Initial Psychiatric Evaluation

This form is to be completed by a psychiatrist, CNS or other APN with credential in psychiatry and prescribing privileges, to document an initial psychiatric evaluation.

Data Field	Person Demographic Information
Person's Name	Record the first name, last name, and middle initial of the person. Order of name is at agency discretion.
Record Number	Record your agency's established identification number for the person.
Date of Admission	Record the date of admission per agency policy (usually first service date for this service episode).
Organization/Program Name	Record the organization/program for whom you are delivering the service.
DOB	Record the person's date of birth
Gender	Indicate person's gender by checking the appropriate box. If checking "Transgender" box, also complete box of current gender designation for insurance purposes.
Data Field	**Present at Session**
List Name(s) of Person(s) Present	Check appropriate box: *Person Present; Person No Show; Person Canceled.* If *Provider Canceled* is checked, document explanation as relevant. If *Others Present* is checked, identify name(s) and relationship(s) to person.
Data Field	**Place of Evaluation**
Place of Evaluation	Check the appropriate box to indicate where the evaluation took place. If other, specify.
Data Field	**Presenting Concern**
Presenting Concerns in person's own words; what occurred to cause the person to seek services now	Use the person's own words to document the reason the person is asking for help. This should be a concise but complete description of why the person is seeking help now; including troublesome symptoms, behaviors and problems in functioning in life roles.
Data Field	**Comprehensive Assessment**
History of Present Illness	Document/summarize any history with the present illness. This can include onset of symptoms and what was done to manage illness prior to seeking help. Check *None Reported* if applicable.
Comprehensive Assessment has been completed?	Check Yes or No and indicate date of most recent assessment.
Data Field	**Primary Care Provider Information**
Primary Care Provider (PCP) Name and Credentials/ Address/ Telephone Number/Fax/Date of Last Exam	Record the person's PCP contact information. This may be a RNP or Pediatrician but must be the medical professional primarily in charge of the person's overall physical health care.
Data Field	**Physical Health History**
Physical Heath History	Review the Physical Health section of the Comprehensive Assessment with the person and record the date of the Comprehensive Assessment reviewed. If there is no additional pertinent physical health history, check *No Additional History to be Added*. If there is additional pertinent physical health history, **OR** if the Comprehensive Assessment was not reviewed, check *Additional History/ Comments* and provide the

	information.
Data Field	**Family Mental Health / Substance Use History**
Family Mental Health / Substance Use History	Check all that apply or *none reported* and comment as necessary.
Data Field	**Substance Use/Addictive Behavior History**
Substance Use /Addictive Behavior History	Review the Substance Use/Addictive Behavior section of the Comprehensive Assessment with the person and record the date of the Comprehensive Assessment reviewed. If there is no additional pertinent substance use/addictive behavior history, check *No Additional History to be Added*. If there is additional pertinent substance use history, **OR** if Comprehensive Assessment was not reviewed: check *Additional History Indicated Below* and provide the information on this form in the grid below. For reporting substance use, include age of first use, date of last use, frequency, amount and method of use.
Toxicology Screen Completed	Record *Yes* or *No*. If yes, indicate results.
Data Field	**Treatment History**
Type of Service/ Mental Health or Substance Use Name of Provider/Agency/ Dates of Service/Completed (Y/N)	Review the Treatment History section in the Comprehensive Assessment (mental health (MH) and substance use (SU) with the person and record the date of Comprehensive Assessment reviewed. If there is no additional pertinent treatment history, check *No Additional History to be Added*. If there is additional treatment information, **OR** if the Comprehensive Assessment has not been reviewed, check Additional *History Indicated Below* and provide the information on this form in the grid below. record the treatment episodes on this form in the grid below
Data Field	**Assessment Domains**
Additional Pertinent Information	Review each area if the Assessment Domains listed in the Comprehensive Assessment and record the date of Comprehensive Assessment reviewed. For each area, if there is no additional pertinent treatment history, check *No*. If there is additional treatment information, **OR** if the Comprehensive Assessment has not been reviewed, check Yes and provide the information in *Comments*.
Data Field	**Mental Status Exam**
Mental Status Exam	Avoid judgmental perceptions. Take into account cultural differences. Think of creating a picture of the person served so that anyone reading the results of the exam would be able to clearly perceive the person just as you do. Assessment items are "in the moment", in other words as the person presents to you at the present time. There are other sections of the assessment form that address historical information.
Appearance/clothing	Check appropriate boxes to describe physical appearance including clothing, taking into account culture and age of person.
Eye Contact	Check boxes that apply.
Build	Check boxes that apply.
Posture	Check boxes that apply.
Body Movement	Check boxes that apply.
Behavior	Check boxes that apply.
Speech	Check boxes that apply.
Emotional State-Mood (in person's words)	Check boxes that apply. Emotional State-Mood is the sustained internal emotional state of a person. This describes the typical, more consistent emotional state of the person. **Examples:** Typical Mood is balanced and WNL; Mood is typically subdued; Mood is typically anxious and irritable. ***Child Outpatient Example:*** "I feel sad today". Also include a clinical assessment of mood. For example, Joel appears to be in a sad mood and anxious today. ***Adult Outpatient Example:*** Anxious
Emotional State-Affect	Check boxes that apply. Emotional State-Affect is the external expression of present emotional content. This describes the emotional state presently observed or described.

	Child Outpatient Example: Joel presents as sad and anxious with constricted affect. ***Adult Outpatient Example:*** Full range of emotional affect
___ **WNL**	Within normal limits
___**Constricted**	Feelings demonstrated are subdued and do not appear to present the full range usually seen in people of this culture (cultural expectations are vital considerations in this area).
___**Changeable**	Demonstrated feelings shift rapidly from one state to another. Called changeable on the form.
___**Inappropriate**	Demonstrated feelings do not match with subject discussed (e.g. laughing while discussing a trauma experience).
___**Flat**	No reaction emotionally to situation.
___**Full**	Demonstrates a full range of feelings.
__**Blunted, unvarying**	Only slight reaction emotionally to the situation.
Facial Expression	Check boxes that apply.
Perception	
___ **WNL**	If there are no perceptual disturbances, check here
Hallucinations	Hallucinations are perceptions with a compelling sense of reality but occur in the absence of stimuli. Hallucinations should be distinguished from illusions, in which an actual external stimulus is misperceived or misinterpreted. The person may or may not have insight into the fact that he or she is having a hallucination.
___**Tactile**	A hallucination involving the perception of being touched or of something being under one's skin. This is more typical in substance dependent individuals (especially alcoholics) who are detoxifying. The most common tactile hallucination is the feeling that bugs are crawling under the skin.
___**Auditory**	Usually described as voices. To assess, ask the individual, "Do you ever hear anyone talking but cannot tell where the voice is coming from?" If they answer yes, ask if he/she can tell what the voice is saying and he/she can identify the voice.
___**Visual**	Visual hallucinations are usually only experienced by individuals who have ingested an illicit drug or drug overdose, or someone who has experienced a head injury. It is important to ask the person served to describe the visual hallucination and under what circumstances it occurs.
___**Olfactory**	A hallucination involving the perception of odor, such as of burning rubber or decaying fish. This is usually a symptom of a neurological disorder or brain injury.
___**Command****	Command hallucinations are voices telling someone to do something dangerous or harmful (e.g. "kill him").
Thought Content	
___ **WNL**	Check if thought content is within normal limits.
Delusions	Beliefs in things that are not true (e.g. "Aliens have planted a sensor in my head").
___**None reported**	No observable evidence of delusions or delusions are denied.
___**Grandiose**	Thoughts of exaggerated and somewhat improbable status or success: "Mattel is going to buy my game and I'll make millions."
___**Persecutory**	"People are trying to kill me."
___**Somatic**	Physical complaints in the absence of any real cause. Fear that stomach pains are cancer even after a doctor has examined him/her and found no health problem.
___**Illogical**	"My neighbors are throwing away babies in the trash. I can hear them at night."
___**Chaotic**	"The world is going to end on New Year's Day."
___**Religious**	"I am the second coming."
Other Content	
___**Preoccupied**	Person appears to be lost in thought, engrossed or absorbed to such a degree that communication with others is compromised.
___**Obsessional**	Persistent and disturbing intrusive thoughts, ideas or feelings.
___**Guarded**	Statements, ideas, responses are brief and person appears reluctant to provide details or information.
___**Phobic**	Exaggerated fear inexplicable to the person (e.g. airplane flight, spiders, heights).

___**Suspicious**	Inclined to suspect, especially inclined to suspect evil; distrust
___**Guilty**	Focused on unrealistic self-blame.
___**Thought broadcasting**	"I can make those people think what I am thinking."
___**Thought insertion**	"Those people are sending their ideas to me."
___**Ideas of reference**	"Those people standing together over there are talking about me."
Thought Process	
___**WNL**	Within Normal Limits- Thoughts are clear, logical and easily understood.
___**Incoherent**	Thoughts, words or phrases are joined together without a logical or meaningful connection or relevance, and are not understandable despite repeated attempts to explain.
___**Decreased thought flow**	Responses and statements are slow and have a paucity of details.
___**Blocked**	The person has consistent difficulty responding to questions. Answers or statements are either very brief and appear difficult to produce or there are no responses at all.
___**Flight of ideas**	A nearly continuous flow of accelerated speech with abrupt changes from topic to topic that are usually based on understandable associations, distracting stimuli, or plays on words. When severe, speech may be disorganized and incoherent.
___**Loose**	A disturbance of thinking shown by speech in which ideas shift from one subject to another that is unrelated or minimally related to the first. The speaker gives no indication of being aware of the disconnectedness, contradictions, or illogicality of speech. To assess for loose thinking, ask the person to explain a proverb. For example, "People who live in glass houses shouldn't throw stones". An example of loose thinking would be: "If you don't punch holes in the top, everyone dies."
___**Racing**	Demonstrates rapid thinking that is not necessarily bizarre or unusual but thought production is faster than most people typically demonstrate.
__**Chaotic**	Totally disorganized, impossible to understand.
___**Concrete**	To assess for concrete thinking, ask the person to explain a proverb. For example, "People who live in glass houses shouldn't throw stones". An example of concrete thinking would be: "Rocks break glass."
___**Tangential**	A question or statement will prompt a response that begins with one subject and ends with an entirely different subject only vaguely related to the first subject, if at all.
Intellectual Functioning	
___**WNL**	No apparent deficits in intellectual functioning.
___**Lessened fund of common knowledge**	Ask: "Who is the President of the United States?" "Who was President before him or her?"
___ **Impaired concentration**	Person is distracted from basic tasks
___**Impaired calculation ability**	Ask the person to count backwards from 100 by 7's.
Intelligence Estimate	This can be an estimate only in the absence of any accepted intelligence tests or information from other sources. Keep in mind that some psychiatric disorders (depression) can negatively impact IQ scores. Intelligence is generally accepted to be a person's capacity to absorb information and solve problems.
___ **Developmentally Disabled**	IQ under 70 on the Wechsler scale.
___**Borderline**	IQ from 70-79 on the Wechsler scale.
___**Average**	IQ from 90-109 on the Wechsler scale. (80-89 is considered "low average").
___**Above average**	IQ above 110 on the Wechsler scale.
___**No formal testing**	Note if there is no record of formal testing of intellectual functioning (e.g. MMPI)
Orientation	
___**WNL**	Check here if the person can correctly respond to the following questions about person, time and place.
Disoriented to:	
___**Time**	Does the person know what time and day it is (within a few hours)?
___**Place**	Does the person know where he or she is?

___**Person**	Does the person know his/her correct name, age and some facts about his/her life.
Memory	
___**WNL**	Check here if the following three areas are responded to sufficiently.
Impaired:	
___**Immediate recall**	At the beginning of the assessment interview, tell the person you are going to state three objects that you will ask him or her to recall later in the interview. Use three basic objects such as tree, car and floor. After 10-15 minutes, ask the person to tell you what the three items were that you asked him/her to remember from the beginning of the interview.
___**Recent memory**	Can the person tell you what they had for breakfast or what he/she did first thing this morning?
___**Remote memory**	Can the person describe events form his/her childhood or in the past?
___**Short attention span**	Person demonstrates difficulty staying on topic or attending to a task.
Insight	Check the most appropriate description of the person's current functioning.
___**WNL**	Check if the person's insight is within normal limits.
__**Difficulty acknowledging presence of psychological problems**	Reluctantly admits to minimal problems.
__**Mostly blames others for problems**	Projects blame for any problems onto others. Example: "They made me mad!"
__**Thinks he/she has no problems**	Denial of any problems.
Judgment	
___**WNL**	Decision making abilities appear intact and sufficient for day-to-day functioning.
Impaired ability to make reasonable decisions	Utilize scenarios to assess: 1. If you were in a crowded movie theater and noticed there was a fire off to the side in a hallway, what would you do? 2. If you found a fully addressed and stamped envelope on the sidewalk, what would you do?
__**Mild**	Select if impairment to judgment is mild. **Example:** "Tell someone the building is on fire on the way out."
___**Moderate**	Select if impairment to judgment is moderate. **Example**: "Leave the building fast."
___**Severe****	Select if impairment to judgment is severe. **Example:** "Scream "fire" and run out."
Past attempts to Harm to Self or Others	Check the all boxes that apply and comment on all past attempts.
Self Abuse Thoughts	Take care to differentiate between thoughts of self abuse/self harm behaviors and suicidal actions.
___**None reported**	No acknowledgment or evidence of thoughts of self harm behaviors.
___**Cutting****	Thoughts of any type of scratching or cutting that draws blood or damages the skin or a body part
___**Burning****	Thoughts of putting hot objects, including open flames in contact with any part of the body so as to damage the skin or a body part.
___**Other**	Thoughts of pulling out hair, damaging eyes , etc.
Suicidal Thoughts	
___**None reported**	Person denies thoughts of taking his or her life.
___**Passive Suicidal Ideation****	Person admits to passively thinking about taking his or her life but does not intend to take action on those thoughts.
___**Intent****	Person admits to seriously considering taking his or her life. This goes beyond feelings of hopelessness or frustration.
___**Plan****	Person describes a viable, actual plan to take his or her life.
___**Means****	Person has in his/her possession the object or objects necessary to complete his/her plan (e.g. stock-pile of pills, gun).
Aggressive Thoughts	
___**None reported**	Person denies thoughts of harming another person.

___**Intent****	Person admits to seriously considering harming another person. This goes beyond feelings of anger or frustration.
___**Plan****	Person describes a viable, actual plan to harm another person.
___**Means****	Person has in his/her possession the object or objects necessary to complete his/her plan (e.g. knife, gun).
Comments	Add any necessary comments about findings from the MSE.
****	**Checking any item with ** requires an immediate risk and/or lethality assessment.**
Data Field	**Summary of Current Mental Health Functioning**
Other symptoms of note or information from other sources (family, referring agency, etc.)	Record any other pertinent information/ symptoms of note, including that from other sources (family, referring agency, etc.).
Data Field	**Diagnoses/Justification and Differential Diagnosis**
Diagnoses/ Rationale	Check appropriate box to indicate whether you are recording a DSM or ICD Diagnosis. Record Axis I – V where indicated. Provide justification for all diagnoses indicating symptoms and behaviors meeting diagnostic criteria. Each agency should have adequate internal processes to ensure the diagnostic impression recorded in the Comprehensive Assessment is reconciled with the diagnoses in the Psychiatric Evaluation.
Data Field	**Medication Information/Side Effects/Adverse Drug Reactions**
Medication Information (Medication, Current or Past, Rationale/Condition, Dosage/Route/Frequency, Person Taking/Took Meds as Prescribed)	If Comprehensive Assessment has not been completed and been reviewed, complete this section. If the CA has been completed and reviewed, provide any relevant updates. **Comments on Past Medications:** Include what medications have worked well previously, any adverse side effects, and/or which one(s) the person would like to avoid taking in the future. If there have been no medication changes (including dosage changes, added or discontinued medications, etc.), check *There Have Been No Medication Changes*. If there are changes, **OR** if the Comprehensive Assessment has not been reviewed, check *Additional Medication Changes Below* and provide the information on this form in the grid below. Include medication name, current (C) or past (P), rationale/condition for which the medication is/was taken, dosage/route/frequency and if meds were taken as prescribed. Be sure to include all types of medications: prescribed, herbal, and over-the-counter. **Example:** If the person has discontinued a medication since the assessment, this should be so indicated by listing medication and checking (P) in the Current/Past column. This would also apply if the person began and discontinued a medication since the assessment reviewed.

Reported side effects/adverse drug reactions/other comments on current or past medications	Record and comment on any side effects reported by person /guardian to past or present medications or check "none reported." This section should be completed for all persons, regardless of whether the information has already been completed in the Comprehensive Assessment.
Does the person served have any medical conditions that require consideration in prescribing (i.e. pregnancy, diabetes, etc.)?	Check yes or none reported or known. If yes, please specify.
Data Field	**Medications Prescribed/Informed Consent/Lab Tests**
	If there are to be no medication changes (including dosage changes, added or discontinued medications or refills), check *None.* If there are changes of any type, check

Medication/Status/Rational and Condition/Dosage, Route, and Frequency/Amount and Refills	either *new/adjusted* (for new medications ordered or medications being prescribed at a different frequency or dose); *refill* (for those medications simply being ordered again without change); or *discontinued* (for medications being discontinued). Include rationale/condition, dosage/route/frequency and the amount/refills being ordered. Also be sure to include all types of medications: prescribed, herbal, over-the-counter.
Explained rationale for medication choices, reviewed mixture of medications, discussed possible risks, benefits, effectiveness (if applicable) and alternative treatment with the person (parent/guardian)	Check *Yes* or *No* to indicate whether the rationale, risks and benefits of the particular mixture of medications prescribed and any alternative treatments or medications and effectiveness (if applicable) have been explained to the person during this evaluation.
Person	Check the appropriate box.
Guardian	Check the appropriate box.
Laboratory Tests Ordered	List all laboratory tests ordered in this session or check *None Ordered* if no laboratory tests were ordered.

Data Field	Follow Up Plan and Other Considerations
Follow Up Plan/Referrals	This section should describe the immediate follow-up plan to this visit. Include as appropriate referrals, labs or other additional testing ordered, medical strategies, other types of treatment and frequency/interval of next visit. Record issues that need to be addressed in future appointments.
Other Psychopharmalogical Considerations to be Added to the Individualized Action Plan	If clinically indicated, record suggestions for consideration of other services to be added and included in the IAP and/or IAP Revision. Check *None indicated at this time* if no other services are to be added.
Person's/ Guardian Response to Plan	Note the Person's/Guardian's response to the follow up plan, or check N/A if not applicable.
Data Field	**Staff Signatures**
Physician/APRN/RNCS Print Name/Credentials	Legibly print name of the prescriber including his/her credentials. Example: Luisa Cabot, MD
Date	Record the date.
Supervisor – Print Name/ Credentials (if needed)	If required, legibly record supervisor's name and credentials.
Date	Record the date.
Physician/APRN/RNCS Signature	Legibly record signature of the prescriber including his/her credentials. Example: Luisa Cabot, MD
Date	Record the date.
Supervisor Signature (if needed)	If required, legibly record supervisor's signature and credentials.
Date	Record the date.
Person's Signature (Optional, if appropriate)	The person is given the option to sign. If completing the note after the session and/or if using electronic notes, person can sign at next session.

Date	Record the date.