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