



<b>Patient Name:</b>				
<b>Diagnosis</b>				
Axis I:				
Axis II:				
Axis III:				
Axis IV: Psychosocial and Environmental Problems: (check all that apply)				
<input type="checkbox"/> Problems with primary support group (Specify):				
<input type="checkbox"/> Problems related to the social environment (Specify):				
<input type="checkbox"/> Educational problems (Specify):				
<input type="checkbox"/> Occupational problems (Specify):				
<input type="checkbox"/> Economic problems (Specify):				
<input type="checkbox"/> Problems with access to Health Care Services (Specify):				
<input type="checkbox"/> Problems related to interaction with the legal system (Specify):				
<input type="checkbox"/> Other psychosocial and environmental problems (Specify):				
Axis V Diagnosis: CAF _____				
<b>Family Support System:</b>				
Person	Relationship	Description of Support	Treatment Involvement	Support Level
<b>Prescription Medications:</b> (provide current and history)				
Drug Name	Dosage	Diagnosis	Date Started/Discontinued	
<b>Symptoms Requiring Inpatient Care:</b> Court Ordered <input type="checkbox"/> Yes <input type="checkbox"/> No				
Symptom	Date Started	Most Recent Date	Intervention	Effectiveness (For CSR or Retro)

<b>Patient Name:</b>				
<b>Precautions:</b> <input type="checkbox"/> Suicide <input type="checkbox"/> Seclusion <input type="checkbox"/> Elopement <input type="checkbox"/> Other (specify):				
Explain Precautions:				
Chronic Behaviors	Date First Started	Most Recent Date	Intervention	Effectiveness
<b>Describe treatment plan goals and dates of plan changes:</b>				
Goal	Start Date	Frequency	Intervention	Progress/Status
<b>Motivation and Stage of Readiness (describe):</b>				
<b>Service intensity: For CSR provide total interventions since last review. For Retrospective provide all totals.</b>				
MD Visits:	Individual Therapy:	Family Therapy:	Group Therapy:	
Other (specify):				
<b>Date of most recent evaluation by psychiatrist:</b>				
Identify key findings from evaluation:				
<b>Diagnostic Laboratory Test completed (include date and findings):</b>				
Lab Type	Date completed	Findings		

<b>I affirm all information provided is a true and accurate description of the above named individual.</b>	
<b>Signature:</b>	<b>Date:</b>

Complete online at [www.pasrr.com](http://www.pasrr.com)