Please Complete and Give to Your Physician

Name_____ Date_____

Main issue that you would like to discuss today (concerns, questions, etc)

_____
_____
_____
_____
_____

Please list any mood or behavioral problems since last visit (such as insomnia, depression, anxiety etc.)

_____
_____
_____

Current Meds:_____
_____
_____
_____

Since the last office visits, have there been any changes in your medical condition of medications?_____ If yes, please explain.

_____
_____
_____

Have you taken your medications as prescribed?_____ If not, why?

_____
_____
_____

Please list any problematic side effects

_____
_____
_____

Overall, is your condition (circle one)
WORST 1 2 3 4 5 6 7 8 9 10 BEST

Are you having suicidal or violent thoughts?

_____
_____
_____

To Be Filled Out By the Physician

Patient's Name _____Date_____

Time spent_____Person's present_____MR#_____

Subjective_____
_____
_____
_____
_____
_____

Mental Status Exam

	WNL		WNL
Appearance	O	Mood	O
Speech/Language	O	Affect	O
Orientation/Cognitive	O	Psychosis	O
Suicidal/Violent	O	Motor Activity	O
Thought Process/Content			O

Assessment: WORST 1 2 3 4 5 6 7 8 9 10 BEST

Diagnosis:
Axis I_____ Axis IV_____
AxisII_____ Axis V_____
AxisIII_____ Unchanged_____(check if yes)

Assessment _____
_____
_____
_____
_____

Lab_____

Plan_____
_____
_____
_____
_____

_____ Follow-Up appointment_____
Physician Signature