Self Care Solutions
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Self Care Solutions Health Psychiatric Assessment-Page 1 of 5

Client Name: ____ **Birth Date:** ________ **Date:** __________

Referred By: ____

General Information:

Age: ____ Race: _______________ Gender: __________ Sexual Orientation: _____________________

Spiritual and/or Cultural Considerations: ____

____

Presenting Problem:

____

____

____

____

Sleep: ____________________________________ Interest: _________________________________

Guilt: _____________________________________ Energy: __________________________________

Concentration: _____________________________ Appetite: ________________________________

Anxiety: ___________________________________ Suicidal/Homicidal Thoughts: _______________

Onset and History:

____

____

____

____

Medical History:

PCP: ____

Allergies: ____

Chronic Illness: ____

____ Signature/Title

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Self Care Solutions Health Psychiatric Assessment-Page 2 of 5

Client Name: ____ **Birth Date:** ________ **Date:** __________

Surgeries: ____

Current Medications (non-psychiatric):

____

____

Psychiatric History:

Hospitalizations: ____

Psychiatric Provider/Therapist: ____

Current Medication: ____

Past Medication Trials: ____

____

____

Drug and Alcohol History:

Alcohol: ____

Drug: ____

Nicotine: ____

Legal Implications:

Arrests: ____

Convictions: ____

CPS Concerns: ____

Abuse History:

Physical: ____

Emotional: ____

Verbal: ____

____ Signature/Title

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Client Name: ____ **Birth Date:** ________ **Date:** __________

Sexual: ____

Family Medical and Psychiatric History:

Maternal: ____

Paternal: ____

Siblings: ____

Relevant Personal History:

Marital Status: S M W D Other _____________

Length of Marriage: ____

Previous Marriage(s): ____

Children (from all relationships): ____

Abortions/Still Births: ____

Early Development: ____

Relationship with Parents: ____

Siblings: ____

____

School History: ____

Social Supports: ____

Work History: ____

____

Mental Status Examination:

Alertness: ____

Orientation: ( ) time ( ) person ( ) place ( ) not oriented

____ Signature/Title

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Client Name: ____ **Birth Date:** ________ **Date:** __________

Appearance: ( ) kempt ( ) unkempt ( ) clean ( ) disheveled ( ) other ______________________________

Attitude: ( ) cooperative ( ) evasive ( ) other ____

Behavior: ( ) appropriate ( ) withdrawn ( ) guarded ( ) paranoid ( ) hostile ( ) non-compliant

( ) manipulative ( ) suspicious ( ) hyperactive ( ) hypoactive

( ) other ____

Memory: immediate recall _____________________ recent _________________ remote ______________

Cognitive Functions: ( ) intact ( ) poor ( ) impaired ( ) other _____________________________________

____

Serial Seven's: _________________________________ Abstract Thinking: _________________________

Intelligence: ____

Hallucinations: ( ) denies ( ) auditory ( ) visual ( ) other ____

Suicidal Ideation: ( ) denies ideation/plan

( ) reports ideation/plan ____

Homicidal Ideation: ( ) denies ideation/plan

( ) reports ideation/plan ____

Impulse Control: ( ) good ( ) fair ( ) poor

Insight: ( ) good ( ) fair ( ) poor

Judgement: ( ) good ( ) fair ( ) poor

____ Signature/Title

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Client Name: ____ **Birth Date:** ________ **Date:** __________

Diagnostic Formulation:

AXIS I ____

AXIS II ____

AXIS III ____

AXIS IV ____

AXIS V ____

Plan of Care:

Safety: ____

Labs (circle if applicable):

CBC, Chemistry Panel, FBS, T3, T4, TSH, Lipids, U/A, U/A Toxicology, U/A HCG, EKG, B12, Folate, Testosterone, Ferritin

Other ____

Medications: ____

____

____

Psychosocial: ____

Referrals: ____

Follow-up Appointment: ____

____ Signature/Title