Name:

Psychiatric Interview

S: Subjective

Initials: Ken Smith	Age: 54	Gender: Male

Include vital signs if provided . Document not provided if not available.

Height	Weight	Allergies (and reaction)
5'9	150	Medication: none Food: shellfish-anaphylaxis Environment: none

History of Present Illness (HPI)

Chief Complaint (CC) Getting care through the VA but because of shortage of providers they are allowing me to receive care outside of the VA. Depression and Bipolar disorder

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
Pt present today to continue to Psychiatric care. Pt reports history of Depression and Bipolar for which he is actively taking medication for. Pt notes that he was dx with bipolar disorder in 2000 after working several shifts as a physician in the military and had a break down. Pt repots that he was diagnosed with ADD in 1998 but was never evaluated nor medicated for the disorder. About six months ago pt wife as well as himself notice that he was a little depressed. Pt was rx Wellbutrin for condition in which he notice that his sleep and mood have improved. Pt report good appetite and exercise 2-3 times per week.

Current Medications: *Include dosage, frequency, length of time used and reason for use; also include OTC or homeopathic products.*

Medication *(Rx, OTC, or Homeopathic)*	**Dosage**	**Frequency**	**Length of Time Used**	**Reason for Use**
Lithium	900	Q hs	15 years	Bipolar
Wellbutrin SR	300	Q am	6 months	Depression
Synthroid	**Unable to obtain**	**Q am before breakfast**	**Unable to obtain**	**Hypothyroid**
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

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Name:

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.*				
Pt report that he did receive emotional and physical abuse during his childhood from mother but not mention if he received any type of treatment for these issues.				
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.*				
Hypothyroidism currently being managed by medication				
Family History (Fam Hx) - *History* i*ncludes but 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 (if information was provided), siblings, and children. Include grandchildren if pertinent.*				
Married 25 years Mother (deceased) has a hx of Bipolar Disorder, Borderline Schizophrenia, and Breast Cancer-Mother deceased Father- history of DM Brother-Depression surrounding divorce Three children ages 19, 21, 23 The 21 y.o daughter is taking medication for depression				

currently working, when was last time client was employed and what was the reason for stopping?), current living arrangements, hobbies, relationship status, tobac

Military Physician retired unknown year.
Married lives with spouse and pets 2 dogs and a cat Unknown if he smokes, have ever used any drugs or alcohol.
Pt reports that he was a good student in school. States that he was diagnose with ADD but never evaluated for the condition. Describes his

motivation habit as anal attentive

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 In the past 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** 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.	☐ Syncope or Lightheadedness Click or tap here to enter text. ☐ Headache Click or tap here to enter text. ☐ Numbness Click or tap	☐ 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	☐ Pain Click or tap here to enter text. ☐Limited ROM ☐ Redness Click or tap

☐ Wheezing Click or tap here to enter	here to enter text.	text.	here to enter text. ☐ involuntary movements

Name:

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.	☐ Tingling Click or tap here to enter text. ☐ Sensation Changes ☐ Speech Deficits Click or tap here to enter text. ☐ Other: Click or tap here to enter text.		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 Hypothyroid ☐ 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.

O: Objective

Document pertinent positive and negative assessment findings. Pertinent positive are the "abnormal" findings and pertinent "negative" are the expected normal findings. Separate the assessment findings

Name:

Mental status exam	Findings
Name:	
Appearance	This is a patient who appears to be of stated age, casually and neatly dressed and in no acute distress.
Behavior	The patient engaged the examiner in a cooperative, friendly and polite manner. The patient demonstrated good eye contact. His stream of mental activity was logical, relevant, coherent and goal directed with no evidence of flight of ideas, loosenes of associations, thought blocking, psychomotor retardation, presured speech, racing thoughts, circumstantiality or tangentiality
Speech	His speech was spontaneous with normal rate, rhythm and tone. His reaction in the questions was normal
	Click or tap here to enter text.
Affect	While his affect was appropriate to the situation, his mood was euthymic with no evidence of depresion, guilt feelings and suicidal or homicidal ideation curently
Thought Process	His comprehension and understanding were good. Therefore, his intelligence was estimated to be above average, consistent with his level of formal education.
	Click or tap here to enter text.
Thought Content	His thought content revealed no evidence of delusional ideation, interference or responses to internal stimuli, hallucinations, ideas of reference, mood swings, compulsions, obsesions, or any specific preoccupations
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List items the
Medication a

Include at l
may us
Childhood tra
own performa
been little en
hyperactivity

Click or tap here to enter text.

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ed with one's
has also
ficit

Reference
Marshall, J. J

trauma and its

Attention and Concentration	Hisconcentrationandattentionwerebothadequate.
Click or tap here to	
Memory	Hismemorywasintactincludinghisimmediate,recentpastandremotememory.
Orientation	Thepatientwasalertandorientedinallthreespheres.Hisattentionandconcentrationwereintact.His fundofgeneralinformationwasgood