1 Patient Information

Name: _____

DOB: _____

Age / Sex: _____

Date of Assessment: _____

Provider: _____

Referral Source (if applicable): _____

2 Chief Complaint

Document the primary reason for evaluation in concise clinical terms, including duration and context...

3 History of Present Illness

Onset and duration of symptoms. Course and progression (improving, worsening, episodic). Severity and functional impact. Precipitating and exacerbating factors. Prior psychiatric or medical treatment. Associated symptoms. Pertinent negatives...

4 Biological Factors

Current and past medical conditions. Medication history and adherence. Substance use (alcohol, tobacco, illicit drugs, prescription misuse). Sleep patterns and energy levels. Relevant family medical and psychiatric history...

5 Psychological Factors

Mood and affect. Thought processes (logical, tangential, disorganized). Thought content (delusions, obsessions, SI/HI). Coping mechanisms and stress tolerance. Insight and self-awareness. Past psychiatric diagnoses, hospitalizations, or therapy...

6 Social Factors

Living situation and housing stability. Family dynamics and support system. Employment or educational status. Financial stressors. Legal issues if applicable. Cultural or spiritual considerations impacting care...

7 Mental Status Examination

APPEARANCE & BEHAVIOR

Appearance:

Behavior:

Speech:

MOOD & AFFECT

Mood (patient-reported):

Affect (range, congruence):

THOUGHT

Thought Process:

Thought Content (include SI / HI assessment):

PERCEPTION & COGNITION

Perception (hallucinations or absence):

Cognition (orientation, attention, memory):

INSIGHT & JUDGMENT

Insight:

Judgment:

Safety (risk level):

8 Risk Assessment

Suicidal ideation (presence, plan, intent):

Homicidal ideation:

Self-harm behaviors:

Protective factors:

Overall risk stratification (low / moderate / high):

9 Assessment

DSM-5 diagnoses or working diagnoses. Clinical impression based on biopsychosocial factors. Severity of condition. Functional impairment and medical necessity for treatment...

10 Plan

Recommended therapy modality (e.g., CBT, supportive therapy). Medication considerations if applicable. Referrals (psychiatry, social work, community resources). Patient education and safety planning...

11 Follow-Up

Specify timeframe and goals for reassessment. Include monitoring of symptoms, safety, and response to treatment...

12 Time & Billing

Total Time Spent: _____

Counseling / Coordination of Care Time: _____

E/M CODING

E/M Level (e.g., 90791 / 90834 / 99204): _____

Basis for Billing (Time-based / MDM): _____

ICD-10 CODES

Primary Diagnosis Code + Description: _____

Secondary Diagnosis Code(s): _____

Physician Name, MD / Clinician Name: _____

Specialty: _____

Date: _____

Time: _____