MODA HEALTH TREATMENT PLAN

Please submit prior to 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	☐	☐	☐	☐	☐
Homicidal Ideation/Impulses	☐	☐	☐	☐	☐
Prior Attempts to Harm ___Self ___Others	☐	☐	☐	☐	☐
Depressed Mood	☐	☐	☐	☐	☐
Appetite Changes	☐	☐	☐	☐	☐
Disturbed Sleep	☐	☐	☐	☐	☐
Poor Concentration	☐	☐	☐	☐	☐
Isolation/Social Withdrawal	☐	☐	☐	☐	☐
Mania/Hypomania	☐	☐	☐	☐	☐
Agitation	☐	☐	☐	☐	☐
Alcohol Abuse/Dependency	☐	☐	☐	☐	☐
Drug Abuse/Dependency	☐	☐	☐	☐	☐
Obsessive Thoughts	☐	☐	☐	☐	☐
Tense/Anxious/Worried	☐	☐	☐	☐	☐
Phobias	☐	☐	☐	☐	☐
Compulsive Behavior	☐	☐	☐	☐	☐
Psychosis	☐	☐	☐	☐	☐
__Flashbacks __Nightmares	☐	☐	☐	☐	☐
Numbness/Avoidance of trauma triggers	☐	☐	☐	☐	☐
Dissociative Episodes	☐	☐	☐	☐	☐
Conduct Problems	☐	☐	☐	☐	☐
Authority Conflict Behavior	☐	☐	☐	☐	☐
Self Mutilation	☐	☐	☐	☐	☐
Recent Loss or Failure	☐	☐	☐	☐	☐
__Assault Episodes __Domestic Violence	☐	☐	☐	☐	☐
__Restricting __Bingeing __Purging	☐	☐	☐	☐	☐

Other Presenting Sypmtoms:_____

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:

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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._____						
_____						
_____	☐	☐	☐	☐	☐	☐
2._____						
_____						
_____	☐	☐	☐	☐	☐	☐
3._____						
_____						
_____	☐	☐	☐	☐	☐	☐
4._____						
_____						
_____	☐	☐	☐	☐	☐	☐

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:** _____

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