Schizophrenia System Disorder Assessment

PATIENT INFORMATION

Name: _____ Date of Birth: _____ dd / mm / yyyy

Contact Information: _____ Emergency Contact: _____

MEDICAL HISTORY

Previous Diagnoses:

Current Medications:

Allergies:

Substance Use:

SYMPTOM ASSESSMENT

Hallucinations:

Delusions:

Disorganized Thinking:

Negative Symptoms (if applicable):

Cognitive Impairment:

Severity Scale: _____

FUNCTIONAL ASSESSMENT

Daily Living Skills:

Occupational Functioning:

Social Relationships:

Self-Care Abilities:

TREATMENT HISTORY

Past Therapies:

Medication History:

Response to Treatment:

Adherence to Medication:

COLLABORATIVE CARE PLAN

Psychiatrist: _____ Psychologist: _____

Social Worker: _____ Care Coordinator: _____

GOALS AND OBJECTIVES

Symptom Reduction:

Medication Adherence:

Daily Functioning Improvement:

Enhanced Quality of Life:

Community Integration:

INTERVENTION STRATEGIES

Pharmacological Interventions:

Psychoeducation:

Cognitive Behavioral Therapy:

Supportive Counseling:

MONITORING AND EVALUATION

Regular Follow-up Schedule: _____

Outcome Measurement Tools:

Patient Feedback and Input:

Treatment Plan Adjustments:

PATIENT AND FAMILY EDUCATION

Schizophrenia Education:

Coping Strategies:

Crisis Management:

Support Resources:

EMPOWERMENT AND RECOVERY

Strengths-Based Approach:

Goal Setting with the Patient:

Celebrating Progress:

Encouraging Self-Advocacy: