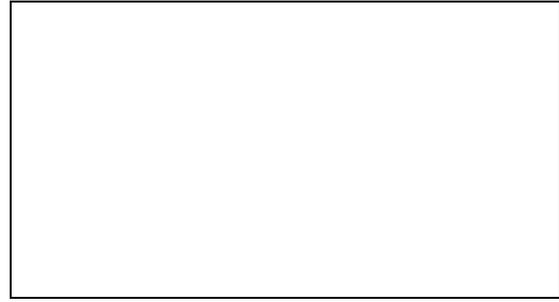




Department of Psychiatry/Behavioral Medicine

**PSYCHIATRIC INTAKE
ASSESSMENT – ADULT**



Time in: _____ Accompanied by: _____

Emergency name and number: _____

Relationship to the patient: _____

Patient Alternate phone number: _____

ALLERGIES: None known: _____ Explain: _____

CURRENT MEDICATIONS:

Name:	Dosage/Frequency	When started
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CHIEF COMPLAINT/DURATION: (per triage sheet)

MEDICAL HISTORY:

B/P _____ P _____ Ht: _____ Wt: _____

Primary care physician: _____

Recent labs: _____

EEG: _____

CT/MRI: _____

MEDICAL HISTORY (continued):

	Y	N	COMMENTS
Constitutional (eg: weight loss, fever)			
Cardiovascular/Hypertension			
GI/Liver			
Neurological (eg: Seizure, CVA)			
Musculoskeletal			
Hematologic/Lymphatic			
Cancer			
Respiratory (eg: COPD, asthma)			
HEENT			
GU			
Skin			
Endocrine (eg: diabetes, thyroid)			
Allergic/Immunologic			
Head/trauma			
Hospitalizations			
Surgeries			
Significant Dx's			

BIOLOGICAL FAMILY MEDICAL HISTORY:

_____ Unknown

	Y	N	Comments
Cardiovascular/Hypertension			
GI/Liver			
Neurological (eg: seizures, CVA, Parkinsons, Huntingtons)			
Cancer			
Respiratory (eg: COPD, asthma)			
GU			
Endocrine			
Other			
Alcohol/Substance abuse			
Psychiatric history			

SOCIAL HISTORY:

Born where? _____ Raised where? _____

Birth order: _____ / _____ Brothers: _____ Sisters: _____

Parents divorced? Yes: _____ No: _____ Specifics: _____

Members in household: _____

Marital status and/or current relationship: _____

S _____ M _____ D (Times _____) W _____

How long? _____ When? _____

Comments: _____

Children: Yes _____ No _____ How many sons? _____ Daughters? _____

Education: _____ Problems: _____

Job description: _____

How long? _____ Problems? _____

Military history: _____

PAST PSYCHIATRIC HX:

Substance "Use" history: (type, duration, severity, treatment Hx; include caffeine & tobacco)

History of emotional, physical or sexual abuse:

Current Stressors: legal, financial, interpersonal.

Vegetative Symptoms: YES NO COMMENT

Sleep	_____	_____	_____
Appetite	_____	_____	_____
Energy	_____	_____	_____
Interest/Motivation	_____	_____	_____
Concentration	_____	_____	_____
Memory	_____	_____	_____
Hopelessness	_____	_____	_____

Manic Symptoms:

<u>Anxiety Symptoms:</u>	<u>YES</u>	<u>NO</u>	<u>COMMENT</u>
(panic, phobias, autonomic symptoms, generalized anxiety)	_____	_____	_____
<u>OCD Symptoms:</u>	_____	_____	_____

Psychotic Symptoms: (Auditory/Visual Hallucinations, paranoia, delusional ideas)

Suicidal or Self-injuries Behaviors:(ideation, plan, intent, means, attempt, etc.)

Current: _____

Past: _____

Homicidal or Assaultive Behaviors:

Eating Disorder:

Cognitive Deficits: (orientation, MR, intellectual decline, wandering, language)

ADD Symptoms:

Comments: _____

Intake RN Signature: _____ Date: _____



MEDICAL ASSOCIATES
C L I N I C

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MENTAL STATUS EXAM

Appearance: WNWD Well kept Other: _____
 Mod kempt Unkempt

Motor activity: Appropriate restless/agitated retarded
 Abnormal movements _____

Speech: Fluent, goal oriented Other: _____
Associations: Intact Loose Tangential

Affect: Bright Labile Irritable Sad
 Anxious Constricted Flat
 Other: _____

Intelligence: Average Above Ave. Low Normal Retarded

Orientation: Name Time Place Comment _____
(check, if normal)

Memory: Immediate Intact Other _____
Recent: Intact Other _____
Remote: Intact Other _____

Delusions/Hallucinations: No Yes

Details _____

Mood: _____

Insight: Normal Other: _____

Judgement: Normal Other: _____

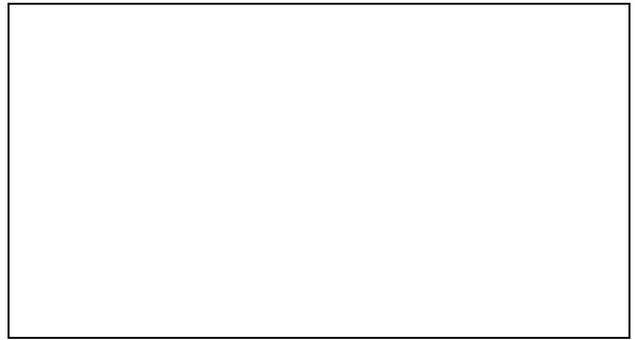
Suicide Assessment: None Other: _____

MMSE _____/30 Details: _____

Comments: _____



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Physician's Impression:

Nursing Evaluation _____ reviewed
Date: _____

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V (Global Assessment of Functioning Scale – Present):

1-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100
Lethality Persists	Lethality Same	Function Poor	Function Impaired	Symptoms Severe	Symptoms Moderate	Symptoms Mild	Symptoms Transient	Symptoms Minimum	Symptoms None

PLAN:

Medications: ↑ Continue same
 ↑ Change: _____

Risk & benefits explained including: _____

Other instructions: _____

Return to Clinic: _____

The patient has been informed to call in the interim should any problems arise.

The patient voices an understanding of the plan.

CC: _____

Signature Doctor _____ Date _____