

Clinical Evaluation

Appointment Details			
Date of assessment:			
Beginning time:	Ending time:	Present at session: <input type="checkbox"/> Patient <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child	
Chief Complaint			
History of Present Illness			
Depression			
<input type="checkbox"/> Denies depression	<input type="checkbox"/> Hopelessness	<input type="checkbox"/> Recurrent thoughts about death/dying	<input type="checkbox"/> Increased appetite (without weight gain)
<input type="checkbox"/> Frequent crying	<input type="checkbox"/> Helplessness	<input type="checkbox"/> Hypersomnia	<input type="checkbox"/> Increased appetite (with weight gain)
<input type="checkbox"/> Feeling sad, empty, or down	<input type="checkbox"/> Worthlessness	<input type="checkbox"/> Loss of appetite (without weight loss)	<input type="checkbox"/> Social withdrawal, agitation
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Purposelessness	<input type="checkbox"/> Loss of appetite (with weight loss)	
<input type="checkbox"/> Loss of energy	<input type="checkbox"/> Difficulty concentrating		
<input type="checkbox"/> Loss of interest	<input type="checkbox"/> Recurrent suicidal ideation		
<input type="checkbox"/> Loss of enjoyment			
Panic	Mania		
<input type="checkbox"/> Denies panic	<input type="checkbox"/> Paresthesias	<input type="checkbox"/> Denies mania	<input type="checkbox"/> Increase in goal-directed activity
<input type="checkbox"/> Pounding heart	<input type="checkbox"/> Derealization	<input type="checkbox"/> Persistently elevated mood	<input type="checkbox"/> Psychomotor agitation
<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Depersonalization	<input type="checkbox"/> Persistently expansive mood	<input type="checkbox"/> Increased involvement in activities that have a high potential for painful consequences
<input type="checkbox"/> Sweating	<input type="checkbox"/> Fear of losing control or "going crazy"	<input type="checkbox"/> Increased energy	<input type="checkbox"/> Diminished judgment
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Fear of dying	<input type="checkbox"/> Inflated self-esteem	<input type="checkbox"/> Diminished insight
<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Persistent concern or worry about additional panic attacks or their consequences	<input type="checkbox"/> Grandiosity	<input type="checkbox"/> Persistently irritable mood
<input type="checkbox"/> Sensation of choking	<input type="checkbox"/> Significant, maladaptive change in behavior related to the attacks	<input type="checkbox"/> Decreased need for sleep	
<input type="checkbox"/> Trembling or shaking	<input type="checkbox"/> Feeling on edge or tense	<input type="checkbox"/> More talkative than usual	
<input type="checkbox"/> Chest pain or discomfort		<input type="checkbox"/> Rapid speech	
<input type="checkbox"/> Nausea or abdominal distress		<input type="checkbox"/> Pressured speech	
<input type="checkbox"/> Feeling dizzy, unsteady, lightheaded, or faint		<input type="checkbox"/> Flight of ideas	
<input type="checkbox"/> Chills or heat sensations		<input type="checkbox"/> Racing thoughts	
		<input type="checkbox"/> Distractibility	

Anxiety	Eating Disorder Behaviors	Abuse	
<input type="checkbox"/> Denies anxiety <input type="checkbox"/> Excessive worry <input type="checkbox"/> Difficulty controlling worry, difficulty concentrating <input type="checkbox"/> Distractibility <input type="checkbox"/> Difficulty falling or staying asleep <input type="checkbox"/> Restlessness <input type="checkbox"/> Feeling on edge or tense	<input type="checkbox"/> Denies eating disorder behaviors <input type="checkbox"/> Binging <input type="checkbox"/> Purging <input type="checkbox"/> Excessive exercise <input type="checkbox"/> Use of diuretics or laxatives <input type="checkbox"/> Use of appetite suppressants <input type="checkbox"/> Restricting	<input type="checkbox"/> Denies abuse <input type="checkbox"/> Physical <input type="checkbox"/> Sexual <input type="checkbox"/> Emotional <input type="checkbox"/> Household dysfunction <input type="checkbox"/> Neglect	
Post-traumatic Stress			
<input type="checkbox"/> Denies post-traumatic stress <input type="checkbox"/> Repeated or extreme exposure to aversive details of the traumatic event(s) <input type="checkbox"/> Recurrent, involuntary, and intrusive distressing memories of the event(s) <input type="checkbox"/> Recurrent distressing dreams related to the event(s) <input type="checkbox"/> Recurrent distressing dreams related the the event(s), dissociative reactions (e.g. flashbacks, re-enactment of trauma) <input type="checkbox"/> Intense or prolonged psychological distress at exposure to internal or external cues <input type="checkbox"/> Marked physiological reactions to internal or external cues <input type="checkbox"/> Persistent avoidance of stimuli associated with the event(s) <input type="checkbox"/> Behaviors, difficulty falling or staying asleep <input type="checkbox"/> Negative alterations in cognition and mood (e.g. memory) <input type="checkbox"/> Direct experience, witnessing, or learning of a traumatic event(s)			
Psychosis (Delusion)			
<input type="checkbox"/> Denies delusions <input type="checkbox"/> Of grandeur <input type="checkbox"/> Of guilt or sin <input type="checkbox"/> Of reference <input type="checkbox"/> Of persecution <input type="checkbox"/> Of persecution <input type="checkbox"/> Of grandiosity <input type="checkbox"/> Of love (erotic) <input type="checkbox"/> Of jealousy <input type="checkbox"/> Of control <input type="checkbox"/> Somatic <input type="checkbox"/> Thought broadcasting <input type="checkbox"/> Thought insertion <input type="checkbox"/> Bizarre <input type="checkbox"/> Flat affect <input type="checkbox"/> Mood-congruent <input type="checkbox"/> Mood-incongruent <input type="checkbox"/> Mood-neutral <input type="checkbox"/> Disorganized speech <input type="checkbox"/> Disorganized behavior			
Psychosis (Hallucinations)	Self-injurious Behavior	Self-injurious Behavior – Insertions/ingestions of Object(s)	
<input type="checkbox"/> Denies hallucinations <input type="checkbox"/> Command <input type="checkbox"/> Visual (simple) <input type="checkbox"/> Visual (complex) <input type="checkbox"/> Tactile <input type="checkbox"/> Olfactory <input type="checkbox"/> Gustatory <input type="checkbox"/> Auditory	<input type="checkbox"/> Denies self-injurious behavior <input type="checkbox"/> Burning skin <input type="checkbox"/> Pinching or picking skin <input type="checkbox"/> Pulling out hair <input type="checkbox"/> Hitting head <input type="checkbox"/> Banging head <input type="checkbox"/> Cutting or excoriating skin	<input type="checkbox"/> Denies self-injurious behavior, specifically insertions/ingestions of object(s) <input type="checkbox"/> In vagina <input type="checkbox"/> In anus <input type="checkbox"/> Swallowing <input type="checkbox"/> Under skin <input type="checkbox"/> Cutting or excoriating skin	
Risk Factors <i>If checked, please provide more details:</i>			
<input type="checkbox"/> Denies risk factors		<input type="checkbox"/> Adolescent, young adult, or elderly age	
<input type="checkbox"/> Single, divorced or widowed		<input type="checkbox"/> History of suicide attempt	
<input type="checkbox"/> Access to firearms		<input type="checkbox"/> Recent discharge from psych hospital	

Risk Factors *If checked, please provide more details:*

Recent loss

Suicide by family member or close friend

History of substance abuse

History of abuse

Male

Protective Factors *If checked, please provide more details:*

In denial

Spiritual/religious beliefs

Perceived social support

Responsibility to family or friends

Other

Past Psychiatric History

History of inpatient, residential, partial or IOP treatment: Yes No

If yes, please provide more details:

History of prior outpatient treatment: Yes No

If yes, please provide more details:

History of suicide attempts: Yes No

If yes, please provide more details:

History of self-injurious behavior: Yes No

If yes, please provide more details:

Access to weapon: Yes No

If yes, please provide more details:

Past Psychiatric History	
If consumer is a minor, has parent been notified of minor's access to the weapon? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	
Past psychiatric medication trials:	
Substance Abuse History	
Current psychiatric medications:	
Currently using or abusing substances: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please provide more details:</i>	
<input type="checkbox"/> Alcohol	<input type="checkbox"/> Tobacco
<input type="checkbox"/> Cannabis	<input type="checkbox"/> Opioids
<input type="checkbox"/> Cocaine	<input type="checkbox"/> Amphetamines
<input type="checkbox"/> Hallucinogens	<input type="checkbox"/> Other
Past Medical History	
Medical conditions: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please provide more details:	
Allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please provide more details:	
Developmental history reported to be within normal limits: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please provide more details:	Surgeries:
History of trouble sleeping: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please provide more details:	TBL/LOC:

Social History			
History of trauma: <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please provide more details:			
Marital Status	Current Living Arrangements	Employment History	Highest Completed Level of Education
<input type="checkbox"/> Married <input type="checkbox"/> Domestic partnership <input type="checkbox"/> Other: <input type="checkbox"/> Divorced <input type="checkbox"/> Single	<input type="checkbox"/> Alone <input type="checkbox"/> With roommate(s) <input type="checkbox"/> With family <input type="checkbox"/> With spouse <input type="checkbox"/> Group home <input type="checkbox"/> Other:	<input type="checkbox"/> Currently employed <input type="checkbox"/> Currently unemployed <input type="checkbox"/> History of unemployment <input type="checkbox"/> History of work misconduct <input type="checkbox"/> Other:	<input type="checkbox"/> Preschool <input type="checkbox"/> Elementary school <input type="checkbox"/> High school <input type="checkbox"/> Other: <input type="checkbox"/> 2-year college <input type="checkbox"/> 4-year college <input type="checkbox"/> Graduate
FOR CHILDREN: Is there a need for special education or accommodations for learning? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/> Other:		Additional social history notes:	
Family History			
Victim of or witness to domestic violence: <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please provide more details:			
Family history of mental health issues: <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please provide more details:			
Family history of suicide or suicide attempts: <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please provide more details:			
Family history of substance abuse: <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please provide more details:			
Additional family history notes:			
Mental Status Exam			
Orientation			
Person:	Place:	Time:	

Mental Status Exam		
General Appearance <i>If checked, please provide more details:</i>		
<input type="checkbox"/> Normal	<input type="checkbox"/> Disheveled	
<input type="checkbox"/> Emancipated	<input type="checkbox"/> Poor hygiene	
Speech		
General speech:	Rate:	Volume:
Articulation:	Prosody:	Tone:
Affect		
<i>Check all that apply:</i> <input type="checkbox"/> Appropriate <input type="checkbox"/> Inappropriate <input type="checkbox"/> Labile <input type="checkbox"/> Constricted <input type="checkbox"/> Blunted <input type="checkbox"/> Flat		
Thought Process	Thought Content	Mood
<input type="checkbox"/> Normal <input type="checkbox"/> Blocking <input type="checkbox"/> Circumstantial <input type="checkbox"/> Flight of ideas <input type="checkbox"/> Loose associations <input type="checkbox"/> Preservation <input type="checkbox"/> Tangential	<input type="checkbox"/> Normal <input type="checkbox"/> Preoccupied <input type="checkbox"/> Obsessions <input type="checkbox"/> Delusions: Bizarre <input type="checkbox"/> Delusions: Grandeur <input type="checkbox"/> Delusions: Ideas of reference <input type="checkbox"/> Delusions: Persecutory <input type="checkbox"/> Delusions: Somatic <input type="checkbox"/> Delusions: Thought broadcasting	<input type="checkbox"/> Anxious <input type="checkbox"/> Fearful <input type="checkbox"/> Depressed <input type="checkbox"/> Dysphoric <input type="checkbox"/> Apathetic <input type="checkbox"/> Neutral <input type="checkbox"/> Happy <input type="checkbox"/> Euthymic <input type="checkbox"/> Elated
Motor <i>If checked, please provide more details:</i>		
<input type="checkbox"/> No abnormalities	<input type="checkbox"/> Psychomotor retardation	<input type="checkbox"/> Psychomotor agitation
<input type="checkbox"/> Motor tics	<input type="checkbox"/> Vocal tics	<input type="checkbox"/> Resting tremor
<input type="checkbox"/> Choreiform movements	<input type="checkbox"/> Pill rolling movements	<input type="checkbox"/> Lip-smacking
<input type="checkbox"/> Fidgeting	<input type="checkbox"/> Squirming in seat	<input type="checkbox"/> Pacing
<input type="checkbox"/> Trembling/shaking	<input type="checkbox"/> Restless legs	<input type="checkbox"/> Abnormal gait

Mental Status Exam		
Perceptions (Hallucinogens)		
<input type="checkbox"/> Normal <input type="checkbox"/> Auditory <input type="checkbox"/> Command <input type="checkbox"/> Visual (simple) <input type="checkbox"/> Visual (complex) <input type="checkbox"/> Visual (auras) <input type="checkbox"/> Olfactory <input type="checkbox"/> Tactile		
Judgment		
Attentiveness to Examiner <i>If checked, please provide more details:</i>		
<input type="checkbox"/> Attentive	<input type="checkbox"/> Distractible	<input type="checkbox"/> Disinterested
<input type="checkbox"/> Bored	<input type="checkbox"/> Internally preoccupied	
<input type="checkbox"/> Perceived social support	<input type="checkbox"/> Responsibility to family or friends	
Memory:	Interview behavior:	
Estimated Intellect	Current Suicidal Ideation	Current Homicidal Ideation
<input type="checkbox"/> Average <input type="checkbox"/> Above average <input type="checkbox"/> Below average	<input type="checkbox"/> Denies current suicidal ideation <input type="checkbox"/> Passive <i>If checked, please specify:</i> <input type="checkbox"/> With plan and without intent <input type="checkbox"/> Without plan and intent <input type="checkbox"/> Active <i>If checked, please specify:</i> <input type="checkbox"/> With plan but without intent <input type="checkbox"/> Active without plan and intent	<input type="checkbox"/> Denies current homicidal ideation <input type="checkbox"/> Yes <i>If checked, please specify:</i> <input type="checkbox"/> Specific person <input type="checkbox"/> Non-specific person <input type="checkbox"/> Passive with plan and without intent <input type="checkbox"/> Passive without plan and intent <input type="checkbox"/> Active with plan but without intent <input type="checkbox"/> Active without plan and intent
Danger to: <input type="checkbox"/> None <input type="checkbox"/> Self <input type="checkbox"/> Others <input type="checkbox"/> Property		
Danger Level <i>If checked, please provide more details:</i>		
<input type="checkbox"/> Not applicable	<input type="checkbox"/> Intent	<input type="checkbox"/> Ideation
<input type="checkbox"/> Attempt	<input type="checkbox"/> Other	
PHQ-9 score:		
GAD-7 score:		
Comments on mental status exam:		

General		
Review of Systems		
Fever:	Chills:	
Weight loss:	Sleep abnormalities:	
HEENT		
Visual abnormalities:	Nasal discharge:	Sore throat:
Ear pain:	Headache:	
RESP		
Shortness of breath:	Wheezing:	
CVS		
Chest pain:	Palpitations:	
Irregular heart beat:	Led edema:	
GI		
Nausea:	Vomiting:	
Diarrhea:	Constipation:	
Abdominal pain:	Blood in stool:	
GU		
Dysuria:	Hesitancy:	Hematuria:

General		
MSS		
Joint pain:	Swelling:	
NS		
Weakness:	Nerve pain:	Numbness:
Skin:	Rashes:	
Psych		
Suicidal ideation:	Homicidal ideation:	
Assessment		
Formulation:		
Diagnosis and impression:		
Patient's strengths/weaknesses:		
Treatment recommendations:		
Plan:		
Follow up:		