

Wildflower Mountain Ranch - Provider Clinical Assessment Form

Client Information

Client Name: _____

Date of Birth: _____

Provider Name: _____

License #: _____

Date: _____

Diagnosis

Primary Diagnosis (with ICD-10 Code): _____

Severity: _____

Secondary Diagnoses: _____

As evidenced by: _____

Clinical Presentation

Describe current symptoms, duration, and severity:

Risk Assessment

Suicidal Ideation: None / Passive / Active

History of Attempts: _____

Self-Harm Behaviors: _____

Risk of Running Away: _____

Risk to Others: _____

Most Recent Incident: _____

Functional Impairment

Home Functioning: _____

School Functioning: _____

Emotional Regulation: _____

Treatment History

Previous Levels of Care (Outpatient, IOP, PHP, Residential):

Why were lower levels of care insufficient?

Medical Necessity

Why is the client not safe in a lower level of care?

What risks are present without treatment?

What would likely happen if treatment is delayed?

Recommended Level of Care

Residential / PHP / IOP (circle one)

Clinical justification:

Treatment Goals

1. _____

2. _____

3. _____

Provider Signature

Signature: _____

Date: _____