

<b>CLIENT INFORMATION</b>	<b>CONFIDENTIAL</b>
---------------------------	---------------------

Client Name: <i>(First &amp; Last)</i> _____		Social Security # or Medi-Cal CIN # _____	Date of Birth _____	Age _____
Client Address _____		Marital Status _____	Client Phone Number _____	
Client Primary Language _____	Client Preferred Language for Treatment _____	Hispanic Origin <i>(Check One)</i> YES NO	Client Ethnicity _____	

**Primary Care Physician Contacted/Consulted:** Yes No **Client Refused** N/A *(please check one)*  
 Name and Phone # of Physician \_\_\_\_\_

**DIAGNOSIS** Use DSM-IV-TR Codes **MUST include ALL Axis**  
 Axis I Primary \_\_\_\_\_ Secondary \_\_\_\_\_ Axis II \_\_\_\_\_  
 Axis III \_\_\_\_\_ Axis IV \_\_\_\_\_  
 Axis V GAF (Current) \_\_\_\_\_ Highest in last 12 months \_\_\_\_\_ Client has been evaluated for Psychiatric medications? YES NO *(Check One)*  
 If Yes, By Whom and When \_\_\_\_\_ Outcome \_\_\_\_\_  
 If No, Why? \_\_\_\_\_ Outcome \_\_\_\_\_

**CURRENT MEDICATIONS: (Include ALL Psychiatric and Medical)**

NAME	CURRENT DOSE	DURATION

<b>Does client need referrals?</b> Yes No If yes, what kind? _____ Have you made the referral? Yes No Can UBH help you with the referral? Yes No Would you like to consult with a UBH clinician? Yes No LCSW/MFT PhD MD Please call 1-800-479-3339	<b>If Client is working with a Case Manager or involved in other programs</b> Who/What Program? _____ Have you had contact with Case Manager / Program? Yes No <i>(Check One)</i> If No, why not _____ If Yes, what was the outcome? _____
---	--

**RELEVANT HISTORY**

Significant Family History: \_\_\_\_\_

Significant Developmental Health History: \_\_\_\_\_

San Diego Regional Center (SDRC) Client : Yes No *(Check One)* If Yes, Name of SDRC Case Manager: \_\_\_\_\_

Significant Mental Health History: \_\_\_\_\_

**Number of Previous Hospitalizations:** \_\_\_\_\_ **Most Recent** \_\_\_\_\_ **Out-Patient Treatment: When** \_\_\_\_\_ **With Whom** \_\_\_\_\_

History of Trauma and/or Abuse \_\_\_\_\_

History of Substance Abuse/Use \_\_\_\_\_ Currently in treatment? Yes No

Education *(highest grade completed)* \_\_\_\_\_  Employment Status *(current)* \_\_\_\_\_

**CURRENT LIVING SITUATION: (Document specific info and check all that apply)**

Alone \_\_\_\_\_ With Family, Whom? \_\_\_\_\_ Board & Care (name) \_\_\_\_\_  
 Independent Living Facility (name) \_\_\_\_\_ Hotel/SRO \_\_\_\_\_  
 Skilled Nursing Facility (name) \_\_\_\_\_ Long Term Care Facility (name) \_\_\_\_\_  
 Homeless: \_\_\_\_\_ How Long? \_\_\_\_\_  
 In Foster Care? Yes No If Yes, w/whom, How Long & Where? \_\_\_\_\_  
 Name of Guardian \_\_\_\_\_ Reunification In Process? Yes No If  
 child/adolescent is family involved? Yes No CPS involvement? Yes No Foster/Adoptive/Biological? *(Check all involved)*

Name of Client: \_\_\_\_\_

**CURRENT TREATMENT:** *(Include all applicable, Substance Abuse, Eating Disorders, Self-Help/Support, etc.)*

**PRESENTING PROBLEM(S) – As described by client**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**CURRENT SYMPTOMS CHECK LIST:** *(Check ALL that apply)*

**Risk Factors:**  Suicidal Ideation: Plan/Intent/Means  History of Attempts  Self-Injurious  Assaultive  Fire Setting  Psychotic  Truancy

**Affect:**  Depressed  Hopeless  Helpless  Guarded  Angry  Anxious  Elated  Marked Mood Changes  Flat  Low Self Esteem

**Thought:**  Distractible  Delusional  Obsessive  Hallucinations  Dissociation  Disorientation  Distortion  Paranoia

**Behavior:**  Sleep Problems  Appetite Problems  Truancy  Threatening  Compulsive  Isolative  Poor Social Skills  Sexual Inappropriateness

**FUNCTIONAL IMPAIRMENTS:** *(Describe how job, school, relationships, daily activities are impacted by symptoms.)*

**TREATMENT GOALS AND METHODS:** *(must be measurable and address symptoms and diagnosis)\*\**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**CLIENT STRENGTHS FOR ACHIEVING GOALS:** *(e.g. family support, involved in faith community, employment, education, independent with Transportation)*

**PROPOSED TREATMENT MODALITIES:** Family and/or collateral parent therapy is required for child and adolescent clients unless contraindicated and explained. For any client, treatment needs to include coordination with the other professionals treating this client.

**CHECK ALL THAT APPLY:** Individual Therapy  Family Therapy with client present  Family Therapy without client present

• Medication Monitoring  Group Psychotherapy  Case Conference  *(describe below)* Case Management  *(describe below)*

**Coordination of Care Description**

Substance Treatment :  Required for effective treatment \*\*  Community Resources/Self Help

**REFERRALS MADE TO** \_\_\_\_\_

**CLIENT ADHERANCE:** Almost Always Sometimes Never

With Medication			
With Treatment/Therapy			
With Recommendations			

**PLEASE HAVE CLIENT SIGN AND DATE  
TREATMENT PLAN BLEOW \*\*\***

Please describe your intervention for non-adherence? \_\_\_\_\_

**DESCRIPTION OF PROGRESS OR LACK OF PROGRESS MADE:** \_\_\_\_\_

**CURRENT REQUEST FOR TREATMENT:** Name of Provider \_\_\_\_\_

Phone number \_\_\_\_\_ Start Date: \_\_\_\_\_ # of Sessions requested \_\_\_\_\_ Anticipated Frequency \_\_\_\_\_

Expected length of treatment \_\_\_\_\_ Treatment Modality CPT code \_\_\_\_\_ Number of Sessions to Date \_\_\_\_\_

Date of first visit \_\_\_\_\_ Date of last visit \_\_\_\_\_

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

\*\*\* I, \_\_\_\_\_ participated in the development of this plan and received a copy

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

**For UBH Disposition Only:**

UBH Clinician: \_\_\_\_\_ Approved # of Sessions: \_\_\_\_\_ CPT Codes Approved \_\_\_\_\_

Authorization Period: Begin Date: \_\_\_\_\_ Previous OTR Received Date: \_\_\_\_\_

Date Reviewed: \_\_\_\_\_ Request Reduced  Request Denied  Date NOA-B Sent \_\_\_\_\_ Logged

Date Authorization Entered and Letter Sent: \_\_\_\_\_ Name of Staff Completing Date Entry \_\_\_\_\_