



Mental Health Evaluation

Date: _____

Veteran Name: _____ DOB: _____

Mental Health Provider: _____

Provider direct phone number: _____

Provider email: _____

Hospital/Clinic Address: _____

Diagnosis or related impairments: _____

Summary of Current Care: _____

How long has applicant been under your care? _____

Will care continue in the future? How frequently? _____

Describe applicant's current overall mental health status: _____

Describe applicant's specific PTSD symptoms: _____

Does applicant have suicidal thoughts? YES _____ NO _____

Assessment of range of current or previous suicidal thoughts: _____

Assessment of suicidal ideation: _____

Has the applicant been clean/sober for 1+ year? YES _____ NO _____

Assessment of substance abuse: _____

Assessment of anger volatility or ability to cope with anger: _____

Please rate the applicant's readiness in the following areas (1 low to 5 high)

Use X or check mark

	1	2	3	4	5
Motivation					
Coping with anger					
Expectations					
Support system					
Memory					
Hopes for future					
Where in recovery cycle					
View on own PTSD					
Attitude on therapy					
Ability to follow through					
Family life					
Understanding that a service dog is not a magic pill					

Assessment of applicant's psychological motivation and ability to properly care for service dog:

Applicant's commitment to adherence of treatment plan: _____

Assessment of ability to handle service dog in public: _____

Assessment of applicant's readiness to handle added attention of service dog: _____

Assessment of applicant's support system: _____

Any additional concerns or comments: _____

Mental Health Provider Name (printed)

Mental Health Provider Signature

Date: _____