11 = OFFICE 99= OTHER FIELD 28 = IF NON-FACE-TO-FACE 12= HOME 72= SATELLITE 03= SCHOOL (LOC IS 11 IF NOT SPECIFIED)

Date:	Face to Face:	Total Time:	Location:	Service Type: **MEDS VISIT**

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:

ADULT PSYCHIATRIC EVALUATION
San Bernardino County
DEPARTMENT OF BEHAVIORAL HEALTH
Confidential Patient Information
See W&I Code 5328

NAME:

DOB:

CHART NO:

PROGRAM:

11 = OFFICE 99= OTHER FIELD 28 = IF NON-FACE-TO-FACE 12= HOME 72= SATELLITE 03= SCHOOL (LOC IS 11 IF NOT SPECIFIED)

MENTAL STATUS: [WNL = Within Normal Limits]	
Appearance/Hygiene:	☐ WNL ☐ Disheveled ☐ Poor hygiene
Behavior:	☐ WNL ☐ Uncooperative ☐ Poor eye contact ☐ Withdrawn ☐ Aggressive/agitated ☐ Intrusive ☐ Pacing
	☐ Talks/smiles/laughs to self ☐ Other (specify):
Speech:	☐ WNL ☐ Rapid ☐ Pressured ☐ Loud ☐ Slow ☐ Soft ☐ Other (specify):
Mood/Affect:	☐ WNL ☐ Depressed ☐ Angry/irritable ☐ Anxious ☐ Flat/blunted ☐ Tearful ☐ Constricted/restricted
	☐ Labile ☐ Other (specify):
Perceptual Process:	☐ WNL Hallucinations: ☐ Auditory ☐ Command in nature ☐ Visual ☐ Other (specify):
Thought Process:	☐ WNL ☐ Loose ☐ Tangential ☐ Circumstantial ☐ Flight of ideas ☐ Disorganized ☐ Thought blocking
Thought Content:	☐ WNL ☐ Suicidal Ideation ☐ Homicidal Ideation
	Delusions: ☐ Paranoid/persecutory ☐ Grandiose ☐ Religious ☐ Nihilistic ☐ Somatic ☐ Erotomanic

Insight:	☐ Good ☐ Fair ☐ Poor	Memory: ☐ WNL Impaired: ☐ Immediate ☐ Recent ☐ Remote	
Judgment:	☐ Good ☐ Fair ☐ Poor	☐ Oriented X 4 OR NOT Oriented to ☐ Person ☐ Place ☐ Time ☐ Situation	

DIAGNOSTIC IMPRESSION (see Diagnosis form in chart for client's official diagnosis): Put principle diagnosis on first line, and then include all other diagnoses below

DSM-5/ICD-10 Code	DSM-5/ICD-10 Name
_____/_____	
_____/_____	
_____/_____	
_____/_____	
_____/_____	

TREATMENT PLAN / RECOMMENDATIONS:

ADULT PSYCHIATRIC EVALUATION
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