Psychiatric History Assignment Template

**S:** Subjective

*Information the client or representative told you*

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| --- | --- | --- | --- | --- | --- | --- |
| Initials: Click or tap here to enter text. | | Age: Click or tap here to enter text. | | | Gender: Click or tap here to enter text. | |
| **Include vital signs if provided . State not provided here if not available.** | | | | | | |
| Allergies (and reaction)  Medication: Click or tap here to enter text.  Food: Click or tap here to enter text.  Environment: Click or tap here to enter text. | | | | | | |
| **History of Present Illness (HPI)** | | | | | | |
| **Chief Complaint (CC)** | | | | | | *CC is a BRIEF statement identifying why the client is here - in the patient’s own words - for instance "I have been feeling depressed," NOT "symptoms of depression for 3 weeks.” History of Present Illness (HPI)*  *(1) develops illness narrative: (****cogent story with clear chronology, not a list*** *of symptoms), and*  *(2) includes specific details of symptoms, and the impact of these symptoms on daily life.* |
| **HPI**  Click or tap here to enter text. | | | | | |
| **Current Medications:** *Include dosage, frequency, length of time used and reason for use; also include OTC or homeopathic products. State NA if no current medications.* | | | | | | |
| **Medication**  *(Rx, OTC, or Homeopathic)* | **Dosage** | | **Frequency** | **Length of Time Used** | | **Reason for Use** |
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| **Past Psychiatric History -** *Includes all previous mental health psychotherapy and medication management. Be as descriptive as possible. Include type of provider, name if provided, year(s) of treatment, types of services received, history of trauma, self-harm or harm to others.* | | | | | | |
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| **Medical History (PMHx) –** *Includes active medical problems (currently getting managed) and past medical problems (no longer needing any intervention), hospitalizations, and surgeries. Depending on the CC, more info may be needed.* | | | | | | |
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| **Family History (Fam Hx) -** History includes, *but it is not limited to illnesses with possible genetic predisposition, contagious or chronic illnesses. Reason for death of any deceased first-degree relatives should be included. Include parents, grandparents, siblings, and children. Include grandchildren if pertinent.* | | | | | | |
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| **Social History (Soc Hx) -** History i*ncludes, but it is not limited to education, occupation,* current employment (If not currently working, when was the last time client worked and what was the reason for stopping?) *current living arrangements, hobbies, relationship status, tobacco, alcohol and other substance use including cannabis or CBD use, legal issues, and any other pertinent data.* |
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| **Review of Systems** **(ROS):** *Address all body systems that may help rule in or out a differential diagnosis Check the box next to each positive symptom and provide additional details. Include all provided information. If not assessed leave blank or select “other” if not applicable to the client.* | | | | | | | | | |
| **Constitutional**  If patient denies all symptoms for this system, check here: | | | **Skin**  If patient denies all symptoms for this system, check here: | | | | **HEENT**  If patient denies all symptoms for this system, check here: | | |
| Fatigue Click or tap here to enter text.  Weakness Click or tap here to enter text.  Fever/Chills Click or tap here to enter text.  Weight Gain Click or tap here to enter text.  Weight Loss Click or tap here to enter text.  Trouble Sleeping Click or tap here to enter text.  Night Sweats Click or tap here to enter text.  Other:  Click or tap here to enter text. | | | Rashes Click or tap here to enter text.  Other:  Click or tap here to enter text. | | | | Diplopia Click or tap here to enter text.  Vision changes Click or tap here to enter text.  Photophobia Click or tap here to enter text.  Earache Click or tap here to enter text.  Tinnitus Click or tap here to enter text.  Epistaxis Click or tap here to enter text.  Vertigo Click or tap here to enter text.  Hearing Changes Click or tap here to enter text.  Other:  Click or tap here to enter text. | | |
| **Respiratory**  If patient denies all symptoms for this system, check here: | | **Neuro**  If patient denies all symptoms for this system, check here: | | **Cardiac and Respiratory**  If patient denies all symptoms for this system, check here: | | | | | **MSK**  If patient denies all symptoms for this system, check here: |
| Cough Click or tap here to enter text.  Hemoptysis Click or tap here to enter text.  Dyspnea Click or tap here to enter text.  Wheezing Click or tap here to enter text.  Pain on Inspiration Click or tap here to enter text.  Snoring : Click or tap here to enter text.  Other:  Click or tap here to enter text. | | Syncope or Lightheadedness Click or tap here to enter text.  Headache Click or tap here to enter text.  Numbness Click or tap here to enter text.  Tingling Click or tap here to enter text.  Sensation Changes  Choose an item.  Speech Deficits Click or tap here to enter text.  Other: Click or tap here to enter text. | | Chest pain Click or tap here to enter text.  SOB Click or tap here to enter text.  Previous cardiac history Click or tap here to enter text.  Other: Click or tap here to enter text. | | | | | Pain Click or tap here to enter text.  Limited ROM Choose an item.  Redness Click or tap here to enter text.  involuntary movements Click or tap here to enter text.  Other: Click or tap here to enter text. |
| **Hematology/Lymphatics**  If patient denies all symptoms for this system, check here: | **GI**  If patient denies all symptoms for this system, check here: | | | | **GU**  If patient denies all symptoms for this system, check here: | | | **Endocrine**  If patient denies all symptoms for this system, check here: | |
| Anemia Click or tap here to enter text.  Other Click or tap here to enter text. | Nausea/Vomiting Click or tap here to enter text.  Dysphasia Click or tap here to enter text.  Diarrhea Click or tap here to enter text.  Appetite Change Click or tap here to enter text.  Heartburn Click or tap here to enter text.  Abdominal Pain Click or tap here to enter text.  Click or tap here to enter text.  Other: Click or tap here to enter text. | | | | | Urgency Click or tap here to enter text.  Polyuria Click or tap here to enter text.  Nocturia Click or tap here to enter text.  Incontinence Click or tap here to enter text.  Other: Click or tap here to enter text. | | Increased appetite Click or tap here to enter text.  Increased thirst Click or tap here to enter text.  Thyroid disorder Click or tap here to enter text.  Heat/cold intolerance Click or tap here to enter text.  Excessive sweating Click or tap here to enter text.  Diabetes Click or tap here to enter text.  Other Click or tap here to enter text. | |