Name: Dina Vitoux **Licensure:** LCSW **License #:** **NPI #:**

---------- Diagnostic Summary ----------

Client Name:		**DOB**:		**1st Date of Service**:	
Gender:		**Marital Status:**		**Ct. #**:	**E-mail:**

CONTACT INFORMATION

Address:		
Cell Phone:	**Work Phone:**	**Home Phone:**
OK to leave message: ❑ No ❑ Yes	**OK to leave message:** ❑ No ❑ Yes	**OK to leave message:** ❑ No ❑ Yes
Preferred Phone: Home ❑ Work ❑ Cell ❑		
Call in Case of Emergency		
Name:		
Contact info: Phone:	**Email:**	
Relationship to client:		

CURRENT LIFE SITUATION

Who Referred You?		
Name:		**May I contact the referral to thank them?** ❑ Yes ❑ No
Contact Info	**Phone #:**	**Email:**

Living situation

❑ alone ❑ w/ family ❑ rooming house ❑ group residence ❑ foster care ❑ other:

Household members and ages:

Culture

Race:

Language spoken at home:

Religion/Faith/Spirituality raised in if any:

Religion/Faith/Spirituality currently practice if any:

Social club/organization

❑ No ❑ Yes (*description)*:

Other agencies or providers involved

❑ None ❑ Yes (*description)*:

Developmental History *(birth, walking, talking, toilet training, etc.)*

❑ None ❑ Yes (*description)*:

Education

Highest grade completed (K-12) or college/university (U1-U8)

❑ None ❑ The following was reported:

Learning Disabilities ❑ No ❑ Yes (*explain)*:

Additional Education ❑ No ❑ Yes (*explain)*:

Further comments on above ❑ No ❑ Yes (*explain)*:

Legal Issues

❑ None ❑ Yes (*description)*:

Vocational *(Job/Career training and/or work experience)*	
❑ None ❑ Yes (*description*):	

Military Service	
❑ None ❑ Yes (*description*):	

RELEVENT MEDICAL HISTORY

PCP Name:					
Address:					
City:		State:		**Zip:**	
Phone:		**Fax:**			

Illnesses and Allergies

❑ None reported ❑ the following was reported *(type, severity)*

Type of Illness or Allergy	Date or Age of Onset	Medications	Relevant Information	Severity

Mental Health History

Psychiatrist Name:					
Address:					
City:		State:		**Zip:**	
Phone:		**Fax:**			

Current Psychiatric Medication/s

❑ None reported ❑ the following was reported

Medication	Dosage	Prescriber	Date Started	Side Effects

Previous Psychiatric Hospitalizations or TX

❑ None reported ❑ the following was reported

Dates or Age	Therapist or Hospital	Type of TX	Reason/Symptoms/Medications	Outcome

Current Presenting Problem					
Why client is seeking services:					
Dates or Age of Onset	**Symptoms**	**Behavioral Example of Symptom**	**Severity** mild, moderate, severe, extreme	**Duration**	**Medication**

Biological Family Mental Health History	Mother	Father	Sister/s	Brother/s	Grdmother	Grdfather	Aunt/Uncle
Depression	❑	❑	❑	❑	❑	❑	❑
Anxiety	❑	❑	❑	❑	❑	❑	❑
Panic	❑	❑	❑	❑	❑	❑	❑
Alcohol/drug abuse (specify):	❑	❑	❑	❑	❑	❑	❑
Eating D.O. (specify):	❑	❑	❑	❑	❑	❑	❑
Bipolar D.O.	❑	❑	❑	❑	❑	❑	❑
Mania	❑	❑	❑	❑	❑	❑	❑
Schizophrenia	❑	❑	❑	❑	❑	❑	❑
Paranoia	❑	❑	❑	❑	❑	❑	❑
Learning Disability (specify):	❑	❑	❑	❑	❑	❑	❑
ADHD	❑	❑	❑	❑	❑	❑	❑
Other:	❑	❑	❑	❑	❑	❑	❑

Adopted or Foster Family Mental Health History	Mother	Father	Sister/s	Brother/s	Grdmother	Grdfather	Aunt/Uncle
Depression	❑	❑	❑	❑	❑	❑	❑
Anxiety	❑	❑	❑	❑	❑	❑	❑
Panic	❑	❑	❑	❑	❑	❑	❑
Alcohol/drug abuse (specify):	❑	❑	❑	❑	❑	❑	❑
Eating D.O. (specify):	❑	❑	❑	❑	❑	❑	❑
Bipolar D.O.	❑	❑	❑	❑	❑	❑	❑
Mania	❑	❑	❑	❑	❑	❑	❑
Schizophrenia	❑	❑	❑	❑	❑	❑	❑
Paranoia	❑	❑	❑	❑	❑	❑	❑
Learning Disability	❑	❑	❑	❑	❑	❑	❑
ADHD	❑	❑	❑	❑	❑	❑	❑
Other:	❑	❑	❑	❑	❑	❑	❑

Other Relevant Family History
Relevant loss/separation, significant illness, traumatic events, etc. of parents/care-givers, siblings, domestic violence, abuse or neglect, etc.

❑ None ❑ The following was reported

Date or Age	Description

TRAUMA HISTORY

Physical/Sexual/Emotional Abuse and/or Neglect of Client

❑ None ❑ The following was reported:

Intimate Partner Violence

❑ None ❑ The following was reported:

SUBSTANCE ABUSE HISTORY

❑ None reported ❑ The following was reported

Date &/or Age	Type of Substance	Describe *(frequency, intensity, duration)*	Follow-up or Result

SELF HARM & RISK ASSESSMENT

Past Suicide Attempts (SA) &/or Suicidal Ideation (SI)

❑ None reported ❑ the following was reported

Date &/or Age	Relevant Information	Follow-up or Result

Current Risk Assessment to Self or Others				
Suicide	**Homicide**	**Assault**	**Other**: Binge eating	**Safety Plan** (*if high risk):
❑ High* ❑ Plan ❑ Means ❑ Access ❑ Medium ❑ Low ❑ NA ❑ Safety Plan	❑ High* ❑ Plan ❑ Means ❑ Access ❑ Medium ❑ Low ❑ NA ❑ Safety Plan	❑ High* ❑ Plan ❑ Means ❑ Access ❑ Medium ❑ Low ❑ NA ❑ Safety Plan	❑ High* ❑ Plan ❑ Means ❑ Access ❑ Medium ❑ Low ❑ NA ❑ Safety Plan	
Frequency, Intensity, Duration:				

Other (*relevant information not contained in previous sections, or additional information/elaboration*):

❑ No other relevant information reported. ❑ The following is relevant:

DIAGNOSTIC FORMULATION

Identifying information

Reason client is seeking services

Relevant Mental Status Issues

Symptoms

Barriers to Tx *(T and Z Codes or bio-psych-social-stressors and their impact on symptoms/functioning)*

Community resources recommended or involved

Summary of mental health issues, hospitalizations, TX *(particularly if it's extensive and/or within the last year)*

Client's Strengths

DIAGNOSIS						
Mental Health Diagnosis		**ICD 10**	**Severity**	**T and Z Codes or other bio/psycho/social stressors**	**ICD 10**	**Severity**
Primary:						
Secondary:						
Tertiary:						

TX Strategies

Signature: _____ **Licensure:** LCSW **Date:** _____