**Psychiatric Evaluation Athena Prompts – (MHNP)**

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| **Patient Name:** | | | | | |
| **Date of Service:** | | | | **Location:** | |
| **HISTORY OF PRESENT ILLNESS**  Client is a **﻿\_\_\_\_\_\_\_\_\_\_\_** year old \_\_\_\_\_\_\_\_ presenting for session due to ﻿\_\_\_\_\_\_\_\_\_\_\_\_\_. Client has experienced the following symptoms/behaviors: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ which have caused impairments/risks in the following:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. | | | | | |
| **RELATIONSHIPS AND FAMILY**  I am currently married or in a significant relationship: yes / no ﻿If Yes, this relationship is: ﻿ Good/fair/poor Why? ﻿\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  My current relationship with my family is: ﻿ Good/fair/poor/NA Why? ﻿\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  My current relationship with my friends is: ﻿ Good/fair/poor/NA Why? ﻿\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Overall, my childhood was: ﻿ Good/fair/poor Why? ﻿\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  A significant friend or relative of mine has died in the last year: ﻿ yes / no  If Yes, Who? Cause of Death? ﻿\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **RELIGION/CULTURE**  Do you consider yourself religious? ﻿ yes / no  Do you attend religious services regularly? ﻿ yes / no  What are the religious, spiritual, cultural, or ethnic considerations that we should be aware of as we meet with you? ﻿\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **EDUCATION**  Are you currently enrolled in school/college/training: ﻿ yes / no  If Yes: ﻿\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  The highest grade I completed in school was: ﻿\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  For me school was: Good/fair/poor | | | | | |
| **EMPLOYMENT/MILITARY**  Current Employment: ﻿\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What kind of work do you do? ﻿\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship with co-workers: ﻿ Good/fair/poor/NA Relationship with supervisor: ﻿ Good/fair/poor/NA  How long have you been there? ﻿\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many days did you work in the last month? ﻿\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  What was your favorite job? ﻿\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Military service: ﻿ yes / no If yes, dates: ﻿\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Were you ever in combat? yes / no | | | | | |
| **ALCOHOL & OTHER DRUG USE**  Do members of your family have a history of alcoholism or problems with drinking or drugs? ﻿ yes / no  Do members of your family presently use alcohol or other drugs? ﻿ yes / no  At any time in the last 30 days have you felt that you should reduce or stop:  Smoking cigarettes? ﻿ yes / no / never  Alcohol Use? ﻿ yes / no / never  Drug use? ﻿ yes / no / never  Has drinking or taking drugs caused you any problems with school, friends, family, spouse, police, or your health? ﻿ yes currently / not currently / yes within the last year / not within the last year  Was drinking or using drugs a problem for you at one point in your life but not a problem now? ﻿ yes / no / never  Does your personality change under the influence? ﻿ yes / no / never If yes, describe briefly: ﻿\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Has your use of alcohol or other drug made any mental health problems you have worse? ﻿ yes / no / never  Substance Abuse: ﻿\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Prescription drugs not from a provider including opioids, benzos, stimulants: ﻿ Current / past / Never  Have you ever felt you should cut down on your use? ﻿ Yes / no / na  Has anyone else expressed concern about your drinking/drug use? ﻿ Yes / no / na  Have people annoyed you by criticizing your use? ﻿ Yes / no / na  Have you ever felt bad or guilty about your use of ? ﻿ Yes / no / na  Are you currently in substance use treatment: ﻿ Yes / no / na  History of substance use treatment ﻿ Yes/no  Have you ever attended AA or NA? ﻿ Yes/no If Yes, about how long did you attend? What is the longest you were ever clean and sober? ﻿\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **MEDICATIONS**  Medication Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date Prescribed: ﻿\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Dosage/Frequency: ﻿\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Side Effects: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  All medication taken as prescribed? Yes / no / na | | | | | |
| **MEDICAL**  Please describe any significant diseases, surgeries, or injuries from your past or present: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you have any known allergies, including medication allergies? ﻿ Yes / no  My last physical examination was on (date): ﻿\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I am on a special diet: ﻿ Yes / no | | | | | |
| **MENTAL HEALTH**  Have you ever seen a counselor or psychiatrist about a problem? ﻿ Yes / no If Yes, did they recommend services for you? ﻿ Yes / no / na If Yes, did you complete this treatment? ﻿ Yes / no / na  During the last month how often have you felt well enough to do what you usually do during the day? ﻿Never/ rarely / often / very frequently  My sleep has been Good / fair / poor ﻿and I sleep for ﻿\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hours.  During the past 6 months I have ﻿ Maintained / lost / gained weight Notes related to weight change: ﻿\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I have recently received the following mental health care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I have previously been diagnosed with the following: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ACTIVE MENTAL HEALTH SYMPTOMS/CONCERNS:  Current Depression: Yes / no / na If Yes, list symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current Anxiety: Yes / no / na If Yes, list symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Obsessions: Yes / no / na Compulsions: Yes / no / na  Feeling Overwhelmed or Stressed: Yes / no / na  Difficulty Planning/Completing Tasks: Yes / no / na Hallucinations: Yes / no / na  Paranoia: Yes / no / na Delusions: Yes / no / na  Other: None|Homicidal ideation|Ideas of reference| Derealization| Depersonalization| Dissociation|Delusions|Grandiose|Bizarre|Persecutory|Odd beliefs  Onset/Occurence of Symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  The Timing of Symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  During the last 6 months have you had suicidal thoughts? Yes / no  During the last 6 months have you had thoughts of harming others? Yes / no | | | | | |
| **VIOLENCE & TRAUMA**  Have you ever been physically, sexually, and/or emotionally abused? ﻿ Yes / no If Yes, please describe (How old were you? Nature of abuse? Who were you abused by? Was anyone arrested?): ﻿\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Did you ever witness a violent death or extreme violence against someone else? Yes / no | | | | | |
| **NEEDS ﻿**  Psychotherapy / medication management / other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **SAFETY PLAN**  Is specific safety plan indicated? ﻿ Yes / no  Reasons for living/gratitude for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  People who I can ask for help: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Making the environment safe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **PSYCHIATRIC EXAM** | | | | | |
| **﻿General Appearance**  alert  well-groomed  well-developed  clean  appears well rested  not alert  disheveled  major physical anomaly  body odor  overweight  underweight  appears fatigued | **Behavior**  maintains eye contact  cooperative  appears engaged  not impulsive  calm  not guarded  does not make eye contact  uncooperative  attitude is disinterested  impulsive  disruptive  guarded | **Mood**  euthymic  not depressed  not anxious  not irritable  not sad  dysphoric  depressed  anxious  irritable  sad | **Affect**  appropriate  not euphoric  has broad range  pleasant  congruent with mood  not tearful  not sad  not angry  not agitated  not hostile  not labile  no excessive/inappropriate laughing  not shallow  not blunted  not restricted  not flat  not constricted  inappropriate  limited range  unpleasant  incongruent with mood  tearful  sad  angry  agitated  hostile  labile  euphoric  excessive/inappropriate laughing  shallow  blunted  restricted  flat  constricted | | **Thought** **Processes**  associations are logical  attention span is normal throughout interview  concentration intact  shows loosening of associations  attention wandered throughout interview  concentration impaired  perseverative  tangential  flight of ideas  thought blocking  poverty of thought  circumferentiality |
| **Thought Content**  normal thought content  no delusions  no obsessions  no hallucinations  no suicidal ideation  no homicidal ideation  delusions  obsessions  visual hallucinations  auditory hallucinations  suicidal ideation  homicidal ideation  Judgment  intact  impaired | **Insight**  intact  impaired  Neurological System | **Orientation**  oriented to time  oriented to place  oriented to person  oriented to situation  disoriented to time  disoriented to place  disoriented to person  disoriented to situation | **Memory**  immediate recall is intact  remembers 3 of 3 items after short period  remote memory is intact  no word retrieval difficulty  immediate recall is impaired  remembers of 3 items after short period  remote memory is impaired  word retrieval difficulty | | **Fund of Knowledge**  broad fund of knowledge  average vocabulary  limited fund of knowledge  below average vocabulary |
| **Speech**  speech is articulate and coherent  normal volume  language is appropriate for education level  language is intact for naming pen and clock  language fluency intact for repetition  speech has long pauses  increased volume  volume is decreased  language is not up to level of education  unable to name: pen / clock / clock or pen  language fluency is impaired for repetition  dysarthric  stutter  absent speech  change in voice quality  impoverished speech | **Gait And Stance**  normal gait characteristics  normal stance phases  normal swing phase  spastic gait  shuffling  antalgic gait  propulsive gait  stooped gait  ataxic gait  assistive device used  increased base of support  limping on the right  limping on the left  arm swing | **Motor**  normal strength in lower extremities  normal muscle tone and bulk  no tremor  no tics  no involuntary movements (dyskinesia)  weakness right upper extremity  weakness left upper extremity  weakness lower right extremity  weakness left lower extremity  bilateral cogwheel rigidity  left cogwheel rigidity  right cogwheel rigidity  atrophy  bradykinesia  dystonia  resting tremor of right upper extremity  resting tremor of left upper extremity  resting tremor of right lower extremity  resting tremor of left lower extremity  fine, rapid tremor  resting tremor of head  coarse tremor of head  perioral tremor  action tremor  motor tics  oral, buccal, lingual dyskinesia  dyskinesia of trunk  dyskinesia of neck  dyskinesia of right upper extremity  dyskinesia of left upper extremity  dyskinesia of right lower extremity  dyskinesia of left lower extremity | | | |
| **ASSESSMENT AND PLAN**  **DIAGNOSES & ORDERS:** | | | | | |
| Psychotherapy Referral: Client is an appropriate candidate for follow-up services via Telehealth and/or Telephone: yes / no Psychotherapy Referral made: yes / no  Other referrals made:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Client is an appropriate candidate for follow-up services via Telehealth and/or Telephone: Yes/no  PROTECTIVE FACTORS:  RISK FACTORS:  RISK ASSESSMENT:  While it is impossible to accurately predict future behaviors, a thorough risk assessment  was performed. Client risk is assessed to be \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Client currently {{denies SI/HI|endorses SI/HI|. Client's sxs/bxs include: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ which cause impairment in the following: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. | | | | | |
| PLAN AND RECOMMENDATION | | | | | |
| Impression: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.  Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.  Therapy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.  Follow up: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.  Client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to treatment plan. | | | | | |