U.S. ARMY RESERVE MEDICAL MANGEMENT CENTER
BEHAVIORAL HEALTH EVALUATION

1. **Name: (last, first MI):_____Rank:_____**
2. **Current symptoms/stressors/relevant history:_____**

_____

_____

3. **Psychiatric or behavioral health disorder history, including treatment and medications:_**

_____

_____

4. **Family history of psychiatric/behavioral health: no☐ yes☐ specify:_____**

_____

5. **Hospitalizations for psychiatric conditions: no☐ yes☐ dates_____**

_____

6. **Suicide attempts/homicide attempts/domestic violence: no☐ yes☐ dates_____**

_____

7. **Current drug/alcohol use/abuse: no☐ yes☐ specify:_____**
8. **Legal issues: no☐ yes☐ describe with date(s)_____**

_____

9. **DWI/DUI in past year: no☐ yes☐ date(s)_____**
10. **Soldier currently in school: no☐ yes☐**
11. **Soldier currently employed: no☐ yes☐**
12. **Soldier's current marital status: _____**

Mental Status Evaluation (check/circle all that apply):

APPEARANCE:	**well groomed ☐**	**over/under weight ☐**	**disheveled ☐**
ATTITUDE:	**cooperative ☐**	**uncooperative ☐**	**belligerent ☐**
BEHAVIOR:	**calm ☐**	**tearful/withdrawn ☐**	**agitated/hyperactive ☐**
MOOD:	**euthymic ☐**	**anxious/manic ☐**	**depressed ☐**
AFFECT:	**appropriate ☐**	**labile ☐**	**inappropriate ☐**
SUICIDAL IDEATION:	**absent ☐**	**passive thoughts ☐**	**current plan ☐**
HOMICIDAL IDEATION:	**absent ☐**	**passive thoughts ☐**	**current plan ☐**
CONCENTRATION:	**intact ☐**	**impaired by history ☐**	**impaired on exam ☐**
PERCEPTION:	**normal ☐**	**hallucinations ☐**	**illusions ☐**
THOUGHT PROCESS:	**intact ☐**	**abnormal/circumstantial ☐**	**grossly abn/bizarre ☐**
THOUGHT CONTENT:	**normal ☐**	**compulsions/obsessions ☐**	**paranoia/delusions ☐**
INSIGHT:	**good ☐**	**partial recognition ☐**	**denial/poor ☐**
JUDGMENT:	**intact ☐**	**impaired ☐**	**severely impaired ☐**
IMPULSE CONTROL:	**good ☐**	**fair ☐**	**poor ☐**
MEMORY:	**intact ☐**	**impaired by history ☐**	**impaired on exam ☐**
COGNITIVE:	**A & O X4 ☐**	**not alert ☐**	**O X 1 2 3 ☐**

DIAGNOSIS (DSM - 5):

Please List Diagnoses

TREATMENT PLAN:

Individual therapy: **no** ☐ **Yes** ☐ **frequency**
Group therapy: Other **no**☐ **yes**☐ **frequency**_____
therapy: **no**☐ **yes**☐ **specify**_____**frequency**_____
Psychotropic medications prescribed: no☐ **yes**☐ **refused**☐

NAME	DOSAGE/FREQUENCY	DATE PRESCIBED

How long have you been providing treatment for the Soldier? Give dates:_____

Is Soldier being counseled by a mental health provider? no☐ **yes**☐
Specify type:
psychiatrist☐ **psychologist**☐ **social worker**☐ **chaplain**☐ **other**_____

Date of initial counseling:_____ **frequency**_____

If on medication, is Soldier asymptomatic on medication(s)? no☐ **yes**☐

If on medication, is the condition stable and controlled on medication(s)? no☐ **yes**☐

In your judgment, does current condition result in any of the following:

no☐ **yes**☐ persistence or recurrence of symptoms which necessitates limitations of duty or duty in protected environment.

no☐ **yes**☐ persistence or recurrence of symptoms which results in interference with effective military performance (ability to manage people, make complex decisions or direct actions where others may be at risk).

no☐ **yes**☐ unsafe for Soldier to carry or have access to weapons.

Recommended limitations, if any, are: permanent☐ **temporary**☐ **# days**_____

NOTE: ***this form must be accompanied by a copy of the Soldier's current progress notes and/or a supporting statement.***

Provider's Printed Name:_____
Provider's Signature: _____
Provider's Medical Specialty:_____
Provider's Office Address:
_____
_____
Provider's Telephone #: (area code and number): _____
Provider's Fax #: (area code and number): _____+_____
Date: _____