

Psychiatric Evaluation Template

1. Patient and Visit Details

- Patient name: _____
- Patient ID / MRN: _____
- Date of birth / age: _____
- Date and time of visit: _____
- Provider name and credentials: _____
- Visit type: ☐ In-person ☐ Video ☐ Audio-only
- Referral source and reason: _____
- Preferred language/interpreter used: _____
- Others present and patient permission: _____
- Information sources: ☐ Patient ☐ Family/caregiver ☐ Referral ☐ Records ☐ Other
- Records reviewed: _____
- Consent and confidentiality limits discussed: ☐ Yes

If telehealth

- Identity verified: ☐ Yes
- Patient's current location: _____
- Callback number: _____
- Emergency contact and local emergency resources: _____
- Telehealth consent documented: ☐ Yes

2. Chief Complaint and History of Present Illness

- Chief complaint (patient's words): _____
- What the patient hopes to address: _____
- Main symptoms: _____
- Onset and duration: _____
- Frequency and severity: _____
- Course: ☐ Improving ☐ Worsening ☐ Stable ☐ Episodic
- What makes it better or worse: _____
- Recent stressors or life changes: _____
- Treatments tried so far and response: _____

Functional Impact

- Sleep: _____
- Appetite: _____
- Energy and concentration: _____
- Work or school: _____
- Relationships and daily activities: _____

3. Past Psychiatric History

- Previous diagnoses and source: _____
- Previous outpatient care and therapy: _____
- Hospitalizations or crisis services (dates, reasons): _____
- Previous aggression or violence, if relevant: _____
- Past suicide attempts: ☐ Denied ☐ Reported ☐ Unknown
- Attempt details (dates, intent, treatment): _____
- Self-injury (type, frequency, most recent): _____

Past medication	Dose	Dates	Response	Side effects	Reason stopped

4. Substance Use

Substance	Amount / how often	Last use
Alcohol		
Tobacco/nicotine		
Cannabis		
Opioids		
Stimulants		
Sedatives		
Other		

- Withdrawal or overdose history: _____
- Past treatment and periods of recovery: _____
- Current recovery supports: _____

5. Medical History

- Medical conditions and surgeries: _____

- Head injury, seizures, neurological concerns: _____
- Allergies and drug reactions: _____
- Current medications and supplements: _____
- Pregnancy or postpartum considerations (if relevant): _____
- Vitals/height/weight / BMI: _____
- Recent labs and tests: _____
- Primary care provider: _____

6. Family and Social History

- Family mental illness: _____
- Family substance use: _____
- Family suicide: _____
- Living situation: _____
- Work or school: _____
- Relationships and support: _____
- Trauma history (ask gently): _____
- Legal issues: _____

7. Mental Status Exam

- Appearance: _____
- Attitude and behavior: _____
- Eye contact and psychomotor activity: _____
- Speech: _____
- Mood (patient's words): _____
- Affect: _____
- Thought process: _____
- Thought content: _____
- Hallucinations: ☐ No ☐ Yes: _____
- Orientation: _____
- Attention and memory: _____
- Insight: ☐ Good ☐ Fair ☐ Poor
- Judgment: ☐ Good ☐ Fair ☐ Poor

8. Risk Assessment

- Suicidal thoughts: ☐ None ☐ Passive ☐ Active
- Plan: ☐ No ☐ Yes: _____
- Intent: ☐ No ☐ Yes
- Access to means: ☐ No ☐ Yes: _____
- Firearms in the home: ☐ No ☐ Yes (storage/plan to secure): _____
- Thoughts of harming others: ☐ No ☐ Yes: _____
- Risk factors: _____

- Protective factors: _____
- Overall risk level: ☐ Low ☐ Moderate ☐ High
- Reason for risk level: _____
- Safety plan completed: ☐ Yes ☐ No ☐ Not needed

9. Screening and Diagnosis

Tool	Score	Notes
PHQ-9		
GAD-7		
C-SSRS		
Other:		

- Primary diagnosis (with ICD-10 code): _____
- Other diagnoses: _____
- Differential diagnosis notes: _____
- Short formulation (2 to 4 lines): _____

10. Treatment Plan and Sign-off

- Medications (new, changed, stopped): _____
- Risks, benefits, and alternatives discussed: ☐ Yes
- Therapy referral: _____
- Labs or tests ordered: _____
- Patient education and consent discussed: ☐ Yes
- Crisis resources given (988 and local): ☐ Yes
- Follow-up date: _____
- CPT code: ☐ 90791 ☐ 90792
- Total time spent: _____ minutes
- Provider signature: _____
- Date: _____