

# 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: \_\_\_\_\_

\_\_\_\_\_

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## Treatment Recommendations

Psychotherapy modalities: \_\_\_\_\_

Medication options (if applicable): \_\_\_\_\_

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

\_\_\_\_\_

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

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## Follow-up Plan

Frequency of follow-up appointments:

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Monitoring of symptoms and treatment response:

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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.

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**Patient's Signature over Printed Name**