# PSYCHIATRIC EVALUATION TEMPLATE

## Patient ID

Name (Last, First): PHN:
DOB: Age: Sex: Ethnicity:
Mode of Admission (if applicable): Date of Evaluation:

## Source of History

## Chief Concern

## History of Present Illness

- Description (***COLDER mnemonic***)
  - Characteristics of symptoms
  - Onset
  - Location / Situation
  - Duration
  - Exacerbation / Stressor
  - Relief
- Response
  - What makes it better / worse?
  - Adaptive skills? Patient assets?
- Impairment
  - Depression? Suicidal thoughts? Safety?

## Relevant Medical History

- Past Psychiatric Hx
  - Successful & unsuccessful treatments?
  - Previous hospitalizations?
  - Previous suicide attempts?
- Past Medical Hx (Head trauma? Seizure?)
- Medications & Allergies
- Past Surgical Hx
- Birth, Developmental & Behavioral Hx
- Targeted Family Hx

## Personal & Social History

- **H**ome
- **E**ducation / Employment
- **E**ating & **E**xercise
- **A**ctivities / Interest
- **D**rugs / Substance Use
- **S**exuality
- **S**pirituality
- **S**afety / Adverse events

## Lab Values / Screening Tools

Height: Weight:
Tool(s): Score:

## Mental Status Examination

- General Appearance
- Attire
- Grooming / Hygiene
- Eye Contact
- Attitude (Cooperative?)
- Facial Expression
- Mood
- Affect
- Behavior
- Motor Activity
- Speech
- Thought Process & Content
  - Alert & Oriented
  - Hallucinations
  - Delusion(s)
- Overall Cognitive Functioning
  - Memory
  - Age-appropriate knowledge
  - Concentration
- Insight
- Judgment
  - Reliability
  - Impulse control

## Diagnostic Impressions

A summary of the most pertinent features of the examination, including clinician's opinion and impressions about the most likely or relevant diagnoses.

## Treatment Plan

- Safety
  - Is the patient certifiable?
  - Should the patient be admitted?
  - What level of observation is required?
- Medication
- Therapy
- Investigations
- Education / Instructions Given to Patient
- Follow Up Plans

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