Brief Initial Psychiatric Evaluation Form

Patient Information

Name: _____ Date of Birth: __ Date: _ MRN/ID: __ Provider: _____

Chief Complaint

History of Present Illness

Current Medications

Medication	Dose	Frequency	Start Date	Effectiveness	Side Effects

Allergies

☐ No Known Drug Allergies ☐ Medication Allergies: _____

Psychiatric History

Previous Diagnoses: _____ Previous Psychiatric Hospitalizations: ☐ No ☐ Yes: _____ Previous Suicide Attempts: ☐ No ☐ Yes: _____ **Previous Treatments: _____**

Substance Use

Alcohol: ☐ None ☐ Current ☐ Past | Amount/Frequency: _____ **Tobacco: ☐ None ☐ Current ☐ Past | Amount/Frequency: ____ Cannabis: ☐ None ☐ Current ☐ Past | Amount/Frequency: _____ Other Substances: _____**

Medical History

Significant Medical Conditions: _____ Recent Changes in Health: _____
Current Medical Providers: _____

Family History

Psychiatric History in Family: _____ Medical Conditions in Family: _____

Mental Status Examination

Appearance: ☐ Well-groomed ☐ Disheveled ☐ Other: _____

Behavior: ☐ Calm ☐ Agitated ☐ Restless ☐ Other: _____

Speech: ☐ Normal rate/volume ☐ Pressured ☐ Slow ☐ Other: _____

Mood: ☐ Euthymic ☐ Depressed ☐ Anxious ☐ Irritable ☐ Elevated ☐ Other: _____

Affect: ☐ Full range ☐ Restricted ☐ Blunted ☐ Flat ☐ Other: _____

Thought Process: ☐ Linear ☐ Tangential ☐ Circumstantial ☐ Disorganized ☐ Other: _

Thought Content: ☐ No SI/HI/Psychosis ☐ Suicidal ideation: ☐ Passive ☐ Active ☐ With plan ☐ With intent ☐ Homicidal ideation: ☐ Passive ☐ Active ☐ With plan ☐ With intent ☐ Delusions: _____ ☐ Hallucinations: _____ ☐ **Other:** _____

Cognition: ☐ Alert and oriented x3 ☐ Impaired: _____

Insight: ☐ Good ☐ Fair ☐ Poor ☐ None

Judgment: ☐ Good ☐ Fair ☐ Poor ☐ Impaired

Risk Assessment

Current Suicidal Ideation: ☐ No ☐ Yes: _____ **Current Homicidal Ideation:** ☐ **No** ☐ **Yes: _____ Access to Means:** ☐ No ☐ Yes: _____ **Protective Factors:** _____ **Overall Risk Level:** ☐ Low ☐ Moderate ☐ High ☐ Imminent

Diagnostic Impression

1. _____
2. _____
3.

Treatment Plan

Medications: ☐ Continue current ☐ Changes: _____ **Psychotherapy:** ☐ Individual ☐ Group ☐ Family ☐ Other: ____ **Frequency of Follow-up:** ☐ **Weekly** ☐ **Biweekly** ☐ **Monthly** ☐ **Other: ___ Labs/Testing Ordered: _____ Referrals: _____**
Safety Plan: ☐ Not indicated ☐ Completed (see attached)

Additional Notes

Provider Signature: _____ Date: __ Credentials: _____ License #: _____

Web Implementation Notes

This form should be implemented with: - Single-page design with essential elements only - Prominent chief complaint and assessment sections - Quick-select buttons for common diagnoses - Simplified medication section - Estimated completion time: 5-7 minutes - "Quick text" templates for common presentations - Optional timer function - PDF export functionality - Save/load capability - Mobile-responsive design