

# ODS BEHAVIORAL HEALTH TREATMENT PLAN

*Please submit by treatment plan due date*

**Client Name:** \_\_\_\_\_ **Initial Date of Treatment:** \_\_\_\_\_

**Subscriber's ID:** \_\_\_\_\_ **Client DOB:** \_\_\_\_\_ **# Sessions Completed:** \_\_\_\_\_

**List ALL Dates of Service (past 3 months):** \_\_\_\_\_

**Diagnosis: (DSM IV)**

Axis I    .        Axis I    .        Axis II    .

Axis III (Medical) \_\_\_\_\_

Axis IV (Psychosocial stressors) \_\_\_\_\_

Current GAF:        Highest GAF Past Year:

**Current Symptoms:**

Please mark the level that best describes the severity of the **current** symptoms listed below. Mark only one level of severity for each symptom and mark "None" for symptoms that are not present.

	None	Mild	Moderate	Serious	Severe
Suicidal Ideation/Impulses .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homicidal Ideation/Impulses .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prior Attempts to Harm ___Self ___Others .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressed Mood .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite Changes .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disturbed Sleep .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor Concentration .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Isolation/Social Withdrawal .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mania/Hypomania .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Agitation .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Abuse/Dependency .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Abuse/Dependency .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive Thoughts .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tense/Anxious/Worried .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phobias .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Compulsive Behavior .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychosis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___Flashbacks ___Nightmares .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness/Avoidance of trauma triggers .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dissociative Episodes .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conduct Problems .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Authority Conflict Behavior .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self Mutilation .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recent Loss or Failure .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___Assault Episodes ___Domestic Violence .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___Restricting ___Bingeing ___Purging .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Presenting Sympmtoms: \_\_\_\_\_

**Previous Treatment:**

- None                       Outpatient Substance Abuse Program                       Outpatient Psychotherapy
- Self-help                       Inpatient Substance Abuse Program                       Inpatient Psychotherapy
- Psychotropic Medication (If checked, was medication helpful?)                       Yes                       No
- Evaluation by psychiatrist/psychiatric nurse practitioner

**Current Psychotropic Medications:**  No                       Yes If yes, please complete below:

Name	Dosage	Start Date	Prescriber
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If you are not prescribing these medications, are you coordinating care with the prescriber?                       Yes                       No  
 Are you coordinating care with the client's PCP?                       Yes                       No  
 If Yes, With Whom: \_\_\_\_\_

# ODS BEHAVIORAL HEALTH TREATMENT PLAN

*Please submit by treatment plan due date*

**Client Name:** \_\_\_\_\_

**Measures of Symptom Presentation**

(For example: scales, self-ratings, symptom inventory, or outcome questionnaires, etc. which measure frequency/duration of symptoms at outset & current.)

**Baseline Results**  
(At start of treatment)

**Current Results**

1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

**Measurable, Behavioral Goals**

(What are the goals for the symptoms listed above?)

**Progress Since Start of Treatment**

New Goal	No Improvement	Some Improve	Moderately Improved	Much Improved	Goal Met
-------------	-------------------	-----------------	------------------------	------------------	-------------

1. _____		□	□	□	□	□	□
_____	□	□	□	□	□	□	□
_____	□	□	□	□	□	□	□
_____	□	□	□	□	□	□	□
_____	□	□	□	□	□	□	□
_____	□	□	□	□	□	□	□
_____	□	□	□	□	□	□	□
_____	□	□	□	□	□	□	□

**Interventions** Please list the treatment intervention(s) you are utilizing.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Estimated date for completing this episode of treatment:** \_\_\_\_\_ **# of additional visits** \_\_\_\_\_

**Practitioner PRINTED Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**City/State** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Business Email:** \_\_\_\_\_ **Signature:** \_\_\_\_\_