Dr. Kelly S. Johnson
Estuary Healing Arts center
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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: ❑ No ❑ Yes	**OK to leave message:** ❑ No ❑ Yes	**OK to leave message:** ❑ No ❑ Yes
Preferred Phone: Home ❑ Work ❑ Cell ❑		
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?** ❑ Yes ❑ No
Phone #:	**Email:**

Living situation

❑ alone ❑ w/ family ❑ rooming house ❑ group residence ❑ foster care ❑ other:

Household members and ages:

Culture

Race:

Language spoken at home:

Religion/Faith/Spirituality raised in if any:

Religion/Faith/Spirituality currently practice if any:

Social club/organization

❑ No ❑ Yes (*description)*:

Other agencies or providers involved

❑ None ❑ Yes (*description)*:

Developmental History *(birth, walking, talking, toilet training, etc.)*

❑ None ❑ Yes (*description)*:

Education

Highest grade completed (K-12) or college/university (U1-U8):

❑ None ❑ The following was reported:

Learning Disabilities ❑ No ❑ Yes (*explain)*:

Additional Education ❑ No ❑ Yes (*explain)*:

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)*:

RELEVENT MEDICAL HISTORY

PCP Name:
Address:
Zip:
Phone: **Fax:**

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:
Zip:
Phone: **Fax:**

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	❑	❑	❑	❑	❑	❑	❑
Anxiety	❑	❑	❑	❑	❑	❑	❑
Panic	❑	❑	❑	❑	❑	❑	❑
Alcohol/drug abuse (specify):	❑	❑	❑	❑	❑	❑	❑
Eating D.O. (specify):	❑	❑	❑	❑	❑	❑	❑
Bipolar D.O.	❑	❑	❑	❑	❑	❑	❑
Mania	❑	❑	❑	❑	❑	❑	❑
Schizophrenia	❑	❑	❑	❑	❑	❑	❑
Paranoia	❑	❑	❑	❑	❑	❑	❑
Learning Disability (specify):	❑	❑	❑	❑	❑	❑	❑
ADHD	❑	❑	❑	❑	❑	❑	❑
Other:	❑	❑	❑	❑	❑	❑	❑

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

Other Relevant Family History (*Relevant loss/separation, significant illness, traumatic events, domestic violence, substance abuse, abuse/neglect, etc. of parents/care-givers, siblings)*

❑ None ❑ 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):
❑ High*	❑ High*	❑ High*	❑ High*	
❑ Plan	❑ Plan	❑ Plan	❑ Plan	
❑ Means	❑ Means	❑ Means	❑ Means	
❑ Access	❑ Access	❑ Access	❑ Access	
❑ Intent	❑ Intent	❑ Intent	❑ Intent	
❑ Medium	❑ Medium	❑ Medium	❑ Medium	
❑ Low	❑ Low	❑ Low	❑ Low	
❑ NA	❑ NA	❑ NA	❑ NA	
❑ Safety Plan	❑ Safety Plan	❑ Safety Plan	❑ 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

Relevant Mental Status

Symptoms

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

Community resources recommended or involved

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

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:** _____