MUST BE COMPLETED BY MENTAL HEALTH PROVIDER.

Client:

Date of Services: Start: **End:**

Frequency of Visits: **Daily:** ☐ **Weekly:** ☐ **Monthly:** ☐

Diagnosis: (DSM Code & Diagnosis)

Services Rendered:

- ☐ Initial Evaluation
- ☐ Individual Psychotherapy
- ☐ Family Psychotherapy
- ☐ Group Therapy
- ☐ Anger Management
- ☐ Substance Abuse Therapy

Behavior:

- ☐ Open
- ☐ Guarded
- ☐ Withdrawn
- ☐ Defensive
- ☐ Oppositional
- ☐ Hostile
- ☐ Manipulative
- ☐ Impaired
- ☐ Threatening
- ☐ Impulsive
- ☐ Tearful
- ☐ Self-Harm

Mood/Affect:

- ☐ Flat
- ☐ Depressed
- ☐ Manic
- ☐ Anxious
- ☐ Fearful
- ☐ Irritable
- ☐ Angry
- ☐ Labile
- ☐ Incongruent

Signs/Symptoms of Abuse:

- ☐ Sexual
- ☐ Physical
- ☐ Psychological
- ☐ Neglect

Progress:

- ☐ Exceptional
- ☐ Good
- ☐ Stable
- ☐ Steady
- ☐ Slow
- ☐ Regressing

Current Psychotropic Medication:

Med: _____ Med: _____ Med: _____
Dose: _____ Dose: _____ Dose: _____

Med: _____ Med: _____ Med: _____
Dose: _____ Dose: _____ Dose: _____

Treatment Goals for Individual:

Additional Pertinent Information:

WITHIN THE 6 MONTHS, HAS PATIENT BEEN:

Hospitalized for mental health related issue(s): ☐Yes ☐No

Must submit discharge paperwork to be complete

Mental Health outpatient treatment: ☐Yes ☐No

Please explain

Residential Treatment Facility: Must provide ☐Yes ☐No

discharge paperwork to be complete

Self-harm: ☐Yes ☐No

Attempted Suicide: ☐Yes ☐No

Suicide Ideation: ☐Yes ☐No

If yes, please check the ones that apply:

- ☐Preoccupation Suicidal Ideation
- ☐Previous Attempt(s)
- ☐Impulsiveness
- ☐Available Means
- ☐Hostile Intent
- ☐History of Violence
- ☐Ideation History
- ☐Current Ideation
- ☐Viable Plan
- ☐Settling of Affairs
- ☐Previous Intimidation
- ☐Current Intent

For each box checked, please explain each one below:

Please note: This is not a therapeutic program. It is military-like, stressful, structured environment.

Do you feel that would be successful at MYCA? ☐Yes ☐No
Please explain,

Do you feel that **should attend the MYCA?** ☐Yes ☐No
Please explain,

Printed Name **Organization** **Title**

Phone Number **Signature** **Date**

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Email or fax completed form to: DMVA-Apply-MYCA@MICHIGAN.GOV or 517-763-0404.