

Psychiatric Evaluation Template

Patient Name:		Date:	
DoB:	Age:	Sex:	Gender:
Contact Number:		Email:	
Accompanied By:		Relationship to Patient:	
Emergency Contact Name:		Phone Number:	
Patient's Signature:			
<u>Chief Complaint and Duration</u>			
<u>Clinical Review</u>			
1. Psychosocial History			
2. Medical/Mental Health Treatment History			
3. Educational/Work History			
4. Social Work History			
5. Family History			
6. 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 Behaviour

Mood and Affect

Mental Status Exam (Continued)

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: