CONTRA COSTA
BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

Mental Health Client Problem List

NAME/MRN

Facility Name: _____ ID: _____ Program Name: _____ ID: _____

Problem (Provide diagnostic narrative; or list symptoms, conditions, and/or risk factors)	**DMS-5 and ICD-10 code** (if applicable)	**Problem Identified By** (Name & Credentials)	**Date Problem Identified**	**Date Problem Resolved / Deleted**	**Removed by** (Name and Credentials)

_____ _____ _____

Signature/License/Designation Printed Name Date