TEMPLATE

Psychiatric Evaluation Template

Complete all fields. Use additional pages if needed.

Patient Name

Date of Birth

Date of Evaluation

Evaluator Name & Credentials

Referral Source

Gender

- ◯ Male
- ◯ Female
- ◯ Non-binary
- ◯ Prefer not to say

Chief Complaint (in patient's own words)

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History of Present Illness

Document onset, duration, severity, and progression of current symptoms.

Current Symptoms & Timeline

Symptom Severity

- ◯ Mild
- ◯ Moderate
- ◯ Severe

Precipitating Factors / Triggers

Impact on Daily Functioning (work, relationships, self-care)

Previous Treatment Attempts for Current Episode

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Past Psychiatric History

Document all prior mental health diagnoses, hospitalisations, and treatments.

Previous Psychiatric Diagnoses

Previous Hospitalisations

- ◯ None
- ◯ 1
- ◯ 2-3
- ◯ 4+

Hospitalisation Details (dates, facilities, reasons)

Previous Psychotherapy (type, duration, outcome)

Medication History (medication, dosage, response, reason for discontinuation)

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Medical & Family History

Document relevant medical conditions, medications, and family psychiatric history.

Current Medical Conditions

Current Medications (including OTC & supplements)

Known Allergies (especially medication allergies)

Family History of Mental Health Conditions

- [ ] Depression
- [ ] Bipolar disorder
- [ ] Schizophrenia
- [ ] Anxiety disorders
- [ ] Substance use disorders
- [ ] Suicide attempts
- [ ] ADHD
- [ ] None known

Family History Details

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Social & Substance Use History

Assess psychosocial context and substance use patterns.

Living Situation

- ◯ Lives alone
- ◯ With partner/spouse
- ◯ With family
- ◯ Group home
- ◯ Homeless/unstable
- ◯ Other

Employment Status

- ◯ Employed full-time
- ◯ Employed part-time
- ◯ Unemployed
- ◯ Student
- ◯ Retired
- ◯ Disabled

Substances Used (current or past)

- ☐ Alcohol
- ☐ Tobacco/nicotine
- ☐ Cannabis
- ☐ Opioids
- ☐ Stimulants
- ☐ Benzodiazepines
- ☐ Hallucinogens
- ☐ None

Substance Use Details (frequency, quantity, last use)

Trauma / Adverse Experiences (if patient consents to disclose)

Legal History (if relevant)

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Mental Status Examination

Systematic observation of the patient's current psychological state.

Appearance

- [ ] Well-groomed
- [ ] Dishevelled
- [ ] Appropriate dress
- [ ] Unusual dress
- [ ] Good hygiene
- [ ] Poor hygiene

Psychomotor Activity

- ( ) Normal
- ( ) Retarded
- ( ) Agitated
- ( ) Restless
- ( ) Catatonic

Speech

- [ ] Normal rate
- [ ] Rapid
- [ ] Slow
- [ ] Loud
- [ ] Soft
- [ ] Pressured
- [ ] Monotone
- [ ] Slurred

Mood (patient-reported)

- ( ) Euthymic
- ( ) Depressed
- ( ) Anxious
- ( ) Irritable
- ( ) Euphoric
- ( ) Angry

Affect (observed)

- [ ] Appropriate
- [ ] Flat
- [ ] Blunted
- [ ] Labile
- [ ] Constricted
- [ ] Incongruent

Thought Process

- ( ) Logical/goal-directed
- ( ) Tangential
- ( ) Circumstantial
- ( ) Loose associations
- ( ) Flight of ideas
- ( ) Thought blocking

Thought Content

- [ ] Normal
- [ ] Delusions
- [ ] Obsessions
- [ ] Phobias
- [ ] Ideas of reference
- [ ] Paranoia
- [ ] Suicidal ideation
- [ ] Homicidal ideation

Perceptual Disturbances

- [ ] None
- [ ] Auditory hallucinations
- [ ] Visual hallucinations
- [ ] Tactile hallucinations
- [ ] Illusions

Orientation

- [ ] Person
- [ ] Place
- [ ] Time
- [ ] Situation

Insight

- ( ) Good
- ( ) Partial
- ( ) Poor

Judgement

- ( ) Good
- ( ) Fair
- ( ) Poor

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Risk Assessment

Evaluate risk of harm to self and others. Document thoroughly.

Suicidal Ideation

- ◯ None
- ◯ Passive (wishes to be dead)
- ◯ Active without plan
- ◯ Active with plan
- ◯ Active with plan and intent

Prior Suicide Attempts

- ◯ None
- ◯ 1
- ◯ 2-3
- ◯ 4+

Homicidal Ideation

- ◯ None
- ◯ Thoughts without plan
- ◯ Thoughts with plan
- ◯ Identified target

Risk Factors Present

- ☐ Social isolation
- ☐ Substance use
- ☐ Access to means
- ☐ Recent losses
- ☐ Chronic pain
- ☐ Family history of suicide
- ☐ Previous attempts
- ☐ Impulsivity

Protective Factors Present

- ☐ Social support
- ☐ Children/dependents
- ☐ Religious beliefs
- ☐ Treatment engagement
- ☐ Future orientation
- ☐ Problem-solving skills
- ☐ Fear of death

Overall Risk Level

- ◯ Low
- ◯ Moderate
- ◯ High
- ◯ Imminent

Safety Plan (if applicable)

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Assessment & Treatment Plan

Synthesise findings into diagnostic impressions and recommendations.

Clinical Formulation / Summary

DSM-5 Diagnosis / Differential Diagnoses

Recommended Interventions

- [ ] Individual therapy
- [ ] Group therapy
- [ ] Medication management
- [ ] Psychiatric hospitalisation
- [ ] Substance use treatment
- [ ] Neuropsychological testing
- [ ] Lab work/medical clearance
- [ ] Safety planning

Treatment Plan Details & Follow-Up

Evaluator Signature

Signature

Date: ___/___/_____