BEHAVIORAL HEALTH

Anxiety follow-up

Blank documentation outlines. Adapt to the encounter and your practice requirements; complete only findings and care actually documented.

ENCOUNTER

Patient name:

Date of birth:

Date and time of encounter:

Clinician:

INTERVAL HISTORY

Changes since the previous visit

Symptoms, triggers and functional impact as reported

Sleep and substance use as reported

Coping strategies used

MEASURES

Screening tool used, score and date

Previous score and date for comparison

Depression screening result if performed

TREATMENT

Medication use as reported, response and adverse effects

Therapy or counseling engagement

ASSESSMENT AND PLAN

Current status and reasoning

Medication decisions and rationale

Therapy referral or coordination

Safety concerns assessed and actions taken

FOLLOW-UP

Follow-up timing and purpose

Return precautions discussed

Patient questions and understanding