PSYCHIATRIC ASSESSMENT

Chief Complaint/Reason for Referral:

History of Present Illness (include level of function, test results, time course of symptoms):

Psychiatric History (include outpatient, inpatient, medications, danger to self, danger to others):

Substance Abuse History (include treatment):

Medical History:

Allergies:

Social, Developmental, and Family History (include abuse history):

Mental Status Examination:

Orientation and level of consciousness:

Appearance and behavior:

Speech:

Perception:

Thought process:

Thought content:

Affect/mood:

Vegetative function:
**PSYCHIATRIC ASSESSMENT**

<table>
<thead>
<tr>
<th>PATIENT NAME:</th>
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<tbody>
<tr>
<td>DOC NUMBER:</td>
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<tr>
<td>DATE OF BIRTH:</td>
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<tr>
<td>FACILITY:</td>
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Danger to self/danger to others:

Memory/cognitive function:

Other/comments:

**Clinical Formulation:**

**Diagnoses:**

**Plan:**

Medications with target symptoms:

Additional testing:

Special watch or alerts:

Referral/follow-up:

_________________________  _______________________
PRACTITIONER'S PRINTED NAME AND TITLE  SIGNATURE