

Psychiatric Evaluation Form (Page 1 of 3)

Chief Complaint:

History of Present Illness:

Current Symptoms:

Duration: Acute or Chronic

Depression: Yes or No

If yes:

Anxiety: Yes or No

Panic attacks: Yes or No

Psychosis: Yes or No

If yes:

Past Psychiatric History

History of Depression Yes or No

History of Anxiety Yes or No

History of Mania Yes or No

Suicide attempts/gestures Yes or No

If yes:

1st Visit to a Psychiatrist

Last Visit to a Psychiatrist

Psychiatric Hospital Admission Yes or No

If yes, last admit

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Past Medical History

Medications

Family History

Social/Developmental/Educational

Substance Abuse History

Smoker	Yes or No
Illicit Drugs	Yes or No
ETOH	Yes or No

Legal History

Labs

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Psychiatric Evaluation Form (Page 3 of 3)

Mental Status Examination

Appearance: Well-groomed/ Neat/ Casual/ Unkempt/ Other: _____
Weight: Average/ Overweight/ Slim Posture: Normal/ Stooped/ Stiff/ Bizarre

Mood: Euthymic/ Depressed/ Dysphoric/ Angry/ Elated/ Other: _____

Affect: Appropriate/ Anxious/ Apathetic/ Sad/ Tearful/ Fearful/ Confused/ Angry

Speech: Normal/ Slow/ Blocking/ Non-spontaneous/ Loose Associations/ Flight of Ideas/ Incoherent/ Circumlocution
Short answers/ Pressured

Thought Process: Normal Associations/ Loose/ Circumstantial/ Tangential/ Other: _____

Thought Content: Hallucinations (auditory_____/ visual_____/ Delusions/ Paranoid/ Grandiose/ Not psychotic/ OCD
Other: _____

Intelligence Average/ Above Average/ Below Average/ Other: _____

Memory: Intact/ Abnormal/ Developmental

Insight: None/ Partial/ Full

Judgment: Good/ Average/ Fair/ Impaired/ Questionable

MMSE

Assessment/Diagnosis

Axis I

Axis II

Axis III

Axis IV

Axis V

Plan:

Physician Signature _____ **Date & Time** _____

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