The intent of this information is to provide the Capital Guardian Youth Challe*NG*e Academy health care personnel the background to provide appropriate care.

Name: _____ DOB: _____ Age: _____ Gender: Male Female
Last First Middle

Home Address: _____
Street Address City State Zip Code

Custodial Parent/Guardian: _____ Phone: _____

Current Mental Health Evaluation

Does the **participant** have a previous mental health disorder history? Yes No

If yes, diagnoses: _____

Is the **participant** currently receiving any mental health treatment (psychotherapy or medication)? Yes No

If yes, please provide details on the type of treatment: _____

_____

Mental Health History

In the past, was the **participant** diagnosed or treated for any mental health disorder? Yes No

If yes, details on diagnosis and treatment: _____

_____

Has the **participant** received a PHQ9 assessment to determine his or her mental state status? Yes No

If yes, the score and conclusion: _____

_____

Signature of Licensed Medical Personnel: _____ Date: _____

Printed Name: _____

Title: _____

Address: _____

Phone number: _____