



Children's Services of Virginia, Inc.

MENTAL HEALTH TREATMENT FORM

Child's Name: _____ DOB: _____

Child's Presenting Problem: _____

Frequency of Counseling Sessions: _____

Treatment Goals: _____

Summary of Treatment Progress: _____

Diagnosis: ***PLEASE COMPLETE ALL FIVE AXES FOR MEDICAID PURPOSES.***

AXIS I _____

AXIS II _____

AXIS III _____

AXIS IV _____

AXIS V: CURRENT GAF _____ PAST GAF _____

Medication Prescribed: _____

What are the side effects? _____

Physician Prescribing Medication: _____

Therapeutic Recommendations: _____

Signature and Title _____ Date _____