PSYCHIATRIC EVALUATION

I. Identifying Data: (Please print)
   Name: ____________________________ Age: _________
   Phone: ( ) ____________________ Sex: _________
   Source: _________________________________________

II. Chief Complaint / Reason for Consultation:

   __________________________________________________

   __________________________________________________

III. History of Present Illness:

   __________________________________________________

   __________________________________________________

   __________________________________________________

   __________________________________________________

IV. Past Psychiatric History: (May Include A & D)  No past tx. □
   History of suicidality?  Y / N
   Describe: _______________________________

   History of violent behavior?  Y / N
   Describe: _______________________________

VI. Past Medical History: (Dates if approp.)

   Serious illnesses?  Y / N __________________
   _________________________________

   Surgeries?  Y / N __________________________
   _________________________________

   Seizures?  Y / N ___________________________
   _________________________________

   Closed head injury?  Y / N __________________
   _________________________________

   CNS infection?  Y / N __________________
   _________________________________

   HIV or AIDS?  Y / N    Last T-cell count: _______

VII. Substance Abuse:

   Drug     Route     Typical daily amt.     First use     Last use / amt.
   ____________________________
   ____________________________
   ____________________________

   History of withdrawal?  Y / N    Describe:

IX. Family History:

   Examed by: ____________________________ Date: ____ / ____ / ____ Time: ___________________
Mental Status Exam:
(Circle all that apply or describe.)
Appearance: well-groomed disheveled bizarre
Attitude: cooperative uncooperative guarded suspicious
Activity: calm hyperactive agitated tremors or tics
Affect: euthymic tearful stable labile
Mood: (in pt's own words) “ ____________________________ ”
Speech: normal rapid pressured loud slurred incoherent
Thought process: linear circumstantial tangential flight of ideas loose associations
Thought content: hallucinations: (describe) __________________________
                        delusions: (describe) __________________________
                        other: (describe) __________________________
Sensorium: (Complete appropriate portion(s) of MMSE.) Comment: __________________________
Cognition: (Complete appropriate portion(s) of MMSE.) Comment: __________________________
Insight: __________________________ ; Judgement: __________________________
SUICIDAL IDEATIONS: YES / NO Plan: __________________________
HOMICIDAL IDEATIONS: YES / NO Identified victim: __________________________
If yes to above, was the person notified? YES / NO Date and time of notification: __________________________
Notified by whom? If not notified, why? __________________________

Mini-Mental State Exam:
Max Score ORIENTATION
5 ( ) What is the year / season / date / day / month?
5 ( ) Where are we: state / county / city / hospital / floor?
REGISTRATION
3 ( ) Name 3 objects:
1 second for each. Then ask the patient all 3 after you have said them. Give 1 point for each correct answer. Then repeat them until he/she learns all 3. Count trials and record.
ATTENTION AND CALCULATION
5 ( ) Serial 7’s. 1 point for each correct answer. Stop after five answers. May also spell “WORLD” backwards.
RECALL
3 ( ) Ask for the 3 objects repeated above. Give 1 point for each correct answer.
LANGUAGE
9 ( ) Name a pencil and a watch. (2 pts.)
( ) Repeat the following. “No if’s, and’s, or but’s.” (1 pt.)
( ) Follow a 3-stage command: (3 pts.)
( ) Read and obey the following: “CLOSE YOUR EYES” (1 pt.)
( ) Write a sentence. (1 pt.)
( ) Copy design or draw clock face. (1 pt.)
TOTAL SCORE: __________________________

Review Of Systems (ROS):
Constitutional: __________________________
Eyes: __________________________
ENMT: __________________________
Cardiovascular: __________________________
Respiratory: __________________________
GI: __________________________
GU: __________________________
Musculoskeletal: __________________________
Integumentary: __________________________
Neuro: __________________________
Psych: __________________________
Endocrine: __________________________
Hem/lymph: __________________________
Allergy/immun: __________________________
Notation indicating all other systems are negative
History unobtainable due to: __________________________
Sleep: __________________________
Interest: __________________________
Guilt: __________________________
Energy: __________________________
Concentration: __________________________
Appetite: __________________________
Weight: __________________________
Memory: __________________________
Activity: __________________________
Libido: __________________________
Other: __________________________
Vital signs:  T _______  P _______  
R _______  BP _______  
Ht _______  Wt _______

Pertinent lab or physical exam data:
Musculoskeletal:  ☐ Muscle strength/tone______________  
☐ Gait/station ____________________________

Differential diagnosis:
<table>
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<th>AXIS I:</th>
<th>DMS-IV code</th>
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<td>AXIS IV:</td>
<td>current _______ last year _______</td>
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Synthesis of information:  
____________________________________________________________________________________________  
____________________________________________________________________________________________  
____________________________________________________________________________________________  
____________________________________________________________________________________________  
____________________________________________________________________________________________  

Recommendations:  
 ☐  
 ☐  
 ☐  
 ☐  
 ☐  
 ☐  
 ☐  
 ☐  
 ☐  
 ☐  

Disposition:  home admission respite jail

Admission: facility: _______________________  accepted by: _______________________  
status: voluntary  6-103  Was night court notified?  YES / NO

Outpatient follow-up:  referred to: _______________________  date: _______________________  

Examined by: _______________________  Attending: _______________________  Date: ___ / ___ / ___  Time: _______