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**Mental Health Data Form**

Client’s Name:

Age: DOB: Sex: Height: Weight:

Parent/Legal Guardian: Phone: H W

Address:

Physician: Phone:

Mental Health Professional: Phone:

**Diagnosis (DSM-IV)**

Axis I

Axis II

Axis III

Axis IV

Axis V

**Presenting Problems**

**Current Medications**

Route

Drug

Dose

Time

Purpose

**Psychiatric Treatment History**

Where

Current Therapy

When

Diagnosis

Outpatient Therapy

Inpatient Therapy

**PATH Intl. Standards for Certification & Accreditation**

**2018**