

Mental Health Evaluation Report

Background Information

Date: _____

Participant's Name: _____

Participant's Social Security Number: _____

Patient's Name: _____ Date of Birth: _____

This Report Is: An Initial Report A Subsequent Report

Therapist's Name: _____ Professional Status: _____

License/Certification Number: _____ State: _____

Date Issued: _____ Expiration Date: _____

Initial Treatment Date: _____

Anticipated Treatment Termination Date: _____

Number of Treatments (Visits) Since Initiation of Treatment: _____

Diagnosis (DSM-IV Diagnostic Code or Provisional Diagnosis): _____

Patient Referred By: _____

Is Treatment A Result of A Court Order? Yes No

History – Symptoms – Plan of Treatment

1. Patient symptoms or episodes:

Past history:

Current symptoms:

2. What symptoms have changed or improved with this patient since you began treatment?

3. Describe the changes in this patient's condition (i.e., coping skills, relationship roles, new capabilities).

4. What do you plan to address in the next treatment period?

5. What is your estimate of the future length of treatment?

6. List current medications and dosage.

7. What makes this patient's continued treatment medically necessary?

I hereby certify that the foregoing statements are correct and complete to the best of my knowledge.

Signature and Degree of Treating Therapist

Date

Important: The information provided in this form is for the purpose of utilization review only. All information is strictly confidential.