Psychiatric Evaluation Template

Patient Name: _____ Date: _____ dd / mm / yyyy

DoB: _____ dd / mm / yyyy Age: _____

Sex: _____ Gender: _____

Contact Number: _____ Email: _____

Accompanied By: _____ Relationship to Patient: _____

Emergency Contact Name: _____ Phone: _____

Patient's Signature

Chief Complaint and Duration

CLINICAL REVIEW

1. Psychosocial History

2. Medical/Mental Health Treatment History

3. Educational/Work History

4. Social Work History

5. Family History

5. Other

SYMPTOMS

Sleep

Interests

Guilt

Energy

Concentrating

Appetite

Suicidal Ideation

Homicidal Ideation

Mood (Range 0-10): _____

MENTAL STATUS EXAM

Observation Detail: Complete each category below for all clients

Appearance

Speech

Attitude and Behavior

Mood and Affect

Additional Detail: if not within normal limits in each category below, provide observation detail

Thought Process and Content; within normal limits?

◯ Yes ◯ No

If no, provide detail below:

Orientation; within normal limits?

◯ Yes ◯ No

If no, provide detail below:

Perception; within normal limits?

◯ Yes ◯ No

If no, provide detail below:

Memory; within normal limits?

◯ Yes ◯ No

If no, provide detail below:

Fund of Knowledge; within normal limits?

◯ Yes ◯ No

If no, provide detail below:

Concentration; within normal limits?

◯ Yes ◯ No

If no, provide detail below:

Abstract Thought; within normal limits?

◯ Yes ◯ No

If no, provide detail below:

Insight and Judgement; within normal limits?

◯ Yes ◯ No

If no, provide detail below:

Psychiatrist's Name: _____

Psychiatrist's Signature