

Dr. Kelly S. Johnson
Estuary Healing Arts center
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License #071-005691
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----- **Diagnostic Summary** -----

Client Name:	DOB:	1st Date of Service:
Gender:	Marital Status:	Ct. #:
		E-mail:

CONTACT INFORMATION		
Address:		
Cell Phone:	Work Phone:	Home Phone:
OK to leave message: <input type="checkbox"/> No <input type="checkbox"/> Yes	OK to leave message: <input type="checkbox"/> No <input type="checkbox"/> Yes	OK to leave message: <input type="checkbox"/> No <input type="checkbox"/> Yes
Preferred Phone: Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/>		
Call in Case of Emergency		
Name:		
Phone:	Email:	
Relationship to client:		

CURRENT LIFE SITUATION

Who Referred You?	
Name:	May I contact the referral to thank them? <input type="checkbox"/> Yes <input type="checkbox"/> No
Phone #:	Email:

Living situation
<input type="checkbox"/> alone <input type="checkbox"/> w/ family <input type="checkbox"/> rooming house <input type="checkbox"/> group residence <input type="checkbox"/> foster care <input type="checkbox"/> other:
<i>Household members and ages:</i>

Culture
Race:
Language spoken at home:
Religion/Faith/Spirituality raised in if any:
Religion/Faith/Spirituality currently practice if any:

Social club/organization
<input type="checkbox"/> No <input type="checkbox"/> Yes (<i>description</i>):

Other agencies or providers involved
<input type="checkbox"/> None <input type="checkbox"/> Yes (<i>description</i>):

Developmental History (<i>birth, walking, talking, toilet training, etc.</i>)
<input type="checkbox"/> None <input type="checkbox"/> Yes (<i>description</i>):

Education
Highest grade completed (K-12) or college/university (U1-U8):
<input type="checkbox"/> None <input type="checkbox"/> The following was reported:
Learning Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes (<i>explain</i>):
Additional Education <input type="checkbox"/> No <input type="checkbox"/> Yes (<i>explain</i>):



Further comments on above No Yes (explain):

Legal Issues
 None Yes (description):

Vocational (Job/Career training and/or work experience)
 None Yes (description):

Military Service
 None Yes (description):

RELEVANT MEDICAL HISTORY

PCP Name:
 Address:
 Phone: Fax: Zip:

Illnesses and Allergies
 None reported the following was reported

Type of Illness or Allergy	Date or Age of Onset	Medications	Relevant Information	Severity

Mental Health History

Psychiatrist Name:
 Address:
 Phone: Fax: Zip:

Current Psychiatric Medication/s
 None reported the following was reported

Medication	Dosage	Prescriber	Date Started	Side Effects

Previous Psychiatric Hospitalizations, Individual and/or Group Treatment – if any, or cite NONE
 None reported the following was reported

Dates or Age	Therapist or Hospital	Type of TX	Reason/Symptoms/Medications	Outcome

Current Presenting Problem

Why client is seeking services:					
Dates or Age of Onset	Symptoms	Behavioral Example of Symptom	Severity mild, moderate, severe, extreme	Duration	Medication

Mental Health History Biological Family	Mother	Father	Sister/s	Brother/s	Grdmother	Grdfather	Aunt/Uncle
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Panic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol/drug abuse (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating D.O. (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar D.O.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mania	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paranoia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning Disability (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Mental Health History Adopted or Foster Family	Mother	Father	Sister/s	Brother/s	Grdmother	Grdfather	Aunt/Uncle
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Panic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol/drug abuse (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating D.O. (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar D.O.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mania	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paranoia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning Disability (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Relevant Family History <i>(Relevant loss/separation, significant illness, traumatic events, domestic violence, substance abuse, abuse/neglect, etc. of parents/care-givers, siblings)</i>	
<input type="checkbox"/> None <input type="checkbox"/> The following was reported	
Date or Age	Description

TRAUMA HISTORY

Physical/Sexual/Emotional Abuse and/or Neglect of Client
 None The following was reported:

Intimate Partner Violence
 None The following was reported:

SUBSTANCE ABUSE HISTORY

None reported The following was reported

Date &/or Age	Type of Substance	Describe (frequency, intensity, duration)	Follow-up or Result

SELF HARM & RISK ASSESSMENT – if relevant, or cite NONE

Past Suicide Attempts (SA) &/or Suicidal Ideation (SI)
 None reported the following was reported

Date &/or Age	Relevant Information	Follow-up or Result

Current Risk Assessment to Self or Others – to discuss with clinician at time of appointment

Suicide	Homicide	Assault	Other:	Safety Plan (*if high risk):
<input type="checkbox"/> High* <input type="checkbox"/> Plan <input type="checkbox"/> Means <input type="checkbox"/> Access <input type="checkbox"/> Intent <input type="checkbox"/> Medium <input type="checkbox"/> Low <input type="checkbox"/> NA <input type="checkbox"/> Safety Plan	<input type="checkbox"/> High* <input type="checkbox"/> Plan <input type="checkbox"/> Means <input type="checkbox"/> Access <input type="checkbox"/> Intent <input type="checkbox"/> Medium <input type="checkbox"/> Low <input type="checkbox"/> NA <input type="checkbox"/> Safety Plan	<input type="checkbox"/> High* <input type="checkbox"/> Plan <input type="checkbox"/> Means <input type="checkbox"/> Access <input type="checkbox"/> Intent <input type="checkbox"/> Medium <input type="checkbox"/> Low <input type="checkbox"/> NA <input type="checkbox"/> Safety Plan	<input type="checkbox"/> High* <input type="checkbox"/> Plan <input type="checkbox"/> Means <input type="checkbox"/> Access <input type="checkbox"/> Intent <input type="checkbox"/> Medium <input type="checkbox"/> Low <input type="checkbox"/> NA <input type="checkbox"/> Safety Plan	
Frequency, Intensity, Duration:				

Other (relevant information not contained in previous sections, or additional information/elaboration)
 None reported. The following is relevant

For therapist to complete
DIAGNOSTIC FORMULATION

Identifying information

Reason client is seeking services

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Relevant Mental Status

Symptoms

Barriers to Tx (<i>T and Z Codes or bio-psych-social-stressors and their impact on symptoms/functioning</i>)

Community resources recommended or involved

Summary of mental health issues, hospitalizations, TX and any relevant medical issues (<i>particularly if extensive and/or within the last year</i>)

Client's Strengths

DIAGNOSIS					
Mental Health Diagnosis	ICD 10	Severity	Bio/Psycho/Social Stressors or T and Z Codes	ICD 10	Severity
Primary:					
Secondary:					
Tertiary:					

TX Strategies

Signature: _____ **Licensure:** _____ **Date:** _____