SAMPLE CLINICAL DOCUMENTATION

Initial Assessment - Couples

Info

Service Provided	*Initial Assessment - Couples*
Present at session	*Primary client and Partner*
Location of service	☑ *Telehealth* ☐ *Office (in person)*
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.	☑ *Yes – client at home* ☐ *Yes – client in another location, which has been confirmed* ☐ *No*
Client is appropriate for Telehealth	☑ *Yes* ☐ *No* ☐ *N/A*

Demographics

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

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

Measures

Baseline Scores (at intake)	• *CSSRS: 0 (3/23/2024, 3:28 PM)* • *GAD7: 17 (3/23/2024, 3:28 PM)* • *CAGE-AID: 0 (3/23/2024, 3:28 PM)* • *PHQ9: 2 (3/23/2024, 3:28 PM)*

Based on the clinical measure:	*Discussed increased severity, Established baseline level of functioning to assess for treatment progress*
I reviewed measures for this session:	*Yes*

Couples Assessment

Identify why the couple is seeking treatment at this time. You may include direct quotes from the couple	*Primary client identifies "everytime after we are intimate, I start to feel panicked, like I'm having a heart attack. I don't understand why this is happening.". This is resulting in client being distant with partner post episodes. Partner identifies feeling "shut out and unsure how to help."*
Length of time in relationship and in what form (e.g., dating, living together, married)?	*Dating 4 years; cohabiting 18 months.*
Does alcohol/ drug use contribute to strain in the relationship?	☑ *None reported* ☐ *Yes, as follows:*
History of any type of abuse within the relationship?	☑ *None reported* ☐ *Yes, as follows:*
Couples strengths	*Hopeful, self-aware, both invested in growth and skills practice.*
Other pertinent info related to the couple	*None*

History of Present Illness

Presenting problems/chief complaint: Identify why the client is seeking treatment at this time, including onset, duration and severity of symptoms. You may include direct quotes from the client.	*Reports near-daily anxiety for 12 months, with 30–60 minute surges after intimacy, characterized by ruminative thinking, sweating, tachycardia, restlessness, and withdrawal. Partner observes shutdown/avoidance and difficulty reconnecting post-episode.*
Current Symptoms	*Ruminative thinking, sweating, tachycardia, restlessness, withdrawal*
Area(s) of functional impairment	*Social/Relational, Work*
How are symptoms specifically impacting clients functioning in this	*Consistent anxiety attacks post intimacy with partner. This is causing client to avoid initiating intimacy with partner due to fears of an anxiety attack.*

area?	*This is causing relational disconnect and increased friction in the relationship. Client additionally notices that worry about his relationship is impacting his focus at work.*
History of mental health treatment/substance use treatment	*No prior treatment.*
Family history of mental health/substance use (including treatment, if any)	*Maternal history of severe anxiety.*

Psychosocial

Highest level of education	☐ *Current Student (ie grade school or high school)* ☐ *Less than High School* ☐ *High school/GED* ☐ *Some college* ☑ *College Graduate* ☐ *Post-Grad* ☐ *Client has an AS degree* ☐ *Vocational college*
Current employment status	☑ *Employed full time (>35 hours/week)* ☐ *Employed Part time* ☐ *Unemployed* ☐ *Student* ☐ *Homemaker* ☐ *Military* ☐ *Retired* ☐ *Disabled* ☐ *Self Employed*
Name of Employer or School	*Marketing department at ABC Company.*
Military involvement	☑ *No* ☐ *Yes, describe (free text)*
Social Concerns (educational, employment, legal, financial, other)	*Relationship stress occasionally impacting work focus.*
Interpersonal/family information	*Supportive relationship with parents; no siblings.*
Current living situation (e.g. alone, with family, with partner)	*Cohabiting with partner; 1 pet cat.*

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? *N/A or None is not an appropriate response.*	*Both white, non-religious. Primary client reports sexuality largely accepted; partner reports past safety concerns in rural hometown.*
Trauma or Abuse History	☑ *None reported* ☐ *Yes, as follows:*
Client Strengths	*Motivated, engaged, insight present; partner collaborative.*

Substance Use

Current Substance Use	*Alcohol*
Frequency of use	*Occasionally*
Date of last use	*Last Saturday*
Age of first use	*17*
Details of current substance use	*Limited alcohol use on weekends in a social manner (drinks with dinner when eating at a restaurant). 1-2 glasses of wine only.*
Previous substance use	☐ *No* ☑ *Yes, as follows: Binge drinking during college (age 18 - 23)*

Health History

Health history and/or current medical conditions:	☑ *None* ☐ *Yes, as described:*
Current medications:	☑ *None* ☐ *Yes, as described:*
Primary Care Physician	☐ *None* ☑ *Yes, as follows: Dr. Sample Name at 123 Mainstreet Care, City, State*
Psychiatrist/NP	☑ *None* ☐ *Yes, as follows:*

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?	☐ *Yes* ☑ *No*
2. In the last 30 days, Have you actually had any thoughts of killing yourself?	☐ *Yes* ☑ *No*

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

3. Have you been thinking about how you might do this?	☐ *Yes* ☑ *No*
4. Have you had these thoughts and had some intention on acting on them?	☐ *Yes* ☑ *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?	☐ *Yes* ☑ *No*
6. Have you ever done anything, started to do anything, or prepared to do anything to end your life?	☐ *Yes* ☑ *No* 6.a In your Lifetime? ☐ *Yes* ☑ *No* 6.b In the past 3 months? ☐ *Yes* ☑ *No*

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:	☑ *No/denies* ☐ *Yes, as follows:*
Current suicidal ideation:	☑ *No*

	☐ *Occasional/Fleeting* ☐ *More than half the time* ☐ *Constant*
Current suicidal intent:	☑ *No/denies* ☐ *Yes, as follows:*
Current suicidal plan:	☑ *No/denies* ☐ *Yes, as follows:*
Access to means:	☑ *No/denies* ☐ *Yes, as follows:*
Self-harm behaviors:	☑ *No/denies* ☐ *Yes, as follows:*
Comments on risk to self	*No hx of SI or self harming behaviors. No evidence of risk to self present*

Risk to others

Prior physical aggression / destruction of property / other risk to others	☑ *No/denies* ☐ *Yes, as follows:*
Current physical aggression/destruction of property/other risk to others	☑ *No/denies* ☐ *Yes, as follows:*
Current homicidal ideation	☑ *No/denies* ☐ *Yes, as follows:*
Access to weapons	☑ *No/denies* ☐ *Yes, as follows.*
Commentary on risk to others	*Client displays no risk issues towards others.*
Rating of overall risk to self / others	☑ *None Reported* ☐ *Low/mild* ☐ *Moderate Risk* ☐ *High Risk*
Reason/explanation for rating	*Denies current or hx of SI/HI/self harming behaviors. No evidence of risk issues at this time.*

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

MSE (Mental Status Exam)

Affect	☐ *Angry* ☐ *Alert* ☑ *Appropriate* ☐ *Excitable* ☐ *Flat* ☐ *Inappropriate* ☐ *Labile* ☐ *Sad* ☐ *Constricted* ☐ *limited*
Mood	☐ *agitated* ☐ *Angry* ☑ *Anxious* ☐ *Apathetic* ☐ *Calm* ☐ *Depressed* ☐ *Euthymic* ☐ *Excitable* ☐ *Frustrated* ☐ *Happy* ☐ *Impulsive* ☐ *Introspective* ☐ *Irritated* ☐ *Peaceful* ☐ *Pensive* ☐ *perplexed* ☐ *Sad* ☐ *tearful*
Orientation to Time, Place, and Person	☑ *Within Normal Limits* ☐ *Disoriented- Person* ☐ *Disoriented- Situation* ☐ *Disoriented- Place* ☐ *Disoriented- Time*
Recent Memory	☑ *Within normal limits* ☐ *Immediate*

	☐ *Impaired* ☐ *Intact* ☐ *Poor* ☐ *Selective* ☐ *brain fog*
Remote Memory	☑ *Within normal limits* ☐ *Impaired* ☐ *Intact* ☐ *Poor* ☐ *selective*
Intellect	☑ *Average* ☐ *Above* ☐ *Below*
Attention Span and Concentration	☑ *Within normal limits* ☐ *Attentive* ☐ *Alert* ☐ *Confused* ☐ *Distracted* ☐ *Impaired* ☐ *Intact* ☐ *Lethargic* ☐ *Poor*
Grooming and Appearance	☑ *Well-groomed* ☐ *Careless* ☐ *Disheveled* ☐ *neatly dressed* ☐ *poor hygiene* ☐ *Not available*
Behavior	☑ *appropriate to situation* ☐ *inappropriate to situation*
Hallucinations	☑ *None* ☐ *Present, describe*
Delusions	☑ *None* ☐ *Present, describe*
Obsessions	☑ *None* ☐ *Present, describe*

Thought Processes	☑ *clear, linear, logical* ☐ *Disorganized* ☐ *Illogical* ☐ *Irrelevant* ☐ *Perseverating* ☐ *Relevant* ☐ *Scattered* ☐ *Blocked* ☐ *tangential*
Speech	☑ *Normal Rate & Volume* ☐ *Mute* ☐ *paucity of speech* ☐ *Pressured* ☐ *Rate-fast* ☐ *Rate-slow* ☐ *Slurred* ☐ *Volume-loud* ☐ *volume- quiet*
Motor	☑ *Normal* ☐ *Excessive* ☐ *Slow* ☐ *Not available*
Impulse control	☑ *Adequate* ☐ *Impaired (describe):*
Insight	☑ *Good* ☐ *Fair* ☐ *Poor* ☐ *Limited* ☐ *absent*
Judgment	☑ *Within Normal Limits* ☐ *Impaired- minimal* ☐ *Impaired - moderate* ☐ *Impaired - severe*
Comments on MSE (optional)	

Clinical Summary

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.	*Primary client meets criteria for Anxiety Disorder, Unspecified (F41.9) due to recurrent, situational anxiety episodes causing clinically significant relational impairment. Differential includes GAD and performance/attachment-related anxiety; continue assessment. Therapy is medically necessary to reduce anxiety-related avoidance and communication breakdowns that impair relational functioning and daily coping. Without intervention, symptoms are likely to persist or worsen. Plan: Weekly couples therapy (CBT, communication training, interoceptive exposure, and attachment-informed interventions) for 12–16 weeks, to be reviewed at session 8.*
Diagnosis	*F41.9 Anxiety Disorder, Unspecified*
Date of service	*06/24/2024*
Session start time	*8:00am*
Session end time	*9:02am*

Signature

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