**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 / noWhat 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/NAHow 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 / neverAlcohol Use? ﻿ yes / no / neverDrug use? ﻿ yes / no / neverHas 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 yearWas drinking or using drugs a problem for you at one point in your life but not a problem now? ﻿ yes / no / neverDoes 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 / neverSubstance Abuse: ﻿\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Prescription drugs not from a provider including opioids, benzos, stimulants: ﻿ Current / past / NeverHave you ever felt you should cut down on your use? ﻿ Yes / no / naHas anyone else expressed concern about your drinking/drug use? ﻿ Yes / no / naHave people annoyed you by criticizing your use? ﻿ Yes / no / naHave you ever felt bad or guilty about your use of ? ﻿ Yes / no / naAre you currently in substance use treatment: ﻿ Yes / no / naHistory of substance use treatment ﻿ Yes/noHave 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 / naDuring the last month how often have you felt well enough to do what you usually do during the day? ﻿Never/ rarely / often / very frequentlyMy 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 / naFeeling Overwhelmed or Stressed: Yes / no / na Difficulty Planning/Completing Tasks: Yes / no / na Hallucinations: Yes / no / naParanoia: Yes / no / na Delusions: Yes / no / na Other: None|Homicidal ideation|Ideas of reference| Derealization| Depersonalization| Dissociation|Delusions|Grandiose|Bizarre|Persecutory|Odd beliefsOnset/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**alertwell-groomedwell-developedcleanappears well restednot alertdisheveledmajor physical anomalybody odoroverweightunderweightappears fatigued | **Behavior**maintains eye contactcooperativeappears engagednot impulsivecalmnot guardeddoes not make eye contactuncooperativeattitude is disinterestedimpulsivedisruptiveguarded | **Mood**euthymicnot depressednot anxiousnot irritablenot saddysphoricdepressedanxiousirritablesad | **Affect**appropriatenot euphorichas broad rangepleasantcongruent with moodnot tearfulnot sadnot angrynot agitatednot hostilenot labileno excessive/inappropriate laughingnot shallownot bluntednot restrictednot flatnot constrictedinappropriatelimited rangeunpleasantincongruent with moodtearfulsadangryagitatedhostilelabileeuphoricexcessive/inappropriate laughingshallowbluntedrestrictedflatconstricted | **Thought** **Processes**associations are logicalattention span is normal throughout interviewconcentration intactshows loosening of associationsattention wandered throughout interviewconcentration impairedperseverativetangentialflight of ideasthought blockingpoverty of thoughtcircumferentiality |
| **Thought Content**normal thought contentno delusionsno obsessionsno hallucinationsno suicidal ideationno homicidal ideationdelusionsobsessionsvisual hallucinationsauditory hallucinationssuicidal ideationhomicidal ideationJudgmentintactimpaired | **Insight**intactimpairedNeurological System | **Orientation**oriented to timeoriented to placeoriented to personoriented to situationdisoriented to timedisoriented to placedisoriented to persondisoriented to situation | **Memory**immediate recall is intactremembers 3 of 3 items after short periodremote memory is intactno word retrieval difficultyimmediate recall is impairedremembers of 3 items after short periodremote memory is impairedword retrieval difficulty | **Fund of Knowledge**broad fund of knowledgeaverage vocabularylimited fund of knowledgebelow average vocabulary |
| **Speech**speech is articulate and coherentnormal volumelanguage is appropriate for education levellanguage is intact for naming pen and clocklanguage fluency intact for repetitionspeech has long pausesincreased volumevolume is decreasedlanguage is not up to level of educationunable to name: pen / clock / clock or penlanguage fluency is impaired for repetitiondysarthricstutterabsent speechchange in voice qualityimpoverished speech | **Gait And Stance**normal gait characteristicsnormal stance phasesnormal swing phasespastic gaitshufflingantalgic gaitpropulsive gaitstooped gaitataxic gaitassistive device usedincreased base of supportlimping on the rightlimping on the leftarm swing | **Motor** normal strength in lower extremitiesnormal muscle tone and bulkno tremorno ticsno involuntary movements (dyskinesia)weakness right upper extremityweakness left upper extremityweakness lower right extremityweakness left lower extremitybilateral cogwheel rigidityleft cogwheel rigidityright cogwheel rigidityatrophybradykinesiadystoniaresting tremor of right upper extremityresting tremor of left upper extremityresting tremor of right lower extremityresting tremor of left lower extremityfine, rapid tremorresting tremor of headcoarse tremor of headperioral tremoraction tremormotor ticsoral, buccal, lingual dyskinesiadyskinesia of trunkdyskinesia of neckdyskinesia of right upper extremitydyskinesia of left upper extremitydyskinesia of right lower extremitydyskinesia 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 / noOther referrals made:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Client is an appropriate candidate for follow-up services via Telehealth and/or Telephone: Yes/noPROTECTIVE 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. |