

Client's Name:

Client DOB:

Date:

SEXUAL ABUSE PROTECTION: PARENT TREATMENT FOR NON-OFFENDING/NON-PROTECTING PARENTS

MENTAL STATUS / PSYCHIATRIC SYMPTOMS

INSTRUCTIONS: Check [✓] box or circle number for the most appropriate answer. If "NORMAL" is checked, go to next question. If not "NORMAL", rate pertinent items only. 1=MILD, 2=MODERATE, 3=SEVERE (MARKED)

Form with columns for GENERAL APPEARANCE, MOTOR ACTIVITY, SPEECH, INTERVIEW BEHAVIOR, FLOW OF THOUGHT, AFFECT, MOOD, CONTENT OF THOUGHT, and INTELLECT. Each item includes a rating scale (1-3) and a 'NORMAL' checkbox.

ADDITIONAL COMMENTS: [Empty text area for notes]

Staff Signature and Title: _____ Date: _____
If unlicensed:
Supervisor's Signature and Title: _____ Date: _____