

Client Name _____ **SS #** _____

Risk Factors (SI/HI, Domestic Violence, Sexual Abuse) ___Low ___Medium ___High ___No risk

Safety Plan _____

Additional or Contributing Issues

- Academic/Employment Living/Social Situation Health/Medical
 Family/Relationships Financial/Legal Other

Details _____

Psychiatric/Psychological

Current Signs and Symptoms

- 0 = None
 1 = Mild (Impacts quality of life but no significant impairment of day-to-day functioning.)
 2 = Moderate (Significant impact on quality of life and/or day-to-day functioning.)
 3 = Severe (Profound impact on quality of life **AND** day-to-day functioning.)

Depressed Mood	0 1 2 3	Irritability	0 1 2 3	Tangential	0 1 2 3
Appetite Disturbance	0 1 2 3	Anxiety	0 1 2 3	Loose Assoc.	0 1 2 3
Sleep Disturbance	0 1 2 3	Panic Attacks	0 1 2 3	Delusions	0 1 2 3
Low Energy/Fatigue	0 1 2 3	Phobias	0 1 2 3	Hallucinations	0 1 2 3
Psychomotor Retardation	0 1 2 3	OCD	0 1 2 3	Aggressive	0 1 2 3
Poor Concentration	0 1 2 3	Eating Disorder	0 1 2 3	Conduct Dis.	0 1 2 3
Agitation	0 1 2 3	Paranoia	0 1 2 3	ADHD	0 1 2 3
Lability	0 1 2 3	Sex Dysfunction	0 1 2 3	Other _____	

Prior treatment History _____

Substance Abuse/Addiction(s)

Onset _____

Use Pattern _____

Duration & frequency _____

Family Hx _____

Current Use _____

EMPLOYEE RESOURCE SYSTEMS, INC.
2005 CLIENT DATA FORM
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PHONE (866) 377-5550 FAX (312) 780-6344

Client Name _____ **SS #** _____

Date of Session _____ Date of Authorization _____

Clinical Impressions _____ Session # _____

Rationale/Plan for next session

Clinician's Signature _____ Date _____
(Make additional copies as needed.)



Date of Session _____ Date of Authorization _____

Clinical Impressions _____ Session # _____

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FOR ERS USE ONLY ---- CLIENT ID# _____