

Frontier Health and Wellness

Continuity of Care: Therapeutic Services Summary

Client Name: _____ Date of Birth: _____
Date of first appt/intake: _____ Date of most recent appt: _____ Date of Next Appt: _____

Initial Presenting Problem(s):

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> General Anxiety | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Dissociation | <input type="checkbox"/> Suicidal Thoughts |
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Low-Self Esteem | <input type="checkbox"/> Dysthymia | <input type="checkbox"/> Paranoia |
| <input type="checkbox"/> Addiction | <input type="checkbox"/> Social Anxiety | <input type="checkbox"/> Eating Disorder(s) | <input type="checkbox"/> Grief |
| <input type="checkbox"/> Family Discord | <input type="checkbox"/> Attachment Disorder | <input type="checkbox"/> Obsessive Bx or Thoughts | <input type="checkbox"/> PTSD |
| <input type="checkbox"/> Frequent Nightmares | <input type="checkbox"/> Autism | <input type="checkbox"/> Oppositional/Defiant Bx | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Personality Disorder | <input type="checkbox"/> Bipolar | <input type="checkbox"/> Conduct Disorder | <input type="checkbox"/> Hx of Trauma |
| <input type="checkbox"/> Mood Disorder | <input type="checkbox"/> Depression | <input type="checkbox"/> ADHD | <input type="checkbox"/> Hx of Abuse |

Other: _____

Engagement in Therapy: Fully Engaged Fairly Engaged Disengaged Mandated/Required Frequent Refusal

Therapy Goals:

Clients Progress:

Factors that have limited progress:

Interventions:

Client Strengths:

Client Supports:

Any other pieces of information that you feel would be valuable to treatment planning for this client:

Provider Name: _____ Clinic Name: _____ Date: _____

Provider Signature: _____