

Date:	Face to Face:	Total Time:	Location:	Service Type: <b>MEDS VISIT</b>
IDENTIFYING DATA:				
CHIEF COMPLAINT:				
HX OF PRESENT ILLNESS:				
PSYCHIATRIC HISTORY:				
Inpatient:				
Outpatient:				
Past medications:				
Current medications:				
Suicidal/homicidal ideation/attempts:				
Physical/Sexual abuse:				
Substance abuse:				
MEDICAL HISTORY:				
Allergies:				
FAMILY HISTORY:				
SOCIAL/CULTURAL HX:				

<b>ADULT PSYCHIATRIC EVALUATION</b> <b>San Bernardino County</b> <b>DEPARTMENT OF BEHAVIORAL HEALTH</b> <b>Confidential Patient Information</b> <b>See W&amp;I Code 5328</b>	NAME:
	DOB:
	CHART NO:
	PROGRAM:

<b>MENTAL STATUS:</b> [WNL = Within Normal Limits]	
Appearance/Hygiene:	<input type="checkbox"/> WNL <input type="checkbox"/> Disheveled <input type="checkbox"/> Poor hygiene
Behavior:	<input type="checkbox"/> WNL <input type="checkbox"/> Uncooperative <input type="checkbox"/> Poor eye contact <input type="checkbox"/> Withdrawn <input type="checkbox"/> Aggressive/agitated <input type="checkbox"/> Intrusive <input type="checkbox"/> Pacing
	<input type="checkbox"/> Talks/smiles/laughs to self <input type="checkbox"/> Other (specify):
Speech:	<input type="checkbox"/> WNL <input type="checkbox"/> Rapid <input type="checkbox"/> Pressured <input type="checkbox"/> Loud <input type="checkbox"/> Slow <input type="checkbox"/> Soft <input type="checkbox"/> Other (specify):
Mood/Affect:	<input type="checkbox"/> WNL <input type="checkbox"/> Depressed <input type="checkbox"/> Angry/irritable <input type="checkbox"/> Anxious <input type="checkbox"/> Flat/blunted <input type="checkbox"/> Tearful <input type="checkbox"/> Constricted/restricted
	<input type="checkbox"/> Labile <input type="checkbox"/> Other (specify):
Perceptual Process:	<input type="checkbox"/> WNL    Hallucinations: <input type="checkbox"/> Auditory <input type="checkbox"/> Command in nature <input type="checkbox"/> Visual <input type="checkbox"/> Other (specify):
Thought Process:	<input type="checkbox"/> WNL <input type="checkbox"/> Loose <input type="checkbox"/> Tangential <input type="checkbox"/> Circumstantial <input type="checkbox"/> Flight of ideas <input type="checkbox"/> Disorganized <input type="checkbox"/> Thought blocking
Thought Content:	<input type="checkbox"/> WNL <input type="checkbox"/> Suicidal Ideation <input type="checkbox"/> Homicidal Ideation
	Delusions: <input type="checkbox"/> Paranoid/persecutory <input type="checkbox"/> Grandiose <input type="checkbox"/> Religious <input type="checkbox"/> Nihilistic <input type="checkbox"/> Somatic <input type="checkbox"/> Erotomanic
Insight:	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor      Memory: <input type="checkbox"/> WNL    Impaired: <input type="checkbox"/> Immediate <input type="checkbox"/> Recent <input type="checkbox"/> Remote
Judgment:	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Oriented X 4    OR NOT Oriented to <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time <input type="checkbox"/> Situation
<b>DIAGNOSTIC IMPRESSION</b> (see Diagnosis form in chart for client's official diagnosis): <b>Put principle diagnosis on first line, and then include all other diagnoses below</b>	
<u>DSM-5/ICD-10 Code</u>	<u>DSM-5/ICD-10 Name</u>
_____ / _____	
_____ / _____	
_____ / _____	
_____ / _____	
_____ / _____	
<b>TREATMENT PLAN / RECOMMENDATIONS:</b>	

<b>ADULT PSYCHIATRIC EVALUATION</b> <b>San Bernardino County</b> <b>DEPARTMENT OF BEHAVIORAL HEALTH</b> <b>Confidential Patient Information</b> <b>See W&amp;I Code 5328</b>	<b>NAME:</b>
	<b>DOB:</b>
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