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Psychiatric Review of Systems

Outpatient Documentation Template — For Psychiatrists and PMHNPs

PATIENT & VISIT INFORMATION

PATIENT NAME		
DATE OF BIRTH		
DATE OF VISIT		
CLINICIAN		
VISIT TYPE	☐ Initial Evaluation ☐ Med Check	☐ Follow-Up ☐ Telehealth
E/M CODE TARGET	☐ 99213 99215	☐ 99214 ☐ ☐ Other

HOW TO USE: Check Yes or No for each symptom. Complete all domains for 99215. For 99213/99214, cover domains relevant to the presenting concern plus suicidality. The suicidality domain must be individualized at every visit — do not copy forward.

1. MOOD AND AFFECTIVE SYMPTOMS

SYMPTOMS

Symptom / Domain	Yes	No
Depressed mood	☐ Yes	☐ No
Anhedonia / loss of pleasure	☐ Yes	☐ No
Euphoria / elevated mood	☐ Yes	☐ No
Irritability	☐ Yes	☐ No

Emotional lability / mood swings	☐ Yes	☐ No
Mood cycling (highs and lows)	☐ Yes	☐ No
Hopelessness	☐ Yes	☐ No
Worthlessness / excessive guilt	☐ Yes	☐ No

NOTES / PATIENT DESCRIPTION

2. ANXIETY AND WORRY

SYMPTOMS

Symptom / Domain	Yes	No
Generalized worry / excessive anxiety	☐ Yes	☐ No
Panic attacks	☐ Yes	☐ No
Specific phobias / avoidance behavior	☐ Yes	☐ No
Social anxiety	☐ Yes	☐ No
Somatic anxiety (racing heart, sweating, SOB)	☐ Yes	☐ No
Obsessions / compulsions	☐ Yes	☐ No
Restlessness or feeling on edge	☐ Yes	☐ No

NOTES / PATIENT DESCRIPTION

3. PSYCHOTIC SYMPTOMS

SYMPTOMS

Symptom / Domain	Yes	No

Auditory hallucinations	☐ Yes	☐ No
Visual hallucinations	☐ Yes	☐ No
Other hallucinations (tactile, olfactory)	☐ Yes	☐ No
Paranoid ideation / persecutory beliefs	☐ Yes	☐ No
Grandiosity	☐ Yes	☐ No
Ideas of reference	☐ Yes	☐ No
Disorganized thinking / thought blocking	☐ Yes	☐ No
Negative symptoms: social withdrawal	☐ Yes	☐ No
Negative symptoms: flat affect / avolition	☐ Yes	☐ No

NOTES / PATIENT DESCRIPTION

4. SUBSTANCE USE

SYMPTOMS

Symptom / Domain	Yes	No
Alcohol use (current)	☐ Yes	☐ No
Cannabis use (current)	☐ Yes	☐ No
Stimulant use (amphetamines, cocaine)	☐ Yes	☐ No
Opioid use	☐ Yes	☐ No
Sedative / benzodiazepine use (non-prescribed)	☐ Yes	☐ No
Other substance use	☐ Yes	☐ No
Patient identifies use as problematic	☐ Yes	☐ No
Change in pattern since last visit	☐ Yes	☐ No

SUBSTANCE(S), FREQUENCY, LAST USE

5. SLEEP

SYMPTOMS

Symptom / Domain	Yes	No
Difficulty falling asleep (onset insomnia)	☐ Yes	☐ No
Difficulty staying asleep (maintenance insomnia)	☐ Yes	☐ No
Early morning awakening	☐ Yes	☐ No
Hypersomnia / sleeping too much	☐ Yes	☐ No
Non-restorative sleep	☐ Yes	☐ No
Nightmares	☐ Yes	☐ No
Sleep-related disturbances (apnea symptoms, walking)	☐ Yes	☐ No
Change in sleep pattern since last visit	☐ Yes	☐ No

TYPICAL HOURS / SCHEDULE / CHANGES

6. SUICIDALITY AND SELF-HARM ⚠️ REQUIRED AT EVERY VISIT — Do not copy forward.

SUICIDALITY / SELF-HARM SCREENING

Symptom / Domain	Yes	No
Passive suicidal ideation (wish to be dead)	☐ Yes	☐ No
Active suicidal ideation, no plan	☐ Yes	☐ No
Active suicidal ideation with plan	☐ Yes	☐ No
Intent to act	☐ Yes	☐ No

Access to means (firearms, medications, other)	☐ Yes	☐ No
Recent self-harm behavior	☐ Yes	☐ No
Non-suicidal self-injury	☐ Yes	☐ No
Homicidal ideation	☐ Yes	☐ No
Change from last visit	☐ Yes	☐ No

PATIENT'S EXACT WORDS

PRECIPITATING STRESSORS

PROTECTIVE FACTORS

SAFETY PLAN DISCUSSED

ACTION TAKEN / REFERRAL

7. COGNITIVE SYMPTOMS

SYMPTOMS

Symptom / Domain	Yes	No
Difficulty concentrating	☐ Yes	☐ No
Memory difficulties	☐ Yes	☐ No
Slowed processing speed	☐ Yes	☐ No
Forgetfulness / losing items	☐ Yes	☐ No
Word-finding difficulty	☐ Yes	☐ No
Confusion or disorientation	☐ Yes	☐ No
Patient perceives change from baseline	☐ Yes	☐ No

ONSET AND PATTERN

8. TRAUMA AND PTSD SYMPTOMS

SYMPTOMS

Symptom / Domain	Yes	No
Intrusive memories / flashbacks	☐ Yes	☐ No
Nightmares related to traumatic event(s)	☐ Yes	☐ No
Emotional numbing / detachment	☐ Yes	☐ No
Hypervigilance	☐ Yes	☐ No
Exaggerated startle response	☐ Yes	☐ No
Avoidance of trauma-related reminders	☐ Yes	☐ No
Dissociative episodes	☐ Yes	☐ No
New or worsening symptoms since last visit	☐ Yes	☐ No

NOTES (PATIENT-REPORTED LANGUAGE)

9. PSYCHOSOCIAL STRESSORS AND FUNCTIONING

SYMPTOMS

Symptom / Domain	Yes	No
Relationship / interpersonal stressors	☐ Yes	☐ No
Occupational / academic stressors	☐ Yes	☐ No
Financial stressors	☐ Yes	☐ No

Housing instability	☐ Yes	☐ No
Legal stressors	☐ Yes	☐ No
Loss / grief (recent bereavement)	☐ Yes	☐ No
Caregiver burden	☐ Yes	☐ No
Change in functional baseline since last visit	☐ Yes	☐ No

PRIMARY STRESSOR / FUNCTIONAL IMPACT

OVERALL RISK LEVEL — CLINICIAN ASSESSMENT

RISK LEVEL

Circle or mark one. Reflects clinician judgment based on the full visit, not a calculated score.

None / Baseline	Low	Moderate	High / Acute

JUSTIFICATION FOR RISK LEVEL

DISPOSITION / PLAN

FOLLOW-UP INTERVAL

CLINICIAN SIGN-OFF

CLINICIAN NAME (PRINT)	
CREDENTIALS / LICENSE #	

SIGNATURE		
DATE / TIME COMPLETED		
NOTE FINALIZED IN EHR?	☐ Yes	☐ No

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