Initial Psychiatric Evaluation Form

Dr. Lumos DNP, PMHNP-BC

Last Name: _____

First Name: _____

DOB: _____

Address: _____

_____

Phone Number: _____

Email: _____

Current Weight: _____

Current Height: _____

Gender: (please check one)

____ Female

____ Male

____ Transgender Female/Transwoman/MTF

____ Transgender Male/Transman/FTM

____ Gender Queer

____ Additional Category (please specify): _____

____ Decline to answer:

What sex were you assigned at birth? (please check one)

_____Male

_____Female

_____Other

_____Decline to answer

What pronouns do you prefer? (check all that apply)

_____She/her/hers

_____He/him/his

_____They/them/theirs

_____Other: Please specify: _____

Do you identify as: (check all that apply)

_____Straight

_____Gay

_____Lesbian

_____Bisexual

_____Other: _____

Reasons for seeking help?

_____Depression

_____Stress

_____Anxiety

_____Post-traumatic stress disorder (PTSD)

_____Bipolar disorder

_____Schizoaffective disorder

_____Schizophrenia

_____Personality disorder

_____Attention deficit hyperactivity disorder (ADHD)

_____Other: _____

Anxiety

Do you experience anxiety? (check one)

_____Yes

_____No

Over the LAST 2 WEEKS, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Worrying too much about different things	☐	☐	☐	☐
Trouble relaxing	☐	☐	☐	☐
Being so restles	☐	☐	☐	☐
Becoming easily annoyed or irritable	☐	☐	☐	☐
Feeling afraid as if something awful might happen	☐	☐	☐	☐

Depression

Do you experience Depression? (please check one)

_____Yes

_____No

Over the LAST 2 WEEKS, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐
Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself, or that you are a failure or have let yourself - or your family down	☐	☐	☐	☐

Over the LAST 2 WEEKS, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Trouble concentrating on things, such as reading newspaper or watching television	◯	◯	◯	◯
Moving or speaking so slowly that other people could have noticed. Or the opposite- being so figety or restless that you have been moving around a lot more than usual	◯	◯	◯	◯
Though that you would be better off dead, or thoughts of hurting yourself	◯	◯	◯	◯

If you checked off ANY problems above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (please check one)

_____**not difficult at all**

_____**somewhat difficult**

_____**very difficult**

_____**extremely difficult**

Female

Are you pregnant? Or think you may be pregnant? (Please check one)

_____yes

_____no

Are you planning to become pregnant? (Please check one)

_____**yes**

_____**no**

_____**maybe**

Birth control methods:

_____

Most recent mammogram (leave blank if you have not had one)

_____

Last menstrual cycle (leave blank if you do not have one)

_____

Current Providers/Doctors

(please list provider name and contact number if possible)

Current psychiatric provider: (list name and phone number)

_____

Current therapist/counselor: (list name and phone number)

_____

Current primary care provider: (list name and phone number)

_____

Mental Health Treatment goals

What are your treatment goals? Please describe in your own words:

_____

_____

_____

_____

_____

_____

_____

_____

Allergies

List drugs, foods, environmental agents, topicals, supplements, herbs, animal allergies and reaction:

_____

_____

Current Medications:

List all current medications including Non-Prescription Drugs:

Current Medication	Size/Dose	How you take

Medical Information:

General Health *

Check any/all that apply
Check all that apply.

- [ ] Recent changes in appetite
- [ ] Weight gain or weight loss
- [ ] Fevers
- [ ] Chills or sweats
- [ ] NONE OF THE ABOVE
- [ ] Other: _____

Head *

Check any/all that apply
Check all that apply.

- [ ] Occasional mild headaches
- [ ] Migraines
- [ ] Recent trauma or concussion
- [ ] NONE OF THE ABOVE
- [ ] Other: _____

Eyes *

Check any/all that apply
Check all that apply.

- [ ] Recent visual changes or double vision
- [ ] Presbyopia (need bifocals)
- [ ] Cataracts
- [ ] Glaucoma
- [ ] NONE OF THE ABOVE
- [ ] Other: _____

Ears *

Check all that apply.

- [ ] Ringing
- [ ] Infection
- [ ] Drainage or pain
- [ ] Mild hearing loss
- [ ] Hearing impaired
- [ ] Hearing aid
- [ ] NONE OF THE ABOVE
- [ ] Other: _____

Nose/Throat/Mouth *

Check any/all that apply
Check all that apply.

- [ ] Frequent nose bleeds
- [ ] Bleeding gums
- [ ] Sores in mouth or lips
- [ ] Difficulty swallowing
- [ ] Hoarseness
- [ ] NONE OF THE ABOVE
- [ ] Other: _____

Lungs *

Check any/all that apply
Check all that apply.

- [ ] Wheezing
- [ ] Chronic cough
- [ ] Emphysema
- [ ] COPD
- [ ] Coughing up blood
- [ ] TB
- [ ] Positive skin test
- [ ] Sleep apnea
- [ ] Use of CPAP
- [ ] Pulmonary embolism
- [ ] Asthma
- [ ] NONE OF THE ABOVE
- [ ] Other: _____

Heart *

Check any/all that apply
Check all that apply.

- [ ] Chest pain or angina
- [ ] Heart skips
- [ ] Rapid heart rate
- [ ] Exertional or nocturnal shortness of breath
- [ ] Cardia testing within the last year (EKG, stress test, cardia catheterization or echo)
- [ ] Heart attack
- [ ] Atrial fibrilation
- [ ] Pacemaker
- [ ] Mitral valve prolapse
- [ ] Hypertension
- [ ] NONE OF THE ABOVE
- [ ] Other: _____

Breast *

Check any/all that apply
Check all that apply.

- [ ] Current breast mass
- [ ] Nipple discharge
- [ ] Personal history of breast cancer
- [ ] Breast augmentation
- [ ] Current abnormal mammogram or sonogram
- [ ] NONE OF THE ABOVE
- [ ] Other: _____

Gento-urinary *

Check any/all that apply
Check all that apply.

- [ ] Difficulty urinating
- [ ] Difficulty holding urine
- [ ] Frequent urination at night
- [ ] Blood in urine
- [ ] Kidney stones
- [ ] Herpes
- [ ] Prostate cancer (MEN only)
- [ ] Discharge from penis (MEN only)
- [ ] Menopause (WOMEN only)
- [ ] Hysterectomy (WOMEN only)
- [ ] Ovaries removed (WOMEN only)
- [ ] NONE OF THE ABOVE
- [ ] Other: _____

Musculoskeletal *

Check any/all that apply
Check all that apply.

- [ ] Pain in joints
- [ ] Pain in muscles
- [ ] Muscle weakness
- [ ] Fibromyalgia
- [ ] Arthritis under treatment
- [ ] Chronic back problems
- [ ] Swollen ankles
- [ ] Varicose veins
- [ ] NONE OF THE ABOVE
- [ ] Other: _____

Neurological *

Check any/all that apply
Check all that apply.

- [ ] Dizziness
- [ ] Loss of conciousness
- [ ] Transient loss of function
- [ ] Stroke
- [ ] Seizures
- [ ] NONE OF THE ABOVE
- [ ] Other: _____

Skin *

Check any/all that apply
Check all that apply.

- [ ] Rash
- [ ] Psoriasis
- [ ] Non-healing lesions
- [ ] History of skin cancers or melanoma
- [ ] NONE OF THE ABOVE
- [ ] Other: _____

Endocrine *

Check any/all that apply
Check all that apply.

- [ ] Thyroid disorder
- [ ] Masses
- [ ] Heat or cold intolerance
- [ ] Taking thyroid medication
- [ ] Diabetes under treatment
- [ ] Excessive thirst, hunger or urination
- [ ] Adrenal or pituitary disorder
- [ ] NONE OF THE ABOVE
- [ ] Other: _____

Hematologic *

Check any/all that apply
Check all that apply.

- [ ] Anemia
- [ ] Bruise easily
- [ ] Excessive bleeding
- [ ] Swollen glands
- [ ] Leukemia
- [ ] Lymphoma
- [ ] Transfusions
- [ ] Blood clots
- [ ] Phlebitis
- [ ] Deep venous thrombosis
- [ ] Anticoagulated with Coumadin
- [ ] Sickle cell
- [ ] NONE OF THE ABOVE
- [ ] Other: _____

Medical History

Past medical problems, non-psychiatric hospitalization, or surgeries:

_____

_____

_____

Have you ever had an EKG? (check one)

____yes. When? _____ If abnormal, please describe: _____

____no.

Date, doctor/provider, and place of last physical exam:

_____

Have you ever been diagnosed with Coronavirus (SARS-CoV-2 or COVID-19)?

___Yes If yes, then when? _____ Were you hospitalized? _____

___No

Have you had a COVID-19 vaccine?

___Yes If yes, when? _____

___No

Personal and Family Medical History (check all that apply)

	Self	Mother	Father	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐	☐
Asthma/Respiratory disease	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐
Heart Disease Pressure	☐	☐	☐	☐	☐	☐	☐
Chronic Pain	☐	☐	☐	☐	☐	☐	☐
Liver problems	☐	☐	☐	☐	☐	☐	☐

	Self	Mother	Father	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather
Anemia	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Stomach or intestinal issues	☐	☐	☐	☐	☐	☐	☐
Epilepsy or seizures	☐	☐	☐	☐	☐	☐	☐
Head Trauma	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐

Past Psychiatric History

Have you ever had feelings that you didn't want to be alive? (Check one)

___Yes, currently

___Yes, in the past

___No

How often do you have these thoughts?

_____

Have you ever tried to kill or harm yourself before? (Check one)

___Yes

___No

Do you have access to guns? (Check one)

___Yes

___No

Outpatient psychiatric treatments

i.e. Age when first saw psychiatric provider/psychiatrist/therapist/counselor

_____

Psychiatric hospitalizations (When? Reason for hospitalization?)

_____

_____

_____

Past psychiatric medications

If you have ever taken any psychiatric medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you remember)

Has anyone in your family been diagnosed with or treated for a psychiatric illness? (please list)

Has any family member been treated with a psychiatric medication?

(Please list who was treated, what medications they took, and how effective the treatment was. If none, please leave blank.)

Substance use

Have you ever been treated for alcohol or drug use or abuse? (Check one)

___Yes

___No

If yes, for which substances?

_____

_____

_____

_____

If yes, where were you treated and when?

_____

_____

How many days per week do you drink alcohol?

_____

How many alcoholic drinks do you have in one day?

_____

Do you think you may have a problem with alcohol or drug use?

___Yes

___No

Have you used any street drugs in the past *3* months?

___Yes

___No

If yes, which ones?

_____

_____

_____

_____

Have you ever abused prescription medication?

___Yes

___No

If yes, which ones and for how long?

_____

_____

_____

Do you use marijuana products? (if yes, please list any products from cannabis sativa such as THC, CBD, etc.)

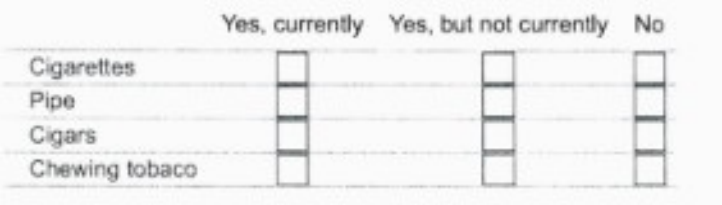
_____

If yes, please list how much and how often:

_____

Tobacco History

Describe tobacco use: (check all that apply)



	Yes, currently	Yes, but not currently	No
Cigarettes	☐	☐	☐
Pipe	☐	☐	☐
Cigars	☐	☐	☐
Chewing tobaco	☐	☐	☐

If yes to any, how often per day on average?

_____

If yes to any, how many years?

_____

Family Background and Childhood History

Your developmental history: (check all that apply)

___No developmental delays

___Pregnancy complications

___Birth complications

Were you adopted? (check one)

___Yes

___No

Where were you born? Where were you raised?

_____

Please list your siblings and their ages:

_____

_____

_____

_____

_____

Did your parents divorce? (Check one)

___Yes

___No

If yes, who did you live with? (Check all that apply)

	Full time	Mostly	Half & half
Mother	☐	☐	☐
Father	☐	☐	☐
Other	☐	☐	☐

Are your parents living? (Check all that apply)

	Yes	No
Mother	☐	☐
Father	☐	☐

Legal History

Briefly describe any past or current legal troubles:

_____

_____

_____

_____

_____

Education

Select highest degree COMPLETED (check one)

___ Some high school

___ High School graduate or GED

___ Some college

___ Associates degree

___ Bachelor's degree

___ Master's degree

___ Doctorate, PhD, MD

Occupation (list job title)

_____

Military History (check one)

___Yes, currently

___ Yes, inactive/discharged/retired

___ No

Religion (please write "yes" or "no". If yes, please list religion.

_____

Please describe your current relationship status: (check all that apply)

_____Single

_____Married

_____In a civil union

_____In a domestic partnership, living together

_____Partnered, not living together

_____Divorced

_____Widowed

_____In a committed relationship

_____ Separated

_____Other: _____

Living situation (Who do you live with? House/apartment/own/rent)

_____

Support System (list anyone who you feel supports you in your life)

_____

Abuse or Trauma History (check all that apply)

___ History of physical abuse

___ History of sexual abuse

___ History of emotional abuse

___ Other

Are you currently or have you ever been in a relationship where you were hurt, threatened, or made to feel afraid?

___Yes

___No

Children (biological, adopted, step, etc.)

Do you have children? If so, list how many, ages, and names.

_____

_____