|  |  |
| --- | --- |
| Person’s Name:        | Date of Psychiatric Evaluation:       |
| Date of Birth:        | Treating Psychiatrist:       |
| Address:       |  |

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| **CURRENT SYMPTOMS/PRESENTING PROBLEM****0=None** **1=** **Mild**/ Occasional impairment but no interference with daily activities **2=** **Moderate**/ Currently experiencing difficulties and frequent disruption to daily activities **3=** **Severe**/Currently experiencing severe distress or chronic disruption to daily activities; potential risk for harm to self/others**NA**= **Not Assessed** |

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| **Anxiety** | 0[ ]  | 1[ ]  | 2[ ]  | 3[ ]  | NA[ ]  |
| **Aggressive Behavior** | 0[ ]  | 1[ ]  | 2[ ]  | 3[ ]  | NA[ ]  |
| **Attention Deficit Hyperactivity Disorder** | 0[ ]  | 1[ ]  | 2[ ]  | 3[ ]  | NA[ ]  |
| **Inappropriate Sexual Behavior** | 0[ ]  | 1[ ]  | 2[ ]  | 3[ ]  | NA[ ]  |
| **Legal Problems** | 0[ ]  | 1[ ]  | 2[ ]  | 3[ ]  | NA[ ]  |
| **Mood Disturbance (Depression)** | 0[ ]  | 1[ ]  | 2[ ]  | 3[ ]  | NA[ ]  |
| **Mood Disturbance (Mania)** | 0[ ]  | 1[ ]  | 2[ ]  | 3[ ]  | NA[ ]  |
| **Mood Disturbance (Bipolar-Depression and Mania)** | 0[ ]  | 1[ ]  | 2[ ]  | 3[ ]  | NA[ ]  |
| **Post-Traumatic Stress Disorder** | 0[ ]  | 1[ ]  | 2[ ]  | 3[ ]  | NA[ ]  |
| **Property Destruction**  | 0[ ]  | 1[ ]  | 2[ ]  | 3[ ]  | NA[ ]  |
| **Psychosis/Hallucinations/Delusions** | 0[ ]  | 1[ ]  | 2[ ]  | 3[ ]  | NA[ ]  |
| **Repetitive, stereotyped behavior** | 0[ ]  | 1[ ]  | 2[ ]  | 3[ ]  | NA[ ]  |
| **Self-injurious behavior** | 0[ ]  | 1[ ]  | 2[ ]  | 3[ ]  | NA[ ]  |
| **Somatic Complaints** | 0[ ]  | 1[ ]  | 2[ ]  | 3[ ]  | NA[ ]  |
| **Substance Abuse/Dependence** | 0[ ]  | 1[ ]  | 2[ ]  | 3[ ]  | NA[ ]  |
| **Medical/Physical Condition that affects behavior (e.g. Dementia, Diabetes)** | 0[ ]  | 1[ ]  | 2[ ]  | 3[ ]  | NA[ ]  |
| **Weight Change associated with a Behavioral Diagnosis** | 0[ ]  | 1[ ]  | 2[ ]  | 3[ ]  | NA[ ]  |
| **Other**  | 0[ ]  | 1[ ]  | 2[ ]  | 3[ ]  | NA[ ]  |

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| **CURRENT DIAGNOSES** |  |
| Mental Health Diagnosis |       |
| Intellectual/Developmental Diagnosis(Refer to Health Passport) |       |
| Medical Diagnosis(Refer to Health Passport) |       |

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| **Diagnoses that are resolved or in remission** |  |
| Mental Health Diagnosis Resolved or in Remission |       |

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| **CURRENT RISK ASSESSMENT** **0=None**  **1= Mild**/ Ideation only **2= Moderate**/ Attempts, but no injury within the last year  **3= Severe**/ Caused injury within the last year**NA**= Not Assessed |

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| Patient’s risk for dangerousness to self | 0[ ]  | 1[ ]  | 2[ ]  | 3[ ]  | NA[ ]  |
| Patient’s risk for dangerousness to others | 0[ ]  | 1[ ]  | 2[ ]  | 3[ ]  | NA[ ]  |

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| --- | --- | --- |
| **CURRENT PSYCHOTROPIC MEDICATIONS**  |  |  |
| **Medication** | **Dosage, Frequency, and Route** | **Symptom targeted by medication** |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |

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| All medication dosages are within accepted recommended prescribing guidelines:[ ]  Yes [ ]  No |
| If No, please explain.      |
| For prescribed medications that require serum level monitoring and/or laboratory tests to screen for medication side effects, provide the date test results were last reviewed: Date       |

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| **TREATMENT PLAN****Treatment outcomes over past year** [ ]  Unknown [ ]  Improved [ ]  No Change [ ]  Worse**Medication adherence** [ ]  Unknown [ ]  Poor [ ]  Fair [ ]  Good**Medication side effects reported** [ ]  Unknown [ ]  None [ ]  Mild [ ]  Moderate [ ]  Severe**Current treatment plan reflects stabilization or improvement in symptoms within past 90 days or, if not, patient’s condition has been re-evaluated and adjustments in treatment plan made accordingly.** [ ]  Yes [ ]  No**Medication side effects discussed with patient and patient’s caregiver:** Date      |

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| **Risks and benefits of current treatment** |  |
| Risks |       |
| Benefits |       |

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| **Specific behavioral criteria at which medication titration or discontinuation will be considered:**      |

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| **If titration is not indicated at this time, what is the clinical justification for continuing current medication regimen:**      |

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| **ADDITIONAL TREATMENT RECOMMENDATIONS, IF ANY:**      |
|  |
| **Signature of Treating Physician:**  | **Date:**       |