Frontier Health and Wellness

Client Name:_____ _____

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

Initial Presenting Problem(s):

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

Other:_____

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: _____