Division of Health Service Regulation
Mental Health Licensure and Certification Section

Client Worksheet

Facility Name: _____ MHL#: _____

Client Name: _____ DOB: _____ Sex: _____

DOA: _____ D/C Date: _____ Client #: _____

Diagnosis: _____

Contact information (ex: Case Manager, Guardian): _____

Assessment Date: _____ Including: Presenting problem, needs & strengths, admitting diagnosis, pertinent social, family & medical history:

Treatment/Habilitation Plan Date: _____ Including: Goals or outcomes, strategies, staff responsible schedule for review, basis for evaluation, client/guardian consent, & crisis/behavioral plan (if applicable):

Emergency Information ☐ **Permission to Seek Emergency Care** ☐ **Drug Regimen Review (Psychotropic Meds)** ☐

Interview Date: _____ Time: _____ Place: _____

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Record Review /Notes:

Surveyor Signature: _____ Date: _____