

Nancy's Prevention Clinic

Initial Psychiatric Evaluation – Adults-Web

Name:		Medication Allergies:	Date:
DOB:	Age: <input type="checkbox"/> Male <input type="checkbox"/> Female	Primary Care Doctor:	Last Exam:
LMP:	Birth Control Method:	Date of Last Labs	Where?
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced / How long? _____ <input type="checkbox"/> Widowed <input type="checkbox"/> Separated /How long _____ <input type="checkbox"/> Partner			

Symptoms: Please comment briefly. Complete every line.

Sleep _____

Appetite _____

Depression/sadness/Crying spells _____

Enjoyment _____

Concentration (Can you pay attention?) _____

Self Esteem/Confidence Level _____

Anxiety/Agitation/moodiness _____

Fatigue (Tired) _____

Obsessions (Thoughts you can't quit thinking) _____

Compulsive Behavior (Things you can't quit thinking or can't stop from doing) _____

Spending Money _____

Risk Taking _____

Suicidal Thoughts (Thoughts, Plans, Actions) _____

Paranoia (Fearful, People staring, Someone wishing harm or poisoning You) _____

Hallucination (Hearing voices, Seeing Visions) _____

Can you Stay Alone? _____

Have you ever Gambled? _____

Stressors _____

Other Comments:

Signature of patient _____ **Date** _____ 1/11

Presenting Complaint:	<input type="checkbox"/> Anxiety <input type="checkbox"/> Hearing Voices	<input type="checkbox"/> Mood Swings <input type="checkbox"/> Depression	<input type="checkbox"/> Paranoia <input type="checkbox"/> Drugs
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Nancy Bryant, FNP-C Patient's Name:

 Date:

Nancy's Prevention Clinic

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PSYCHIATRIC HISTORY

DATES

Previous Examiners	
Previous Diagnosis given	
Psychiatric Hospitalizations	
Suicide attempts	

PRESENT MEDICATIONS:

Name	Over the Counter

PAST MEDICATIONS:

Name	Adverse Reactions

IMMUNIZATION HISTORY

Immunizations Current: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
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Patient's Initials _____ **Date:** _____

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Nancy Bryant, FNP-C

Patient's Name:

Date:

Nancy's Prevention Clinic

Initial Psychiatric Evaluation – Adults-Web

YOUR PSYCHIATRIC HISTORY

- | | |
|---|--|
| <input type="checkbox"/> Alcoholism
<input type="checkbox"/> Depression
<input type="checkbox"/> Bipolar/ Manic Depression
<input type="checkbox"/> Anxiety Disorders
<input type="checkbox"/> Panic Disorders
<input type="checkbox"/> Drug Abuse
<input type="checkbox"/> Phobias
<input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Obsessive-Compulsive Disorder
<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/> Imprisonment
<input type="checkbox"/> Post-traumatic Stress Disorder
<input type="checkbox"/> Mental Retardation
<input type="checkbox"/> ADD/HD
<input type="checkbox"/> Eating Disorders
<input type="checkbox"/> Other: |
|---|--|

FAMILY PSYCHIATRIC HISTORY (Do not complete if you adopted)

Blood relative has had

- | | |
|---|--|
| <input type="checkbox"/> Alcoholism
<input type="checkbox"/> Depression
<input type="checkbox"/> Bipolar/ Manic Depression
<input type="checkbox"/> Anxiety Disorders
<input type="checkbox"/> Panic Disorders
<input type="checkbox"/> Drug Abuse
<input type="checkbox"/> Phobias
<input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Obsessive-Compulsive Disorder
<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/> Imprisonment
<input type="checkbox"/> Post-traumatic Stress Disorder
<input type="checkbox"/> Mental Retardation
<input type="checkbox"/> ADD/HD
<input type="checkbox"/> Giftedness
<input type="checkbox"/> Other: |
|---|--|

YOUR MEDICAL HISTORY

Allergies to food, environment, medications	
Hospitalizations	
Surgeries	
Injuries/Accidents	
Significant Illnesses	

HAVE YOU EVER HAD:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Headaches
<input type="checkbox"/> Palpitation/ Skipped beats
<input type="checkbox"/> Dizziness/ Fainting
<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Shortness Of Breath
<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Muscle/Joint/Back pain : | <input type="checkbox"/> Weight Problems
<input type="checkbox"/> Constipation or Diarrhea
<input type="checkbox"/> Menstrual Problems
<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Urinating problems
<input type="checkbox"/> Hot or cold intolerance
<input type="checkbox"/> Sexual Problems | <input type="checkbox"/> Chickenpox
<input type="checkbox"/> Mumps
<input type="checkbox"/> Measles
<input type="checkbox"/> TB
<input type="checkbox"/> Hearing Problems
<input type="checkbox"/> Vision Problems
<input type="checkbox"/> Seizures | <input type="checkbox"/> Anemia
<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Ear Infections
<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Eczema
<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Sickle Cell Disease/Trait |
|--|---|--|---|

FAMILY MEDICAL HISTORY (Do not complete if you adopted)

Blood relative has had

- | | |
|--|---|
| <input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Deafness
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Birth Defects
<input type="checkbox"/> Asthma
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Eczema | <input type="checkbox"/> Stroke
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Cancer
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Heart Disease
Other: |
|--|---|

Patient's Initials _____ **Date:** _____

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Nancy Bryant, FNP-C

Patient's Name:

Date:

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TESTS/ EVALUATIONS	WHERE	DATES
EKG		
EEG		
MRI		
Psychological Evaluation		
ADD/HD test		
Other:		

SUBSTANCE ABUSE HISTORY

LEGAL HISTORY

Exposure To Tobacco Smoke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Legal Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drug Use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Recent Incarceration	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcohol Use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Driving Under Influence	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tobacco Use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Workman's Comp	<input type="checkbox"/> Other	
Coffee/Soda Use	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

ACADEMIC HISTORY

Highest Education Level:	<input type="checkbox"/> Graduate School	<input type="checkbox"/> College Graduate	<input type="checkbox"/> Partial College	<input type="checkbox"/> High School Grad
	<input type="checkbox"/> Partial High School			
	<input type="checkbox"/> Junior High School			
	<input type="checkbox"/> Less than 7 years of school			
	<input type="checkbox"/> Trade School	What area:		
	What year did you graduate?	What is your degree in?		

PSYCHOTHERAPY HISTORY

Have you been in psychotherapy in the past 6 months? <input type="checkbox"/> yes <input type="checkbox"/> No	With whom :
Start Date:	Stop Date :
What Type of Psychotherapy? <input type="checkbox"/> Cognitive	<input type="checkbox"/> Behavioral
	<input type="checkbox"/> Group
	<input type="checkbox"/> Supportive
	<input type="checkbox"/> Other

ABUSE HISTORY

Have you been sexually abused or molested? <input type="checkbox"/> Yes <input type="checkbox"/> No	By whom:
How old when it started? How old when it ended?	
Corporal abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No Emotional Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No	By whom:

Patient's Initials _____ **Date:** _____

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Nancy Bryant, FNP-C

Patient's Name:

Date:

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BIRTH HISTORY

Country You Were Born:	State:
Did your mother use Drugs or Alcohol while pregnant with you?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Did your mother have a Severe illness while pregnant with you?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Comments:	

FAMILY RELATIONSHIPS

Father's Occupation:	Describe Your Relationship with your Father:
Mother Occupation:	Describe Your Relationship with your mother:
Brothers:	Describe Your Relationship with your brother/s:
Sisters:	Describe Your Relationship with your sister/s:
Did your parents divorce? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, How old were you?

PERSONALITY

Describe your personality growing up	Be specific:
Describe your personality now:	Be specific:

MILITARY HISTORY

Have you ever been in the Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No	Honorably discharged : <input type="checkbox"/> Yes <input type="checkbox"/> No
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Patient's Initials _____ **Date:** _____

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SOCIAL/CULTURAL HISTORY

<input type="checkbox"/> Nancy Bryant, FNP-C	Patient's Name:
<input type="checkbox"/>	Date:

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Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced / How long? _____ <input type="checkbox"/> Widowed <input type="checkbox"/> Separated /How long _____ <input type="checkbox"/> Partner		Language Spoken At Home: _____ Hobbies/ Interests: _____	
Number Of Family Members Living In Same House: _____		Times have you been married: 1 2 3 4 5 or more	
Step children? How many in the home? _____ What is your relationship with your spouse or significant other? Be specific _____			
	Name	Occupation	Age
Patient			
Spouse/Partner			
Child			
Child			
Child			
Child			

GOALS FOR TREATMENT

Describe your goals:	Be specific:

Patient's Initials _____ **Date:** _____
Provider's comments: _____

Nancy Bryant, FNP-C

Patient's Name: _____

Date: _____

Nancy's Prevention Clinic

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The Mood Disorder Questionnaire (MDQ)

Instructions: This questionnaire is an important part of providing you with the best heal care possible. Your answer will help in understanding problems that you have.

Please answer each question as best you can.

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Has there ever been a period or time when you were not your usual self and... | <input type="checkbox"/> | <input type="checkbox"/> |
| you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble? | <input type="checkbox"/> | <input type="checkbox"/> |
| you were so irritable that you shouted at people or started fight or arguments? | <input type="checkbox"/> | <input type="checkbox"/> |
| you felt much more self-confident than usual? | <input type="checkbox"/> | <input type="checkbox"/> |
| you got much less sleep than usual and found you didn't really miss it? | <input type="checkbox"/> | <input type="checkbox"/> |
| you were much more talkative or spoke much faster than usual? | <input type="checkbox"/> | <input type="checkbox"/> |
| thoughts raced through you head or you couldn't slow your mind down? | <input type="checkbox"/> | <input type="checkbox"/> |
| you were so easily distracted by thing around you that you had trouble concentrating or staying on track? | <input type="checkbox"/> | <input type="checkbox"/> |
| you were much more active or did many more things than usual? | <input type="checkbox"/> | <input type="checkbox"/> |
| you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night? | <input type="checkbox"/> | <input type="checkbox"/> |
| you were much more interested in sex than usual? | <input type="checkbox"/> | <input type="checkbox"/> |
| you did things that were unusual for you or that other people might have thought were excessive, foolish or risky? | <input type="checkbox"/> | <input type="checkbox"/> |
| spending money got you or your family into trouble? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal trouble; getting into arguments or fights. | | |
| <input type="checkbox"/> No problem <input type="checkbox"/> Minor problem <input type="checkbox"/> Moderate problem <input type="checkbox"/> Serious problem | | |
| 4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, and uncles) had a manic depressive illness or bipolar disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has a health professional ever told you that you have a manic-depressive illness or bipolar disorder? | <input type="checkbox"/> | <input type="checkbox"/> |

Initials _____ Date _____

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Nancy Bryant, FNP-C

Patient's Name:

Date: