Initial Psychiatric Evaluation Form

Patient Information

Name: _____ Date of Birth: __ Date: _ Age: Gender: _ Referred by: _____ Primary Care Provider: _____ Phone: ___

Chief Complaint

History of Present Illness

Onset: ___ Duration: ___ Course: ☐ Improving ☐ Worsening ☐ Fluctuating ☐ Stable

Symptoms (check all that apply): ☐ Depressed mood ☐ Anhedonia ☐ Sleep disturbance ☐ Appetite changes ☐ Energy changes ☐ Concentration issues ☐ Psychomotor changes ☐ Worthlessness/guilt ☐ Anxiety ☐ Panic attacks ☐ Obsessions ☐ Compulsions ☐ Hallucinations ☐ Delusions ☐ Paranoia ☐ Disorganized thinking ☐ Mania/hypomania ☐ Irritability ☐ Impulsivity ☐ Inattention ☐ Hyperactivity ☐ Trauma symptoms ☐ Substance use ☐ Suicidal ideation ☐ Homicidal ideation ☐ Self-harm ☐ Other: _____

Symptom details:

Current stressors:

Previous treatments for current symptoms:

Psychiatric History

Previous psychiatric diagnoses: _____ Previous psychiatric hospitalizations: ☐ No ☐ Yes (details): _____

Previous outpatient treatment: ☐ No ☐ Yes (details): _____

Previous psychiatric medications:

Medication	Dose	Duration	Response	Side Effects	Reason for Discontinuation

History of suicide attempts: ☐ No ☐ Yes (details): _____

History of self-harm: ☐ No ☐ Yes (details): _____

History of violence/aggression: ☐ No ☐ Yes (details): _____

Substance Use History

Substance	Current Use	Amount/ Frequency	Age of First Use	Last Use	Treatment History
Alcohol					
Tobacco					
Cannabis					
Stimulants					
Opioids					
Sedatives					
Hallucinogens					
Other					

History of withdrawal symptoms: ☐ No ☐ Yes (details): _____

History of substance-induced psychiatric symptoms: ☐ No ☐ Yes (details): ___

Medical History

Current medical conditions:

Past medical conditions:

Surgical history:

Allergies: ☐ No known drug allergies ☐ Yes: _____ **Reactions:** _____

Current non-psychiatric medications:

Medication	Dose	Frequency	Purpose

Relevant medical tests/procedures:

Family History

Condition	Family Member(s)
Depression	
Bipolar Disorder	
Anxiety Disorders	
Psychotic Disorders	
ADHD	
Substance Use Disorders	
Suicide Attempts/Completion	
Other Mental Health	

Other relevant family history:

Developmental and Social History

Birth and early development: ☐ Normal ☐ Complications: _____

Childhood trauma/adverse experiences: ☐ No ☐ Yes (details): _____

Educational history: Highest level completed: __ **Academic performance:** __ Learning difficulties: ☐ No ☐ Yes (details): _____

Occupational history: Current employment: ____ **Duration:** ____ Job satisfaction: ☐ High ☐ Moderate ☐ Low ☐ N/A Work stressors: _____ Employment history: _____

Military service: ☐ No ☐ Yes (details): _____ **Combat exposure:** ☐ **No** ☐ **Yes (details):** _____

Legal history: ☐ No ☐ Yes (details): _____

Living situation: Current living arrangement: _____ **Housing stability:** ☐ **Stable** ☐ **Unstable (details):** _____ Financial status: ☐ Stable ☐ Unstable (details): _____

Relationship status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed Duration of current relationship: _____ **Relationship quality:** ☐ **Good** ☐ **Fair** ☐ **Poor** ☐ **N/A Children:** ☐ **No** ☐ **Yes (ages):** _____

Social support: ☐ Strong ☐ Moderate ☐ Limited ☐ None Support sources: _____

Spiritual/religious beliefs:

Cultural factors relevant to care:

Mental Status Examination

Appearance: ☐ Well-groomed ☐ Disheveled ☐ Other: ____ **Attitude:** ☐ Cooperative ☐ Guarded ☐ Hostile ☐ Other: ____ **Psychomotor activity:** ☐ **Normal** ☐ **Agitated** ☐ **Retarded** ☐ **Other:** ___ **Speech:** ☐ **Normal rate/volume** ☐ **Pressured** ☐ **Slow** ☐ **Loud** ☐ **Soft** ☐ **Other:** _____

Mood (self-reported): _____ Affect: ☐ **Full range** ☐ **Restricted** ☐ **Blunted** ☐ **Flat** ☐ **Labile** ☐ **Incongruent** ☐ **Anxious** ☐ **Irritable** ☐ **Euphoric** ☐ **Dysphoric** ☐ **Other: __**

Thought process: ☐ Logical ☐ Tangential ☐ Circumstantial ☐ Loose associations ☐ Flight of ideas ☐ Thought blocking ☐ Other: ____

Thought content: ☐ No abnormalities ☐ Delusions ☐ Paranoia ☐ Obsessions ☐ Phobias ☐ Ruminations ☐ Suicidal ideation ☐ Homicidal ideation ☐ Other: ____
Details: _____

Perceptual disturbances: ☐ None ☐ Hallucinations ☐ Illusions ☐ Depersonalization ☐ Derealization Details: _____

Cognition: Orientation: ☐ Person ☐ Place ☐ Time ☐ Situation Attention/Concentration: ☐ Intact ☐ Impaired (details): ____ **Memory:** ☐ **Intact** ☐ **Impaired (details): _____** **Abstract thinking:** ☐ **Intact** ☐ **Concrete** ☐ **Impaired (details): ___ Fund of knowledge:** ☐ **Age-appropriate** ☐ **Limited (details): ___**

Insight: ☐ Good ☐ Fair ☐ Limited ☐ Poor ☐ Absent **Judgment:** ☐ Good ☐ Fair ☐ Limited ☐ Poor ☐ Impaired

Risk Assessment

Suicidal ideation: ☐ No ☐ Yes If yes: ☐ Passive ☐ Active Plan: ☐ No ☐ Yes (details): _____ **Intent:** ☐ **No** ☐ **Yes (details): _____ Access to means:** ☐ **No** ☐ **Yes (details): _____ Protective factors: _____**

Homicidal ideation: ☐ No ☐ Yes If yes: ☐ Passive ☐ Active Plan: ☐ No ☐ Yes (details): _____ **Intent:** ☐ **No** ☐ **Yes (details): _____ Access to means:** ☐ **No** ☐ **Yes (details): _____ Potential victims: _____**

Self-harm behaviors: ☐ No ☐ Yes (details): _____ **Abuse risk:** ☐ No ☐ Yes (details): _____ **Other risk factors: _____**

Diagnostic Impression

Primary diagnosis: _____ Rule out: _____ Secondary diagnoses: _____ Medical conditions affecting mental health: _____

Assessment and Plan

Assessment summary:

Treatment plan:

1. **Medications:**

1. **Psychotherapy/counseling:**

1. **Laboratory/diagnostic tests:**

1. **Consultations/referrals:**

1. **Safety plan:**

1. **Follow-up plan:** Next appointment: __ **Frequency:** __

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