Halcyon Behavioral
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PSYCHOTHERAPY TREATMENT REPORT

Patient Information

Name: ______________________ Insurance ID: ______________________

Date of Birth: ______________ Sex: □ M □ F Group Coverage Through: ______________________

Treatment Information

Patient First Seen: ______________________ Date of Most Recent Visit: ______________________

Diagnosis: ______________________

Current Symptoms

Symptom				Symptom			
Anxiety	□ Mild	□ Moderate	□ Severe	Mania	□ Mild	□ Moderate	□ Severe
Cognitive Disturbance	□ Mild	□ Moderate	□ Severe	Mood Instability	□ Mild	□ Moderate	□ Severe
Depression	□ Mild	□ Moderate	□ Severe	Obsessions/Compulsions	□ Mild	□ Moderate	□ Severe
Hopelessness	□ Mild	□ Moderate	□ Severe	Panic Attacks	□ Mild	□ Moderate	□ Severe
Hyperactivity	□ Mild	□ Moderate	□ Severe	Psychotic Symptoms	□ Mild	□ Moderate	□ Severe
Inattention	□ Mild	□ Moderate	□ Severe	Restricting/Binging/Purging	□ Mild	□ Moderate	□ Severe
Irritability	□ Mild	□ Moderate	□ Severe	Sleep Disturbance	□ Mild	□ Moderate	□ Severe
Impulsivity	□ Mild	□ Moderate	□ Severe	Weight Change	□ Mild	□ Moderate	□ Severe
Low Energy	□ Mild	□ Moderate	□ Severe	Other			

Current Functional Impairments

Impairment				Impairment			
Family/Relationship	□ Mild	□ Moderate	□ Severe	Physical Health	□ Mild	□ Moderate	□ Severe
Employment/School	□ Mild	□ Moderate	□ Severe	Other ______________			

Current Substance Abuse (SA) *Please Note: Substance - Amount / Use Frequency / Date of Last Use*

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If SA Identified: SA Program: □ Referred □ InProgress □ Completed □ N/A / □ Support Group Attendance / □ Sponsor

Current Risk Assessment: □ No current risk concerns Risk Factor Identified: □ Danger to Self □ Danger to Others

Level: □ Ideation □ Plan □ Intent (□ without means or □ with means) □ Hx DTS/DTO □ Hx Hospitalization

Psychotropic Medication: Prescribed By:______________________ □ PCP □ Psychiatrist □ Other: ____________ Last Seen: _______

Medication(s)/Dose: ____

Coordination of Care

Communication Documented with: □ PCP □ Specialist Physician □ Psychiatrist □ Therapist

Community Referrals made to: ____

Participation/Compliance with Treatment Recommendations

Patient: □ High □ Moderate □ Low* □ None*

Family: □ High □ Moderate □ Low* □ None* N/A

Treatment Progress

Improvement is: □ Major □ Moderate □ Minor* □ None*

*Include in treatment plan below, explanation of how lack of treatment compliance and/or progress is being addressed

Treatment Plan (Goal-oriented resolution of current symptoms, evidence-based techniques, and rationale for continued services):
Include as an attachment any recent survey scores (e.g. PHQ-9, Ham-D 24, BPRS, etc.)

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Visit Frequency: □ Weekly □ Every Other Week □ Monthly □ Other : ____________ Treatment Episode Completion Expected: ____________

My signature below confirms the information provided is accurate and I am providing the requested services