**MENTAL STATUS EXAM & DIAGNOSIS**

| Client Name:  | Service Date:  |
| --- | --- |
|  | Time:  |

Brief Mental Status Exam:







| Client Meets Criteria for Following DSM5 Diagnosis/Diagnoses: |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |

Additional Observations/Notes:

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YOUR PRINTED NAME (Signature/Credentials) (Date)