

# CLIENT TREATMENT REVIEW

TO: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

CLIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

INTAKE DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ DIAGNOSIS: \_\_\_\_\_

## MENTAL HEALTH SERVICES PROVIDED:

\_\_\_\_ Individual      \_\_\_\_ Marital/Couples      \_\_\_\_ Child  
\_\_\_\_ Family      \_\_\_\_ Group      \_\_\_\_ AODA  
\_\_\_\_ Stress/Anger Management      \_\_\_\_ Other: \_\_\_\_\_

## OTHER RESOURCES CONTACTED:

\_\_\_\_ Hospital  
\_\_\_\_ Clinic  
\_\_\_\_ Schools  
\_\_\_\_ Inpatient Program  
\_\_\_\_ Community Organizations

## ASSESSMENT/CONSULTATION:

\_\_\_\_ Psychological Evaluation  
\_\_\_\_ Psychiatric Consultation  
\_\_\_\_ Medication(s) suggested/  
prescribed: \_\_\_\_\_  
\_\_\_\_ AODA Assessment

## PROGRESS:

\_\_\_\_ Outstanding      \_\_\_\_ Less than Expected  
\_\_\_\_ Better than Expected      \_\_\_\_ Unsatisfactory  
\_\_\_\_ As Expected      \_\_\_\_ N/A at this time

LAST CONTACT W/ CLIENT: \_\_\_\_/\_\_\_\_/\_\_\_\_

DATE OF DISCHARGE: \_\_\_\_/\_\_\_\_/\_\_\_\_ REASON FOR DISCHARGE: \_\_\_\_\_

THERAPIST COMMENTS: \_\_\_\_\_

Thank you for your interest and concern regarding this client. Feel free to call me at 643-3663 if you would like to discuss this case.

\_\_\_\_\_  
(Please print Therapist Name)

\_\_\_\_\_  
(Therapist Signature)