hor_307 Woodland Hills Service Area

**\*\*FORM IS DUE within ONE business day of session\*\***

**Submit via encrypted email to:** [**WH-OutsideMedicalCase-Management@kp.org**](mailto:WH-OutsideMedicalCase-Management@kp.org)

**\*\*Incomplete forms will be returned \*\* No retroactive authorization will be issued\*\***

**INITIAL DIAGNOSTIC INTERVIEW** CPT: 90791

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Name:** |  | Kaiser MRN: |  |
| LENGTH OF SESSION: 60-75 minutes | | Date of Service: |  |

INDIVIDUALS PRESENT:

OTHER SOURCES OF INFORMATION:

CHIEF COMPLAINT(S):

ONSET AND DURATION OF SYMPTOMS:

* HISTORY & PRESENTATION

PSYCHIATRIC HISTORY AND MEDICATIONS (diagnoses, psychotherapy, IP/IOP/PHP, etc.):

Self:

Family:

SOCIAL HISTORY:

Occupation:

Education:

Living situation:

Family of Origin:

Immediate Family:

Social Supports:

Religion:

Exercise habits:

Pets:

Hobbies/Interests:

ALCOHOL AND DRUG USE/HISTORY “How much     are you using?:

*Self:*

ETOH:

THC:

Tobacco:

Caffeine:

Narcotic pain medications:

Street/Club drugs:

*Family*:

* TRAUMA/ABUSE HISTORY:
* CLINICAL SYMPTOMS/HISTORY: Check any that apply, describe further as needed

|  |  |  |
| --- | --- | --- |
| Depressed Mood | Feeling Worthless | Decreased Concentration |
| Sadness | Increased Sleep | Indecisiveness |
| Irritable Mood | Decreased Sleep | Weight Gain |
| Decreased Interest or  Pleasure | Pyschomotor  Agitation | Weight Loss When Not  Dieting |
| Excessive Guilt | Increased Appetite | Decreased energy/fatigue |
| Recurrent Thoughts of  Death | Anhedonia and  Decreased Libido | Periods of High Energy  and/or Impulsive Behavior |
| Feeling Hopeless | Low Self- Esteem | Tearfulness |

Additional symptoms/descriptions:

* BARRIERS TO CARE: cultural, religious, or other barriers to care identified?

* MENTAL STATUS EXAM: Describe

Appearance:

Behavior:

Impairment in Cognition or Memory:

Eye contact:

Speech:

Mood:

Affect:

Stream of thought:

Impulse Control:

Judgment:

Insight:

* FUNCTIONAL STATUS
* Does the patient have a significant impairment in an important area of life functioning?

Mild  Moderate  Severe

In the past 3 months, how impaired has the patient been in the following areas of:

1. Age appropriate self care  Mild  Moderate  Severe

2. Interpersonal Relationships (i.e. friends, peers, etc).  Mild  Moderate  Severe

3. Work/school tasks?  Mild  Moderate  Severe

4. Participation in usual social/community activities?  Mild  Moderate  Severe

* Significant Deterioration: Please describe if there is reasonable probability of significant deterioration in an important area of life functioning.

During the past 2 weeks, how much has the patient had to cut down the amount of time spent on work or other activities as a result of any emotional problems (such as feeling depressed or anxious)?  Mild  Moderate  Severe

* INTERVENTION Provided today (Select what applies):

|  |  |  |
| --- | --- | --- |
| History Gathering | Rapport Building | Emotional Support |
| Initial Education on Solution Focused Therapy to begin clarifying goals and formulate solutions | Initial Education on Improving Stress Management Skills to include developing relaxation skills, improved self-care, developing balance in life | Initial Education on cognitive therapy, emphasizing cognitive restricting to increase adaptive thinking, resiliency and problem solving skills |
| Crisis Intervention | Other |  |

* RISK ASSESSMENT:

Suicidal/harm to self: ideation, plan and intent.

Homicidal/harm to others ideation, plan and intent.

* GENERAL SUMMARY AND CLINICAL IMPRESSION:

* DSM V DIAGNOSIS

Primary:

Secondary:

Notable medical condition impacting mental well-being

* TREATMENT PLAN:

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Length of Session: 45-50 minutes

Provider Name and License:

Provider Email and Phone:

Date: