Psychiatric Evaluation

PATIENT NAME: xxxxxxx
CID: xxxxxxx
D.O.B: mm/dd/yyyy
PRIMARY CARE PRACTICE:
BENEFIT PLAN:
DATE OF EVALUATION: mm/dd/yyyy
TIME IN: a.m.
TIME OUT: p.m.

IDENTIFYING DATA:

CHIEF COMPLAINT:

HISTORY OF PRESENT ILLNESS:

PAST PSYCHIATRIC HISTORY:

SUBSTANCE ABUSE HISTORY:

PSYCHOSOCIAL HISTORY:

PAST MEDICAL HISTORY:

MENTAL STATUS EVALUATION:

DIAGNOSTIC FORMULATION:

DIAGNOSES:

Axis I:
Axis II:
Axis III:

Axis IV:
Axis V:

TREATMENT/PLAN:

DATE SEEN: mm dd, yyyy **DATE OF RETURN VISIT: FOUR MONTHS**

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PROVIDER SIGNATURE **DATE**