Mental Health Evaluation

Date of Consultation:

Patient Information

Name:

Age:

Gender:

Date of Birth:

Phone Number:

Chief Complaint/Reason for Evaluation: _____

_____

Medical History

Current medical conditions:

Past medical conditions:

Current medications (including psychiatric medications):

Allergies:

Psychiatric History

Past psychiatric diagnoses (if any):

Previous psychiatric treatments (medication, therapy, hospitalizations):

Family history of psychiatric conditions:

Presenting Symptoms: Please describe the patient's current symptoms and the duration of each symptom:

1.
2.
3.
4.
5.

Psychosocial History

Education level: _____

Occupation: _____

Marital status: _____

Living situation: _____

Support system: _____

Substance Use History

Alcohol use: _____

Tobacco use: _____

Illicit drug use: _____

Prescription medication misuse: _____

Mental Status Examination

Appearance and behavior: _____

Speech: _____

Mood and affect: _____

Thought content: _____

Perception: _____

Cognition: _____

Insight and judgment: _____

Diagnosis/Differential Diagnosis: _____

_____

Treatment Recommendations

Psychotherapy modalities: _____

Medication options (if applicable): _____

Referrals to other healthcare professionals (e.g., psychiatrist, therapist): _____

_____

Lifestyle recommendations (e.g., exercise, sleep hygiene):

_____

_____

Follow-up Plan

Frequency of follow-up appointments:

_____

Monitoring of symptoms and treatment response:

_____

Emergency contact information: _____

Crisis intervention resources: _____

Confidentiality and Consent

I, _____, acknowledge that my mental health evaluation and treatment will be confidential. Information shared will be protected, except in cases of imminent harm, abuse, court orders, or coordination of care. I give informed consent for treatment interventions, understand my right to ask questions, and authorize communication between healthcare providers. I have access rights to my records and can choose to discontinue services. By signing, I confirm my understanding and agreement to these terms, ensuring the privacy of my mental health information.

_____

Patient's Signature over Printed Name