

PAC SUMMARY FORM

The therapist uses this form to summarize important issues while scanning the completed PAC forms.
This summary can help guide the initial evaluation and diagnostic session(s).

Patient Name: _____ **Date** _____

From Overview of PAC Forms completed by the patient:

Presenting Problems (brief notes): 1. _____
2. _____
3. _____

Axis III Medical Conditions: **No Yes** _____

Current Medications: **No Yes** _____

Axis IV Current Severe Stressors: **No Yes** _____

Axis V Overall Functioning: **Mood** ____ **Social Functioning** ____ **Work/School** ____

Other points to note: _____

Axis I Diagnoses to check further: ****Suicidal Items Checked:** Thoughts __ Plan __ Action __

- | | |
|---|---|
| <input type="checkbox"/> Major Depression
<input type="checkbox"/> Dysthymia
depressive items ____ **

<input type="checkbox"/> Manic
<input type="checkbox"/> Past Manic

<input type="checkbox"/> Delusions
<input type="checkbox"/> Schizophrenia

<input type="checkbox"/> Alcohol Dependence/Abuse
<input type="checkbox"/> Drug Dependence/Abuse | <input type="checkbox"/> Panic Disorder with/without AGR
<input type="checkbox"/> Obsessive/Compulsive
<input type="checkbox"/> Past Major Depression
<input type="checkbox"/> Post-Traumatic Stress Disorder
<input type="checkbox"/> Agoraphobia
anxiety items ____
<input type="checkbox"/> Social Phobia
<input type="checkbox"/> Simple Phobia
<input type="checkbox"/> Generalized Anxiety Disorder
anxiety items ____
<input type="checkbox"/> Somatization/ Hypochondriasis
<input type="checkbox"/> Anorexia
<input type="checkbox"/> Bulimia
<input type="checkbox"/> Attention Deficit Disorder |
|---|---|

Axis II Diagnoses to check further: (Note the number of 'yes' items in each category. The validity of each item answered 'yes' needs to be verified, based on DSM-IV criteria; i.e., Is there evidence of the behavior for 1) Lifetime persistence, 2) Pervasiveness, and. 3) Problematic to the individual.

- | | | |
|---|--|---|
| <p><u>Cluster C (Anxious)</u></p> <input type="checkbox"/> Avoidant
<input type="checkbox"/> Dependent
<input type="checkbox"/> Obsessive Compulsive
<input type="checkbox"/> Negativistic
<input type="checkbox"/> Depressive
<input type="checkbox"/> Self-Defeating (<i>No longer in DSM-IV</i>) | <p><u>Cluster A (Withdrawn):</u></p> <input type="checkbox"/> Paranoid
<input type="checkbox"/> Schizoid
<input type="checkbox"/> Schizotypal | <p><u>Cluster B (Impulsive)</u></p> <input type="checkbox"/> Histrionic
<input type="checkbox"/> Narcissistic
<input type="checkbox"/> Borderline
<input type="checkbox"/> Antisocial |
|---|--|---|

____ **TOTAL ITEMS/CLUSTER C** ____ **TOTAL/CLUSTER A** ____ **TOTAL/CLUSTER B**

TOTAL ITEMS ANSWERED FOR ALL 3 CLUSTERS