

# **PSYCHIATRIC EVALUATION TEMPLATE**

## Patient ID

Name (Last, First): DOB:

DOB: Age: S Mode of Admission (if applicable): PHN: Ethnicity:

Sexu

Date of Evaluation:

## Source of History

## Chief Concern

## **History of Present Illness**

## Description (COLDER mnemonic)

Characteristics of symptoms

Omset

Location / Situation

Duration

Exacerbation / Stressor

Relief

#### Response

What makes it better / worse? Adaptive skills? Patient assets?

#### Impairment

Depression? Suicidal thoughts? Safety?

## Relevant Medical History

#### Past Psychiatric Hx

Successful & unsuccessful treatments? Previous hospitalizations?

Previous suicide attempts?

Past Medical Hx (Head trauma? Seizure?)

Medications & Allergies

Past Surgical Hx

Birth, Developmental & Behavioral Hx

Targeted Family Hx

## Personal & Social History

Home

Education / Employment

Eating & Exercise

Activities / Interest

Drugs / Substance Use

Sexuality

Spirituality

Safety / Adverse events

## Lab Values / Screening Tools

Height: Tool(s): Weight: Score:

## Mental Status Examination

General Appearance

Attire

Grooming / Hygiene

Eye Contact

Attitude (Cooperative?)

Facial Expression

Mood

Affect

Behavior

Motor Activity

Speech

### Thought Process & Content

Alert & Oriented Hallucinations

Defusion(s)

#### Overall Cognitive Functioning

Memory

Age-appropriate knowledge

Concentration

Insight

#### **Judgment**

Reliability...

Impulse control

## Diagnostic Impressions

A summary of the most pertinent features of the examination, including clinician's opinion and impressions about the most likely or relevant diagnoses.

## Treatment Plan

Safety

is the patient certifiable?

Should the patient be admitted?

What level of observation is required?

Medication

Therapy

Investigations

Education / Instructions Given to Patient

Follow Up Plans

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**Minjie Lin** 

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