Horizon
Horizon Casualty Services, Inc.

RESET

Progress and Treatment Status Psychologist/Psychiatrist Report

Horizon Casualty Services, Inc.
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Date of Report: ___/___/____

Patient Name: _____ Claim Number: _____

Date(s) of Office Visit: _____

Case Manager Name: _____ Ext: _____ Fax Number: _____

Description of Work or Auto Accident: (Complete on first date of treatment)	
Causal Relationship: (Complete on first date of treatment)	
Subjective Assessment:	☐ Mood disturbance (depression or mania) ☐ Sleep disturbance ☐ Appetite disturbance ☐ Difficulty concentrating ☐ Energy or activity level change ☐ Interest of socialization change ☐ Libido change ☐ Anxiety ☐ Panic ☐ Cognitive Change ☐ Hallucinations ☐ Delusions ☐ Paranoia ☐ Suicidal thoughts ☐ Homicidal thoughts ☐ Somatic symptoms ☐ Alcohol use ☐ Other chemical use
Objective Assessment/Mental Status:	
Diagnoses/ICD-10:	
Treatment Plan: (Duration and Frequency)	Cognitive Therapy _____ Biofeedback _____
Medications:	
Treatment Goals:	
Progress Report/Treatment Evaluation: (Include Medications)	
Anticipated Length of Treatment:	_____ Day(s) ____ Week(s) _____ Month(s)
Estimated Return to Work Date/Work Status:	_____/_____/_____
Actual Return to Work Date:	_____/_____/_____
Maximum Medical Improvement (MMI) Date:	_____/_____/_____
Next Appointment:	_____/_____/_____
Additional Comments:	

Physician Name: _____
(Please Print)

Physician Signature: _____ **Date:** _____/____/_____