Psychiatric Review of Systems

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

Depressed mood

◯ Yes ◯ No

Elevated mood

◯ Yes ◯ No

Irritable mood

◯ Yes ◯ No

Mood swings

◯ Yes ◯ No

Difficulty falling asleep

◯ Yes ◯ No

Frequent awakenings

◯ Yes ◯ No

Early morning awakenings

◯ Yes ◯ No

Non-restorative sleep

◯ Yes ◯ No

Excessive worry

◯ Yes ◯ No

Restlessness

◯ Yes ◯ No

Irritability

◯ Yes ◯ No

Difficulty concentrating

◯ Yes ◯ No

Physical symptoms (e.g., racing heart, sweating)

◯ Yes ◯ No

Hallucinations (visual, auditory, tactile)

◯ Yes ◯ No

Delusions

◯ Yes ◯ No

Disorganized thinking

◯ Yes ◯ No

Obsessive thoughts

◯ Yes ◯ No

Compulsive behaviors

◯ Yes ◯ No

Detachment or numbness

◯ Yes ◯ No

Out-of-body experiences

◯ Yes ◯ No

Loss of memory

◯ Yes ◯ No

Exposure to traumatic events

◯ Yes ◯ No

PTSD symptoms (e.g., flashbacks, nightmares)

◯ Yes ◯ No

Preoccupation with appearance

◯ Yes ◯ No

Dissatisfaction with body image

◯ Yes ◯ No

Engaging in weight control behaviors (e.g., excessive dieting, purging)

◯ Yes ◯ No

Alcohol use

◯ Yes ◯ No

Tobacco use

◯ Yes ◯ No

Illicit drug use

◯ Yes ◯ No

Memory problems

◯ Yes ◯ No

Concentration difficulties

◯ Yes ◯ No

Difficulty making decisions

◯ Yes ◯ No

Thoughts of suicide

◯ Yes ◯ No

Suicide plan

◯ Yes ◯ No

Additional Notes: