MEDICAL RECORD – INITIAL EVALUATION

FAMILY LIFE RESOURCE CENTER
273 Newman Ave., Harrisonburg, VA 22801
Phone: 540-434-8450; Fax: 540-433-3805

Client Name: _____Date: _____

ID No: _____DOB: _____Age: _____

Current Symptoms/Mental Status 1—Moderate (Sometimes) **2—Significant** (often enough to be relevant) **3--Severe** (often)

Mood/Affect	**Thought Content**	**Physical/Neurovegetative**	**Behavior**
___Depressed	___Thought disruption	___Low energy/fatigue	___Withdrawn
___Flat/blunted affect	___Low self-esteem	___Sleep disturbance	___Impulsive
___Sadness/grief	___Poor concentration	___Appetite disturbance	___Inapp. sexual behavior
___Hopelessness	___Negative outlook	__Overeating/wt. gain	___Suicidal gestures
___Irritability	___Racing thoughts	__Poor appetite/wt. loss	___Self-injury
___Tearfulness/Crying	___Tangential	___Pressured speech	___Hyperactive
___Overwhelmed	___Hallucinations	___Loss of sexual desire	___Agitated
___Inappropriate guilt	___Delusions	___Anxiety/panic attacks	___Angry
___Worthlessness	___Grandiosity	___Somatic symptoms	___Disruptive
___Helplessness	___Dissociative states	__Heart/Chest discomfort	___Poor judgment
___Persistent Anger	___Rumination	__Respiratory	___Immature
___Anxiety/fearfulness	___Obsessions	__Gastro-intestinal	___Dependent
___Mood Lability	___Compulsions	__Shakiness/tremor	___Histrionic
___Elevated Mood	___Paranoia	__Tension	___Noncompliant
___Other:_____	___Death thoughts	__Headaches	___Aggressive
	___Inattention	___Restlessness	___Temper outburst
	___Distractibility	___Addiction:_____	___Underactive
	___Disoriented	___Other: _____	___Poor self-care
	___Loss/adjustment Issues		___Other:_____
	___Other:_____		

Threat to Self ☐ Yes ☐ No ☐ Ideation ☐ Intent ☐ Plan **Suicide Contract** ☐ Yes ☐ No
Threat to Others ☐ Yes ☐No ☐Ideation ☐Intent ☐ Plan

Duration of Symptoms:

☐ Less than 6 months ☐ 6 -12 months ☐ 12-24 months ☐ More than 24 months.

Medications:

_____
_____

PCP: _____Contacted: ☐ Yes ☐ No

Therapist Signature: _____

Mental Status Exam: *circle applicable items*

Appearance	Well-groomed	Disheveled	Bizarre	Inappropriate	
Orientation	Fully oriented	Disoriented	Time	Place	Person
Self-perception	No impairment	Depersonalization	Derealization		
Attitude	Cooperative	Belligerent	Suspicious	Uncooperative	Guarded
Motor Activity	Calm	Hyperactive	Agitated	Tremors/Tics	Muscle Spasm
Affect	Appropriate	Labile	Expansive	Constricted	Blunted
	Flat				
Speech	Normal	Delayed	Soft	Loud	Slurred
	Excessive	Perseverating	Pressured	Incoherent	
Thought Process	Intact	Circumstantial	Loosening of Association	Tangential	Flight of Ideas

Memory	Intact	Impaired: Immediate Recent Remote			Amnesia: Partial Global N/A		
Abstraction	Proverb Interpretation: Intact Impaired			Concrete	Idiosyncratic		N/A
Judgment	Intact	Impaired: Minimum Moderate Severe					N/A
Insight	Intact	Impaired: Minimum Moderate Severe					N/A
Somatic	Gastrointestinal Disturbance		Headaches	Obesity	Tics	Blackouts	N/A
Neurovegetative Signs of a Biological Depression Exist in:	Poor Self-Esteem	Suicidal Ideation	Low Energy	Anhedonia	Poor Concentration	Disturbance:	Sleep Appetite Libido

Impairment of Functioning	Moderate	Signficant	Severe
Relationships	☐	☐	☐
Work/School	☐	☐	☐
Self-Care/Daily Living	☐	☐	☐
Other:	☐	☐	☐

Diagnostic Impressions:

Axis I: _____ **Axis IV:**_____

Axis II: _____ **Axis V: Current** _____

Axis III: _____ **Highest Past Year:** _____

Furnishing to or review of this document would be injurious to this client's health and well-being. _____ Yes _____ No

Initials: _____ **Date:** _____

Treatment Goals	Target Date	4 month review	8 month review	12 month review	Date Met

Notes regarding progress towards goal:

Treatment Plan:

- ☐ Individual Therapy
- ☐ Family Therapy
- ☐ Group Therapy
- ☐ Referred for Medication Evaluation
- ☐ Referred for Psychological Testing
- ☐ Referral to Other Sources
- ☐ **Plan has been reviewed the client**

Therapist Signature **Date**