



SAMPLE CLINICAL DOCUMENTATION

Initial Assessment - Child / Adolescent

A parent must be present for the initial assessment for children ages 5-12 and it is recommended a parent/guardian attend for adolescents aged 13-17.

Info

Service Provided	<i>Initial Assessment - Individual</i>
Present at session	<i>Client, Mother of 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 type="checkbox"/> <i>Hispanic</i> <input checked="" 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 checked="" type="checkbox"/> <i>No</i> <input 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 checked="" type="checkbox"/> <i>Female</i> <input type="checkbox"/> <i>Male</i> <input 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 checked="" type="checkbox"/> <i>She/Her</i> <input type="checkbox"/> <i>He/Him</i> <input type="checkbox"/> <i>They/Their</i> <input type="checkbox"/> <i>Xe</i> <input type="checkbox"/> <i>If other, please list:</i>
Marital Status	<input checked="" type="checkbox"/> <i>Single/never married</i> <input 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 checked="" type="checkbox"/> <i>Pansexual</i> <input 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>PHQ9-A: 20 (11/04/2025, 2:34 AM)</i> ● <i>GAD7: 11 (11/04/2025, 2:33 AM)</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
----------------------------------------------	-----

Child / Adolescent Assessment

I reviewed and obtained verbal assent from the minor	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
I reviewed and obtained verbal agreement to respect privacy from the parent/guardian	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Parent, legal guardian names(s)	<i>Sample Name, mother of client (MOC)</i>
Are there any custody arrangements or court orders related to mental health treatment to be shared? Note: It is the responsibility of the consenting parent/guardian to ensure that custody arrangements or court orders are provided and followed for the minor in treatment	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, describe:
Any prenatal or perinatal exposure to toxins/drugs?	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input checked="" type="checkbox"/> Yes, details: <i>Maternal binge alcohol use during early pregnancy; abstinent by 4th month; infant healthy at birth.</i>
Did the child meet developmental milestones?	<input type="checkbox"/> Early <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Late <input type="checkbox"/> Unknown
Adopted?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes, at what age?
Parent's marital status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> Cohabiting <input type="checkbox"/> Separated <input type="checkbox"/> Widowed

If divorced, how old was the child at the time of divorce?	N/A
Describe the child's relationship with each parent:	<i>Strong/close with MOC; mildly more distant recently (developmentally typical); supported via active listening and shared activities.</i>
Relationships with siblings (describe):	<input checked="" type="checkbox"/> N/A <input type="checkbox"/> Describe:
Relationships with peers (describe):	<i>Limited; 1 close friend. History of teasing re: body size and race in predominately white neighborhood</i>
Activities/hobbies:	<i>Videogames, Youtube, Tiktok</i>
Sexual behavior history:	<i>Identifies as pansexual; previously one non-binary partner. Declined details in presence of parent.</i>
Sleep patterns or habits (describe):	<i>Reports persistent fatigue; sleeps 8–10h nights yet naps at school occasionally; 10–12h on weekends; extended time in bed.</i>
Eating habits (describe):	<i>Eats all meals; drinks 2 energy drinks/day; historical restriction due to teasing—denies current restriction.</i>
Does the child have an IEP for special education services?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes, describe <input type="checkbox"/>
Is there a history of or current child protective services involvement?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes, describe

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>"I hate feeling like this." Persistent depressed mood, anhedonia, fatigue, and social withdrawal since age 12 with notable worsening over the past 8 months. PHQ-9A = 20 (severe), GAD-7=11 (moderate). Frequency: daily; Duration: most of the day; Severity: 8/10. Functional impact across school, social, and ADLs. Reports passive SI historically; C-SSRS 0/6 today.</i>
Current Symptoms	<i>Persistent depressed mood, anhedonia, fatigue, and social withdrawal</i>

Area(s) of functional impairment	<i>School, Social, ADLs</i>
How are symptoms specifically impacting clients functioning in this area?	<i>School: grade decline, missed work, attention lapses. Social: withdrawal, few peers. ADLs: inconsistent hygiene (bathing 2x/week).</i>
History of mental health treatment/substance use treatment	<i>None</i>
Family history of mental health/substance use (including treatment, if any)	<i>Family history of depression/anxiety; MOC in recovery—AA + weekly therapy; FOC died of overdose.</i>

Psychosocial

Highest level of education	<input checked="" 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 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 type="checkbox"/> <i>Employed full time (>35 hours/week)</i> <input type="checkbox"/> <i>Employed Part time</i> <input type="checkbox"/> <i>Unemployed</i> <input checked="" type="checkbox"/> <i>Student</i> <input type="checkbox"/> <i>Homemaker</i> <input type="checkbox"/> <i>Military</i> <input type="checkbox"/> <i>Retired</i> <input type="checkbox"/> <i>Disabled</i> <input type="checkbox"/> <i>Self Employed</i>
Name of Employer or School	<i>XYZ School</i>
Military involvement	<input checked="" type="checkbox"/> <i>No</i> <input type="checkbox"/> <i>Yes, describe (free text)</i>
Social Concerns (educational, employment, legal, financial, other)	<i>Limited social supports; college worry due to GPA; ADLs limited.</i>
Interpersonal/family information	<i>FOC is deceased; no siblings.</i>

Current living situation (e.g. alone, with family, with partner)	<i>Resides with MOC; safe home; no weapons.</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>Bi-racial, goth-identified, pansexual; experiences of bullying/exclusion. Values shared identity with clinician; online communities (Discord) are salient supports.</i>
Trauma or Abuse History	<input type="checkbox"/> <i>None reported</i> <input checked="" type="checkbox"/> <i>Yes, as follows: Father's overdose death prior to birth identified as ACE; chronic stressors of bullying.</i>
Client Strengths	<i>Expressive, artistic, warm; motivated for treatment.</i>

Substance Use

Current Substance Use	<i>None</i>
Frequency of use	<i>N/A</i>
Date of last use	<i>N/A</i>
Age of first use	<i>N/A</i>
Details of current substance use	<i>N/A</i>
Previous substance use	<input checked="" type="checkbox"/> <i>No</i> <input type="checkbox"/> <i>Yes, as follows:</i>

Health History

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

Psychiatrist/NP	<input checked="" type="checkbox"/> <i>None</i> <input type="checkbox"/> <i>Yes, as follows:</i>
-----------------	-----------------------------------------------------------------------------------------------------

Risk Assessment

Columbia Suicide Severity Rating Scale (C-SSRS)

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"/> <i>Yes</i> <input checked="" type="checkbox"/> <i>No</i>
2. In the last 30 days, Have you actually had any thoughts of killing yourself?	<input type="checkbox"/> <i>Yes</i> <input checked="" type="checkbox"/> <i>No</i>

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"/> <i>Yes</i> <input checked="" type="checkbox"/> <i>No</i>
4. Have you had these thoughts and had some intention on acting on them?	<input type="checkbox"/> <i>Yes</i> <input checked="" type="checkbox"/> <i>No</i>
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"/> <i>Yes</i> <input checked="" type="checkbox"/> <i>No</i>
6. Have you ever done anything, started to do anything, or prepared to do anything to end your life?	<input type="checkbox"/> <i>Yes</i> <input checked="" type="checkbox"/> <i>No</i> 6.a In your Lifetime? <input type="checkbox"/> <i>Yes</i> <input checked="" type="checkbox"/> <i>No</i> 6.b In the past 3 months? <input type="checkbox"/> <i>Yes</i> <input checked="" type="checkbox"/> <i>No</i>

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:	<i>No reports of prior suicide attempts. Endorses passive/fleeting hx of suicidal ideation with no plans or intent. Last reported presence of SI approximately 3 months ago</i>
Current suicidal ideation:	<i>No current SI per client</i>
Current suicidal intent:	<i>None</i>
Current suicidal plan:	<i>None</i>
Access to means:	<input checked="" type="checkbox"/> <i>No/denies</i> <input type="checkbox"/> <i>Yes, as follows</i>
Self-harm behaviors:	<input checked="" type="checkbox"/> <i>No/denies</i> <input type="checkbox"/> <i>Yes, as follows:</i>
Comments on risk to self	<i>Minimal presence of risk to self concerns; fleeting passing SI present without plan or intent. To be monitored and initiate safety plan if SI ideation increases and/or evidence of evolving plan or intent</i>

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 checked="" type="checkbox"/> <i>No/denies</i> <input type="checkbox"/> <i>Yes, as follows</i>
Commentary on risk to others	<i>N/A</i>

Rating of overall risk to self / others	<input type="checkbox"/> <i>None Reported</i> <input checked="" type="checkbox"/> <i>Low/mild</i> <input type="checkbox"/> <i>Moderate Risk</i> <input type="checkbox"/> <i>High Risk</i>
Reason/explanation for rating	<i>No reported risk to others. Fleeting passive SI without plan/intent; protective factors include supportive parent, treatment engagement, future goals.</i>

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

MSE (Mental Status Exam)

Affect	<input type="checkbox"/> <i>Angry</i> <input type="checkbox"/> <i>Alert</i> <input type="checkbox"/> <i>Appropriate</i> <input type="checkbox"/> <i>Excitable</i> <input type="checkbox"/> <i>Flat</i> <input type="checkbox"/> <i>Inappropriate</i> <input type="checkbox"/> <i>Labile</i> <input type="checkbox"/> <i>Sad</i> <input checked="" type="checkbox"/> <i>Constricted</i> <input type="checkbox"/> <i>limited</i>
Mood	<input type="checkbox"/> <i>agitated</i> <input type="checkbox"/> <i>Angry</i> <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 checked="" 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 checked="" type="checkbox"/> <i>Within normal limits</i> <input 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"/> <i>volume- quiet</i>
Motor	<input checked="" type="checkbox"/> <i>Normal</i> <input type="checkbox"/> <i>Excessive</i> <input type="checkbox"/> <i>Slow</i> <input type="checkbox"/> <i>Not available</i>
Impulse control	<input checked="" type="checkbox"/> <i>Adequate</i> <input type="checkbox"/> <i>Impaired (describe):</i>
Insight	<input checked="" type="checkbox"/> <i>Good</i> <input type="checkbox"/> <i>Fair</i> <input type="checkbox"/> <i>Poor</i> <input type="checkbox"/> <i>Limited</i> <input type="checkbox"/> <i>absent</i>
Judgment	<input checked="" type="checkbox"/> <i>Within Normal Limits</i> <input type="checkbox"/> <i>Impaired- minimal</i>

	<input type="checkbox"/> Impaired - moderate <input type="checkbox"/> Impaired - severe
Comments on MSE (optional)	

Clinical Summary

<p>Provide a summary of your assessment, including details to justify the initial diagnosis 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 Major Depressive Disorder, recurrent, severe (F33.2). Symptoms occur daily with significant impairment in school (academic decline, in-class napping), social relationships (withdrawal), and ADLs (infrequent bathing). Baseline PHQ-9=22 supports severity. Outpatient psychotherapy is medically necessary to reduce depressive symptoms, improve daily functioning, and prevent further decline in academic and social domains. Plan: Weekly CBT with behavioral activation, sleep hygiene training, and family involvement for symptom monitoring; coordinate with PCP to evaluate fatigue (rule out sleep apnea or iron deficiency). Duration: 12 weeks, to be reviewed at session 6.</i></p>
Diagnosis	<i>F33.2 Major Depressive Disorder, recurrent, severe F41.9 Unspecified Anxiety Disorder</i>
Date of service	<i>06/24/2024</i>
Session start time	<i>11:00am</i>
Session end time	<i>12:05pm</i>

Signature

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