LIBERTY HOUSE FOUNDATION, INC.
54 Bay Street
Glens Falls, NY 12801

PSYCHOLOGICAL ASSESSMENT FORM

PATIENT NAME: ______________________________ DATE OF BIRTH: ______________________

CURRENT MENTAL STATUS: ____

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EMPLOYMENT: Please discuss your opinion on the following factors to be considered in relation to training and employment services.

INTERPERSONAL FACTORS: ____

MOTIVATION: ____

FUNCTIONAL LIMITATIONS: ____

CONTRA INDICATORS TO EMPLOYMENT: ____

DIAGNOSIS:

AXIS I: ________________________________ DSM IV#: ______________________________

AXIS II: ________________________________ DSM IV#: ______________________________

PROGNOSIS:

_____ EXCELLENT _____ GOOD _____ FAIR _____ POOR

PSYCHOLOGIST SIGNATURE: ________________________________ DATE: _______________

PRINT OR TYPE NAME: ____

CONSENT: I hereby give my consent to release information from my records to Liberty House Foundation, Inc.

PATIENT SIGNATURE: ____________________________________ DATE: _______________