other</i> <input type="checkbox"/> <i>Unknown</i> <input type="checkbox"/> <i>Declined to answer</i>

Measures

Baseline Scores (at intake)	<ul style="list-style-type: none"> ● <i>CSSRS: 0 (6/23/2024, 3:28 PM)</i> ● <i>GAD7: 18 (6/23/2024, 3:28 PM)</i> ● <i>CAGE-AID: 0 (6/23/2024, 3:28 PM)</i> ● <i>PHQ9: 1 (6/23/2024, 3:28 PM)</i>
Based on the clinical measure:	<i>Discussed increased severity, Established baseline level of functioning to assess for treatment progress</i>

I reviewed measures for this session:	Yes
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History of Present Illness

Presenting problems/chief complaint: Identify why the client is seeking treatment at this time, including <u>onset</u> , <u>duration</u> and <u>severity</u> of symptoms. You may include direct quotes from the client.	<i>Client presents with symptoms of persistent anxiety, excessive worry, and physical tension that interfere with work and interpersonal relationships. Client reports experiencing “constant worry about something bad happening,” noting onset during childhood with significant exacerbation over the past 12 months. Severity currently rated 8/10.</i>
Current Symptoms	<i>Racing thoughts, irritability, restlessness, difficulty sleeping, fatigue, impaired concentration, and uncontrollable worry occurring daily for most of the day.</i>
Area(s) of functional impairment	<i>Work, Social/Relational</i>
How are symptoms specifically impacting clients functioning in this area?	<i>Decreased productivity and concentration at work resulting in missed deadlines and corrective feedback. Anxiety-related insomnia contributes to daytime fatigue. Reports withdrawal and conflict with partner due to irritability and emotional shutdown.</i>
History of mental health treatment/substance use treatment	<i>Brief college counseling for anxiety; no psychiatric medication.</i>
Family history of mental health/substance use (including treatment, if any)	<i>Alcohol use disorder (maternal/paternal grandfathers) and suspected anxiety in immediate family.</i>

Psychosocial

Highest level of education	<input type="checkbox"/> <i>Current Student (ie grade school or high school)</i> <input type="checkbox"/> <i>Less than High School</i> <input type="checkbox"/> <i>High school/GED</i> <input type="checkbox"/> <i>Some college</i> <input checked="" type="checkbox"/> <i>College Graduate</i> <input type="checkbox"/> <i>Post-Grad</i> <input type="checkbox"/> <i>Client has an AS degree</i> <input type="checkbox"/> <i>Vocational college</i>
Current employment status	<input checked="" type="checkbox"/> <i>Employed full time (>35 hours/week)</i> <input type="checkbox"/> <i>Employed Part time</i>

	<input type="checkbox"/> Unemployed <input type="checkbox"/> Student <input type="checkbox"/> Homemaker <input type="checkbox"/> Military <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Self Employed
Name of Employer or School	<i>Lead Data Analyst at XYZ, Inc.</i>
Military involvement	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, describe (free text)
Social Concerns (educational, employment, legal, financial, other)	<i>Reports high occupational stress and financial anxiety; limited social supports; denies legal concerns.</i>
Interpersonal/family information	<i>Supportive relationship with sister; strained with parents due to gender identity.</i>
Current living situation (e.g. alone, with family, with partner)	<i>Cohabits with partner of 3.5 years.</i>
Cultural considerations for treatment How do the client's cultural or other identities impact their perceptions and understanding of their symptoms, help-seeking behavior and engagement with mental health service providers? <i>N/A or None is not an appropriate response.</i>	<i>Identifies as queer, non-binary, reports discrimination related to gender expression. Family's cultural background discourages mental health treatment, contributing to shame and avoidance.</i>
Trauma or Abuse History	<input type="checkbox"/> None reported <input checked="" type="checkbox"/> Yes, as follows: <i>Ct has experienced discrimination due to their gender expression.</i>
Client Strengths	<i>Reliable, compassionate, motivated to learn healthier ways to manage anxiety. Demonstrates insight and engagement.</i>

Substance Use

Current Substance Use	<i>Alcohol</i>
Frequency of use	<i>Weekly</i>
Date of last use	<i>Last Sunday</i>

Age of first use	15
Details of current substance use	1 bottle of wine or 6–8 beers on weekends; denies weekday use. Uses alcohol to decompress; denies withdrawal. Motivation to change: Contemplative.
Previous substance use	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, as follows:
Describe client’s substance use history	<input type="checkbox"/> es <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A

Health History

Health history and/or current medical conditions:	<input checked="" type="checkbox"/> None <input type="checkbox"/> Yes, as described:
Current medications:	<input type="checkbox"/> None <input checked="" type="checkbox"/> Yes, as described: Birth Control
Primary Care Physician	<input type="checkbox"/> None <input checked="" type="checkbox"/> Yes, as follows: Dr. Sample Name at 123 Mainstreet Care, City, State
Psychiatrist/NP	<input checked="" type="checkbox"/> None <input type="checkbox"/> Yes, as follows:

MSE (Mental Status Exam)

Affect	<input type="checkbox"/> Angry <input checked="" type="checkbox"/> Alert <input checked="" type="checkbox"/> Appropriate <input type="checkbox"/> Excitable <input type="checkbox"/> Flat <input type="checkbox"/> Inappropriate <input type="checkbox"/> Labile <input type="checkbox"/> Sad <input type="checkbox"/> Constricted <input type="checkbox"/> limited
Mood	<input type="checkbox"/> agitated <input type="checkbox"/> Angry

	<input checked="" type="checkbox"/> <i>Anxious</i> <input type="checkbox"/> <i>Apathetic</i> <input type="checkbox"/> <i>Calm</i> <input type="checkbox"/> <i>Depressed</i> <input type="checkbox"/> <i>Euthymic</i> <input type="checkbox"/> <i>Excitable</i> <input type="checkbox"/> <i>Frustrated</i> <input type="checkbox"/> <i>Happy</i> <input type="checkbox"/> <i>Impulsive</i> <input type="checkbox"/> <i>Introspective</i> <input type="checkbox"/> <i>Irritated</i> <input type="checkbox"/> <i>Peaceful</i> <input type="checkbox"/> <i>Pensive</i> <input type="checkbox"/> <i>perplexed</i> <input type="checkbox"/> <i>Sad</i> <input type="checkbox"/> <i>tearful</i>
Orientation to Time, Place, and Person	<input checked="" type="checkbox"/> <i>Within Normal Limits</i> <input type="checkbox"/> <i>Disoriented- Person</i> <input type="checkbox"/> <i>Disoriented- Situation</i> <input type="checkbox"/> <i>Disoriented- Place</i> <input type="checkbox"/> <i>Disoriented- Time</i>
Recent Memory	<input checked="" type="checkbox"/> <i>Within normal limits</i> <input type="checkbox"/> <i>Immediate</i> <input type="checkbox"/> <i>Impaired</i> <input type="checkbox"/> <i>Intact</i> <input type="checkbox"/> <i>Poor</i> <input type="checkbox"/> <i>Selective</i> <input type="checkbox"/> <i>brain fog</i>
Remote Memory	<input checked="" type="checkbox"/> <i>Within normal limits</i> <input type="checkbox"/> <i>Impaired</i> <input type="checkbox"/> <i>Intact</i> <input type="checkbox"/> <i>Poor</i> <input type="checkbox"/> <i>selective</i>
Intellect	<input checked="" type="checkbox"/> <i>Average</i> <input type="checkbox"/> <i>Above</i> <input type="checkbox"/> <i>Below</i>
Attention Span and Concentration	<input type="checkbox"/> <i>Within normal limits</i> <input checked="" type="checkbox"/> <i>Attentive</i> <input type="checkbox"/> <i>Alert</i>

	<input type="checkbox"/> <i>Confused</i> <input type="checkbox"/> <i>Distracted</i> <input type="checkbox"/> <i>Impaired</i> <input type="checkbox"/> <i>Intact</i> <input type="checkbox"/> <i>Lethargic</i> <input type="checkbox"/> <i>Poor</i>
Grooming and Appearance	<input checked="" type="checkbox"/> <i>Well-groomed</i> <input type="checkbox"/> <i>Careless</i> <input type="checkbox"/> <i>Disheveled</i> <input type="checkbox"/> <i>neatly dressed</i> <input type="checkbox"/> <i>poor hygiene</i> <input type="checkbox"/> <i>Not available</i>
Behavior	<input checked="" type="checkbox"/> <i>appropriate to situation</i> <input type="checkbox"/> <i>inappropriate to situation</i>
Hallucinations	<input checked="" type="checkbox"/> <i>None</i> <input type="checkbox"/> <i>Present, describe</i>
Delusions	<input checked="" type="checkbox"/> <i>None</i> <input type="checkbox"/> <i>Present, describe</i>
Obsessions	<input checked="" type="checkbox"/> <i>None</i> <input type="checkbox"/> <i>Present, describe</i>
Thought Processes	<input checked="" type="checkbox"/> <i>clear, linear, logical</i> <input type="checkbox"/> <i>Disorganized</i> <input type="checkbox"/> <i>Illogical</i> <input type="checkbox"/> <i>Irrelevant</i> <input type="checkbox"/> <i>Perseverating</i> <input type="checkbox"/> <i>Relevant</i> <input type="checkbox"/> <i>Scattered</i> <input type="checkbox"/> <i>Blocked</i> <input type="checkbox"/> <i>tangential</i>
Speech	<input checked="" type="checkbox"/> <i>Normal Rate & Volume</i> <input type="checkbox"/> <i>Mute</i> <input type="checkbox"/> <i>paucity of speech</i> <input type="checkbox"/> <i>Pressured</i> <input type="checkbox"/> <i>Rate-fast</i> <input type="checkbox"/> <i>Rate-slow</i> <input type="checkbox"/> <i>Slurred</i> <input type="checkbox"/> <i>Volume-loud</i>

	<input type="checkbox"/> volume- quiet
Motor	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Excessive <input type="checkbox"/> Slow <input type="checkbox"/> Not available
Impulse control	<input checked="" type="checkbox"/> Adequate <input type="checkbox"/> Impaired (describe):
Insight	<input checked="" type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Limited <input type="checkbox"/> absent
Judgment	<input checked="" type="checkbox"/> Within Normal Limits <input type="checkbox"/> Impaired- minimal <input type="checkbox"/> Impaired - moderate <input type="checkbox"/> Impaired - severe
Comments on MSE (optional)	

Clinical Summary

<p>Provide a summary of your assessment, including <u>details to justify the initial diagnosis</u> for the client. Include ways in which the client’s mental health symptoms are impairing their functioning in one or more areas of their life and why treatment is needed at this time. This section is reserved for your professional opinion and not meant to be a copy/paste of the client's presenting problem section.</p>	<p><i>Client meets DSM-5 criteria for Generalized Anxiety Disorder (F41.1), evidenced by persistent, excessive worry and difficulty controlling anxiety for over 6 months. Symptoms cause clinically significant impairment in occupational (missed deadlines and corrective feedback due to decreased productivity and concentration) and interpersonal (withdrawal and conflict with partner) functioning. Baseline GAD-7 score of 18 indicates severely elevated anxiety symptoms. No current risk of harm to self or others. Outpatient psychotherapy is medically necessary to reduce anxiety symptoms, restore occupational and relational functioning, and improve coping. Plan: Weekly CBT-based therapy focusing on cognitive restructuring, emotion-regulation, and coping-skills training. Explore alcohol use as a potential maladaptive coping mechanism and consider integrated treatment or referral if indicated. Review progress at session 8; anticipated duration 12–16 weeks.</i></p>
Diagnosis	<i>F41.1 Generalized Anxiety Disorder</i>
Date of service	<i>06/24/2024</i>
Session start time	<i>11:00am</i>

Session end time	12:10pm
Do you think your client would benefit from a psychiatric evaluation?:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Signature

Provider Name	Jane Example
Date	6/24/2024
Time	3:00pm
License Type	LCSW

Risk Assessment

Columbia Suicide Severity Rating Scale (C-SSRS) (Optional)

1. In the last 30 days, Have you wished you were dead or wished you could go to sleep and not wake up?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2. In the last 30 days, Have you actually had any thoughts of killing yourself?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

If the client answered "Yes" to #2, ask the additional questions below:

3. Have you been thinking about how you might do this?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you had these thoughts and had some intention on acting on them?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you started to work out, or worked out the details of how to kill yourself? Do you intend to carry out this plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you ever done anything, started to do anything, or prepared to do anything to end your life?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

	<p>6.a In your Lifetime?</p> <p><input type="checkbox"/> Yes</p> <p><input checked="" type="checkbox"/> No</p> <p>6.b In the past 3 months?</p> <p><input type="checkbox"/> Yes</p> <p><input checked="" type="checkbox"/> No</p>
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Columbia Suicidality Scale Rating:

All No = No Risk Reported

Yes on question 1 or 2 = Low Risk

Yes on Questions 3 or 6a = Moderate Risk

Yes on Questions 4 or 5 or 6b = High Risk

Risk to self

Prior suicidal ideations and/or suicide attempts:	<p><input checked="" type="checkbox"/> No/denies</p> <p><input type="checkbox"/> Yes, as follows:</p>
Current suicidal ideation:	<p><input checked="" type="checkbox"/> No</p> <p><input type="checkbox"/> Occasional/Fleeting</p> <p><input type="checkbox"/> More than half the time</p> <p><input type="checkbox"/> Constant</p>
Current suicidal intent:	<p><input checked="" type="checkbox"/> No/denies</p> <p><input type="checkbox"/> Yes, as follows:</p>
Current suicidal plan:	<p><input checked="" type="checkbox"/> No/denies</p> <p><input type="checkbox"/> Yes, as follows:</p>
Access to means:	<p><input type="checkbox"/> No/denies</p> <p><input checked="" type="checkbox"/> Yes, as follows: Client and partner have one firearm in their apartment that they maintain protection. Firearm is in a lock box.</p>
Self-harm behaviors:	<p><input checked="" type="checkbox"/> No/denies</p> <p><input type="checkbox"/> Yes, as follows:</p>
Comments on risk to self	

Risk to others

Prior physical aggression / destruction of property / other risk to others	<input checked="" type="checkbox"/> <i>No/denies</i> <input type="checkbox"/> <i>Yes, as follows:</i>
Current physical aggression/destruction of property/other risk to others	<input checked="" type="checkbox"/> <i>No/denies</i> <input type="checkbox"/> <i>Yes, as follows:</i>
Current homicidal ideation	<input checked="" type="checkbox"/> <i>No/denies</i> <input type="checkbox"/> <i>Yes, as follows:</i>
Access to weapons	<input type="checkbox"/> <i>No/denies</i> <input checked="" type="checkbox"/> <i>Yes, as follows: Client and partner have one firearm in their apartment that they maintain for protection. Firearm is in a lock box.</i>
Commentary on risk to others	
Rating of overall risk to self / others	<input checked="" type="checkbox"/> <i>None Reported</i> <input type="checkbox"/> <i>Low/mild</i> <input type="checkbox"/> <i>Moderate Risk</i> <input type="checkbox"/> <i>High Risk</i>
Reason/explanation for rating	

Complete the Safety Plan template note for any client with moderate or high risk, and as clinically indicated.