Psychiatric Evaluation

Community Healthcore

Psychiatric Evaluation

Identifying Information

Source(s) of Information

- ◯ Patient
- ◯ Patient / LAR / Parent
- ◯ Patient / Other Family
- ◯ Patient / Other Advocate
- ◯ Patient / Other Mental Health Provider
- ◉ Patient / Records Review (Summarize in HPI)

Presenting Problem(s) (including history / description and impact of current symptoms and related stressors) ☑

Other information / past social and family history for review at follow-up ☑

Does the consumer have a history of swallowing foreign objects?

- ◯ Yes
- ◯ No

If yes: What foreign objects have been swallowed? ☑

Complete

PHQ-9 ADULT

Scoring KEY

0 = Not at all

1 = Several days

2 = More than half the days

3 = Nearly every day

1. Little interest in doing things	0 1 2 3
2. Feeling down, depressed, or hopeless	0 1 2 3
3. Trouble falling asleep or staying asleep, or sleeping too much	0 1 2 3
4. Feeling tired or having little energy	0 1 2 3
5. Poor appetite or overeating	0 1 2 3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down.	0 1 2 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 1 2 3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than ususal.	0 1 2 3
9. Thoughts that you would be better off dead or of hurting yourself.	0 1 2 3

10. If the consumer checked off any problems, how difficult these problems made it for them to do their work, take care of things at home, or get along with other people.

- ◯ Not difficult at all
- ◯ Somewhat difficult
- ◯ Very difficult
- ◯ Extremely difficult

Score

Guide to depression severity

- ◯ 1-4 Minimal Depression
- ◯ 5-9 Mild Depression
- ◯ 10-14 Moderate Depression
- ◯ 15-19 Moderately Severe Depression
- ◯ 20-27 Severe Depression

Today's Date

Complete

PHQ-9 ADOLESCENT

Scoring KEY

0 = Not at all

1 = Several days

2 = More than half the days

3 = Nearly every day

1. Feeling down, depressed, irritable, or hopeless.	0	1	2	3
2. Little interest or pleasure in doing things.	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much.	0	1	2	3
4. Poor appetitie, weight loss, or overeating.	0	1	2	3
5. Feeling tired or having little energy.	0	1	2	3
6. Feeling bad about yourself - or feeling that you are a failure, or that you have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things like school work, reading, or watching TV.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you were moving around a lot more than ususal.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3

In the past year have you felt depressed or sad most days, even if you felt okay sometimes?

- ◯ Yes
- ◯ No

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ◯ Not difficult at all
- ◯ Somewhat difficult
- ◯ Very difficult
- ◯ Extremely difficult

Has there been a time in the past month when you have had serious thoughts about ending your life?

- ◯ Yes
- ◯ No

Have you EVER, in your whole life, tried to kill yourself or made a suicide attempt?

- ◯ Yes
- ◯ No

Total score

Score Interpretation

- ◯ 0-4 No or Minimal Depression
- ◯ 5-9 Mild Depression
- ◯ 10-14 Moderate Depression
- ◯ 15-19 Moderately Severe Depression
- ◯ Severe Depression

Today's Date

Complete

Suicide/Homicide Risk

Suicide Risk Assessment - Columbia Suicide Severity Rating Scale

Within Past 30 Days:

Have you wished you were dead or wished you could go to sleep and not wake up?

- ◯ Yes
- ◯ No

Have you actually had any thoughts of killing yourself?

- ◯ Yes
- ◯ No

Have you been thinking about how you might kill yourself?

- ◯ Yes
- ◯ No

Have you had these thoughts and had some intention of acting on them?

- ◯ Yes
- ◯ No

Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan?

- ◯ Yes
- ◯ No

Within Past 90 Days:

Have you done anything, started to do anything, or prepared to do anything to end your life?

- ◯ Yes
- ◯ No

Homicide Risk Assessment

Have you had thoughts of killing someone else?

- ◯ Yes
- ◯ No

Have you started to work out or worked out the details of how to kill them?

- ◯ Yes
- ◯ No

Suicide / Homicide Risk Assessment Comments ☑

Complete

Medical Conditions

High Risk Medical Diagnoses

Children under age 12:

Did your biological mother have HIV when you were born?

- ◯ Yes
- ◯ No

If yes, proceed to HIV questions below.

Did your biological mother have Hepatitis B when you were born?

- ◯ Yes
- ◯ No

If yes, proceed to Hep B questions below.

HIV Questions

Have you ever been diagnosed with HIV?

- ◯ Yes
- ◯ No

Have you ever been tested for HIV?

- ◯ Yes
- ◯ No

Would you like more information on how and where to obtain testing?

- ◯ Yes
- ◯ No

Hep B Questions

Have you ever been vaccinated against Hepatitis B?

- ◯ Yes
- ◯ No

Have you ever been diagnosed with Hep B?

- ◯ Yes
- ◯ No

Have you ever been tested for Hep B?

- ◯ Yes
- ◯ No

Would you like more information on how and where to obtain testing?

- ◯ Yes
- ◯ No

Does the individual report present or history of any other medical conditions?

- ◯ Yes
- ◯ No

☑ If yes, describe reported medical condition(s) including current related medications:

Complete

Physical Health Assess

PHYSICAL HEALTH ASSESSMENT SCREENING

Has the consumer had a physical exam in the past 12 months?

- ◯ Yes
- ◯ No
- ◯ Unknown

Does the consumer require evaluation for pregnancy or prenatal care?

- ◯ Yes
- ◯ No

Allergies - List (including medication allergies):

☑ Special Precautions

Name of personal physician:

Phone Number:

Referral Determination

- ◯ Referral Not Indicated
- ◯ Referral Indicated due to Acute or Chronic Complaint
- ◯ Referral Indicated due to Hx of Chronic Illness Not in Tx
- ◯ Referral Indicated due to No Physical Exam in Past 12 Months
- ◯ Referral Indicated due to Pregnancy or Prenatal Care Eval

☑ Physical Health Screening Results Refferal(s):

REVIEW OF SYSTEMS

(Document pertinent signs & symptoms pt. is experiencing today or has experienced in the past)

Systems reviewed for pertinent positive/negative signs and symptoms

- ☐ CONSTITUTIONAL
- ☐ EYES
- ☐ EARS/NOSE/THROAT
- ☐ CARDIOVASCULAR
- ☐ RESPIRATORY
- ☐ GASTROINTESTINAL
- ☐ GENITOURINARY
- ☐ MUSCULOSKELETAL
- ☐ INTEGUMENTARY
- ☐ NEUROLOGICAL
- ☐ ENDOCRINE
- ☐ HEMATOLOGIC/LYMPHATIC

Current Review of Systems and Changes Noted ☑

Complete

Adult Substance Use

SUBSTANCE USE

AUDIT - C Alcohol Use Disorders Identification Test

Client Age:

ALCOHOL

1. How often do you have a drink containing alcohol?

A. Never	0
B. Monthly or less	1
C. 2-4 times a month	2
D. 2-3 times a week	3
E. 4 or more times a week	4

2. How many standard drinks containing alcohol do you have on a typical day?

A. 0-2	0
B. 3 or 4	1
C. 5 or 6	2
D. 7 to 9	3
E. 10 or more	4

3. How often do you have six or more drinks on one occasion?

A. Never	0
B. Less than monthly	1
C. Monthly	2
D. Weekly	3
E. Daily or almost daily	4

Total:

A = 0 points

B = 1 point

C = 2 points

D = 3 points

E = 4 points

In men, a score of 4 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders.

In women, score of 3 or more is considered positive (same as above).

However, when the points are all from Question #1 alone (#2 & #3 are zero), it can be assumed that the patient is drinking below the recommended limits and it is suggested that the provider review the patient's alcohol intake over the past few months to confirm accuracy.

Generally, the higher the score, the more likely it is that the patient's drinking is affecting his or her safety.

Total score is considered positive or negative for unhealthy alcohol use?

- ◯ Positive
- ◯ Negative

DRUG USE

Has the client ever experienced the use of illegal drugs or prescription drugs for non-medical reasons?

- ◯ Yes
- ◯ No

Describe History of Substance Use ☑

A response to alcohol use of 'at least twice or more times' and/or a 'yes' response to illegal or non-medical drug use above indicates a positive screen for unhealthy alcohol and/or drug use.

Substance Use Screening Disposition

- ◯ Screening indicates a need for further assessment
- ◯ Negative screening - no further action necessary

Tobacco Use Screening

Tobacco Use Status (*excluding e-cigarettes*)

---SELECT---

Tobacco products the patient uses / used:

- ☐ Bidis
- ☐ Chewing Tobacco
- ☐ Cigars / Cigarillos
- ☐ Cigarettes
- ☐ Vaping
- ☐ Hookah
- ☐ Kreteks
- ☐ Pipe
- ☐ Snuff

How frequently does the patient use tobacco in a day?

---SELECT---

How soon within waking does patient use tobacco?

---SELECT---

How ready is the patient to quit using tobacco?

---SELECT---

Tobacco cessation education / counseling intervention provided

- ◯ Yes
- ◯ No

Substance Use and Tobacco Screening Comments and Refferal(s): ☑

Complete

Child Substance Use

CRAFFT Part A
During the Past 12 Months, did you:

1. Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events)
   - ◯ Yes
   - ◯ No
2. Smoke any marijuana or hashish?
   - ◯ Yes
   - ◯ No
3. Use anything else to get high? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or huff)
   - ◯ Yes
   - ◯ No

Did the individual answer 'Yes' to any questions in Part A?

- ◯ Yes
- ◯ No

CRAFFT Part B

(select 1 for Yes and 0 for No)

[1] [0] 1. Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs?

[1] [0] 2. Do you ever use alcohol or drugs to relax, feel better or fit in?

[1] [0] 3. Do you ever use alcohol or drugs while you are by yourself, or alone?

[1] [0] 4. Do you ever forget things you did while using alcohol or drugs?

[1] [0] 5. Do your family or friends ever tell you that you should cut down on your drinking or drug use?

[1] [0] 6. Have you ever gotten in trouble while you were using alcohol or drugs?

[ ] Total Part B Score

CRAFFT Scoring:
Each 'Yes' response in PART B scores 1 point. A total score of 2 or higher is a positive screen, indicating a need for additional assessment.

Tobacco Use Screening

Tobacco Use Status (*excluding e-cigarettes*)
---SELECT---

Tobacco products the patient uses / used:

- ☐ Bidis
- ☐ Chewing Tobacco
- ☐ Cigars / Cigarillos
- ☐ Cigarettes
- ☐ Vaping
- ☐ Hookah
- ☐ Kreteks
- ☐ Pipe
- ☐ Snuff

How frequently does the patient use tobacco in a day?
---SELECT---

How soon within waking does patient use tobacco?
---SELECT---

How ready is the patient to quit using tobacco?
---SELECT---

Tobacco cessation education / counseling intervention provided

- ◯ Yes
- ◯ No

Substance Use and Tobacco Screening Comments/Referrals

Trauma, Abuse, Neglect, E

TRAUMA, ABUSE, NEGLECT, EXPLOITATION

Review the areas below and indicate yes or no, as reported by the individual

Sexual Abuse
- ◯ Yes
- ◯ No

Physical Abuse
- ◯ Yes
- ◯ No

Emotional Abuse
- ◯ Yes
- ◯ No

History of Neglect
- ◯ Yes
- ◯ No

Military Trauma
- ◯ Yes
- ◯ No

War Affected
- ◯ Yes
- ◯ No

Terrorism Affected
- ◯ Yes
- ◯ No

History of Exploitation/Victimization
- ◯ Yes
- ◯ No

Medical Trauma
- ◯ Yes
- ◯ No

Natural Disaster
- ◯ Yes
- ◯ No

Witness to Family Violence
- ◯ Yes
- ◯ No

Witness to Community Violence
- ◯ Yes
- ◯ No

Witness/Victim of Criminal Activity
- ◯ Yes
- ◯ No

Are there significant issues as a result of reported trauma impacting current presenting problem?
- ◯ Yes
- ◯ Denies

For any 'YES' boxes checked, record how the are negatively impacts their daily functioning☑

Complete

Relationships/Home

Overall Quality of Interpersonal Relationships (include challenges, living situation, and concerns):

Complete

Mental Status Exam

Community Healthcore

Mental Status Exam

ORIENTATION

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

RAPPORT

- [ ] Appropriate
- [ ] Hostile
- [ ] Evasive
- [ ] Distant
- [ ] Inattentive
- [ ] Guarded
- [ ] Shy
- [ ] Poor Eye Contact

APPEARANCE

- [ ] Appropriate
- [ ] Poorly Dressed
- [ ] Poorly Groomed
- [ ] Disheveled
- [ ] Body Odor

MOOD

- [ ] WNL
- [ ] Euthymic
- [ ] Depressed
- [ ] Anxious
- [ ] Jocular
- [ ] Labile
- [ ] Irritable/Angry
- [ ] Elation

AFFECT

- [ ] Neutral
- [ ] Euthymic
- [ ] Depressed
- [ ] Anxious
- [ ] Irritable/angry
- [ ] Blunted/flat
- [ ] Labile
- [ ] Euphoric

SPEECH

- [ ] Normal
- [ ] Increased Latency
- [ ] Decreased Rate
- [ ] Poverty
- [ ] Hyperverbal
- [ ] Incoherent
- [ ] Loud
- [ ] Soft

- [ ] Mute
- [ ] Pressured
- [ ] Mumbled
- [ ] Slurred

THOUGHT CONTENT AND PROCESS

- [ ] Coherent
- [ ] Disorganized
- [ ] Delusional
- [ ] Persecution
- [ ] Reference
- [ ] Paranoia
- [ ] Thought insertion
- [ ] Broadcasting
- [ ] Grandiose
- [ ] Circumstantial
- [ ] Tangential
- [ ] Perseveration
- [ ] Loose Associations
- [ ] Clanging
- [ ] Word Salad
- [ ] Impoverished
- [ ] Worthlessness
- [ ] Loneliness
- [ ] Guilt
- [ ] Hopelessness
- [ ] Accusatory
- [ ] Grievance Collecting

HALLUCINATIONS

- [ ] None
- [ ] Auditory
- [ ] Visual
- [ ] Command
- [ ] Tactile
- [ ] Olfactory
- [ ] Internal Sensations

INSIGHT

- [ ] Excellent
- [ ] Good
- [ ] Fair
- [ ] Poor
- [ ] Grossly impaired

JUDGEMENT

- [ ] Excellent
- [ ] Good
- [ ] Fair
- [ ] Poor
- [ ] Grossly impaired

LANGUAGE

- [ ] Excellent
- [ ] Good
- [ ] Fair
- [ ] Poor

- [ ] Grossly impaired

COGNITIVE ATTENTION CONCENTRATION

- [ ] No Gross Deficits
- [ ] Concentration Problems
- [ ] Concrete
- [ ] Abstract
- [ ] Appropriate for Tested IQ
- [ ] Inattentive / Easily Distracted
- [ ] Limited Attention Span
- [ ] Not formally examined

PSYCHOMOTOR ACTIVITY

- [ ] Normal
- [ ] Restless
- [ ] Retardation
- [ ] Fidgety
- [ ] Hyperactive/Instrusive

MEMORY

- [ ] Examined
- [ ] Not examined
- [ ] Unable to Assess

Immediate

- [ ] Good
- [ ] Fair
- [ ] Impaired

Recent

- [ ] Good
- [ ] Fair
- [ ] Impaired

Past

- [ ] Good
- [ ] Fair
- [ ] Impaired

Mental Status Exam Comments: 

Complete

Diagnostic Review

Please confirm diagnosis "Effective Date" below matches the date for this service. If the effective date does not match, click the "Individual Intake" button and update the effective date within the diagnosis section of the client profile.

Current Diagnosis on File

Reason for Action*

R69 Axis Level

- [ ] Axis Level 1
- [ ] Axis Level 2
- [ ] Axis Level 3

Current Adaptive Behavioral Level [required if Principal Diagnosis is IDD]

Potential Adaptive Behavioral Level [required if Principal Diagnosis is IDD]

IQ Test Score

IQ Test Type

IQ Test Date

SQ Test Score

SQ Test Type

SQ Test Date

* ***Indicates required field***

Complete

Medication Management

☑ Medications:

Vital Signs

The listed vital signs and BMI were recorded and reviewed (see Medical Profile)
Height; Current Weight; Blood Pressure; Temperature; Heart Rate:

- ◯ Yes
- ◯ No
- ◯ N/A

Client's Age:

PDMP Database Reviewed

- ◯ Yes
- ◯ No
- ◯ N/A

Pre-Existing Medications for Medication Reconciliation Reviewed this Visit

- ◯ Yes
- ◯ No

Lab Orders:

- ◯ Check Next Visit
- ◯ See Lab Requisition Today's Date

Complete

Plan / Recommendations

Plan / Recommendations / Referrals

Problem (1)

Status

Plan

Problem (2)

Status

Plan

Problem (3)

Status

Plan

Problem (4)

Status

Plan

Treatment Plan Comments:

Check if referred to:

- Skills Training
- Counseling
- General Physician

RETURN TO:

- Nurse
- NP
- PA
- Doctor
- N/A - Discharged

In Weeks:

Complete