



Psychopharmacology Evaluation

Patient Name: _____ Date of Evaluation: ____/____/____

Location: _____ Telephone: _____

DOB: ____/____/____ Age: _____ Address: _____

Guardian's Name: _____

Sources of Information: guardian chart review interview & patient examination

Billing Contact Person: _____ Telephone: _____

Primary Physician Name: _____ Telephone: _____

Teacher Name: _____ Level of Education: _____

Major Recent Medical and Social Concerns: _____

Cognitive Concerns (such as memory disorder, learning disabilities, mental retardation, severity, and cause of cognitive problems if known):

History of Current Problems (in brief) :

_____ (cont. next page)

Current Medications:

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Past Medications:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

**Triangle Neuropsychiatry
Psychopharmacology Evaluation**

Seizure Type: _____ **Description:** _____

Duration and Frequency of Spells: _____

Psychological Evaluations (most recent testing):

Test: _____ Evaluator: _____ Date: _____

Verbal: _____ Performance: _____ Full Scale: _____

Neuropsychological Testing: _____

Developmental History: _____

Behavior Strategies Attempted: _____

Family Medical History: _____

Neurological:

- Stroke
- Migraines
- Mental Retardation
- Alzheimer's Disease
- Neuropathy
- Seizures
- Sensory Problems
- Cerebral Palsy
- Developmental Disability
- _____
- _____

Endocrine:

- Diabetes
- Thyroid Disease

Cardiovascular:

- Heart Disease
- Hypertension

Respiratory:

- COPD

Gastrointestinal:

- Chron's Disease
- Peptic Ulcer Disease

Infectious Disease:

- _____

Psychiatric:

- Chronic Fatigue Syndrome
- Psychiatric Hospitalization
- Depression
- Suicide Attempt(s)
- Panic Attack(s)
- Mania
- Schizophrenia
- Temper Problem/Aggression
- Anxiety Disorder
- ADHD
- Tourette's Syndrome
- Substance Use Disorder

Skeletal & Rheum.:

- Arthritis
- Auto-Immune

Renal:

- _____

Dermatology:

- _____

Cancer:

- _____

- _____

Other:

- _____

- _____

Social History (Considering current living situation, work/ school, important relationships, legal concerns, financial concerns, health habits such as diet, exercise, smoking, alcohol/other substances) :

Age

Occupation

Years of Schooling

Mother _____

Father _____

Brother(s) _____

Sister(s) _____

Children _____

Patient Name: _____

**Triangle Neuropsychiatry
Psychopharmacology Evaluation**

Review of Systems: _____

- | | | | | |
|--|--|---------------------------------------|--|--------------------------------|
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Croup | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Visual Disturbance | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Apnea | <input type="checkbox"/> Insomnia | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Nausea | <input type="checkbox"/> Endocrine disorder | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Memory Concerns | <input type="checkbox"/> Aerophagia | <input type="checkbox"/> Pica | <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Aspiration | <input type="checkbox"/> Peptic Ulcer | <input type="checkbox"/> Motor Vehicle Collision | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Neck Injury | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Numbness | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Physical Exam BP: _____ P: _____ Wt: _____ Ht: _____

	Normal	Abnormal	Description
General	<input type="checkbox"/>	<input type="checkbox"/>	Alert, in no distress, and without physical complaints.
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	Normocephalic, normal vision and hearing.
	<input type="checkbox"/>	<input type="checkbox"/>	TM's clear and throat without redness.
Neck	<input type="checkbox"/>	<input type="checkbox"/>	Neck is nontender with no lymphadenopathy or thyromegaly.
Chest	<input type="checkbox"/>	<input type="checkbox"/>	Lungs clear.
	<input type="checkbox"/>	<input type="checkbox"/>	Normal heart sounds with no evidence of murmurs.
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen is soft, nontender.
	<input type="checkbox"/>	<input type="checkbox"/>	Normal bowel sounds, no masses or organomegaly.
Extremities	<input type="checkbox"/>	<input type="checkbox"/>	No evidence of recent trauma to extremities, no joint swelling.
Skin	<input type="checkbox"/>	<input type="checkbox"/>	No rashes, icterus, or livedo reticularis.

Neurological Exam

Normal	Abnormal	Description
<input type="checkbox"/>	<input type="checkbox"/>	CN 2-11 normal.
<input type="checkbox"/>	<input type="checkbox"/>	Normal strength, bulk, tone.
<input type="checkbox"/>	<input type="checkbox"/>	Smooth motor pursuit.
<input type="checkbox"/>	<input type="checkbox"/>	Rapid alternating movements normal.
<input type="checkbox"/>	<input type="checkbox"/>	Gait smooth.
<input type="checkbox"/>	<input type="checkbox"/>	No evidence of tics or dyskinesia.

Mental Status Exam

Normal	Abnormal	Description	Yes	No	Description
<input type="checkbox"/>	<input type="checkbox"/>	Oriented x 3	<input type="checkbox"/>	<input type="checkbox"/>	Suicide ideation, on direct questioning
<input type="checkbox"/>	<input type="checkbox"/>	Speech clear, language organized	<input type="checkbox"/>	<input type="checkbox"/>	Homicide ideation
<input type="checkbox"/>	<input type="checkbox"/>	Mood good	<input type="checkbox"/>	<input type="checkbox"/>	Evidence of hallucination or delusions
<input type="checkbox"/>	<input type="checkbox"/>	Thoughts organized			

Patient Name: _____

**Triangle Neuropsychiatry
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Laboratory Studies	Results	Date
CBC & Platelets		
Chem. Panel & Electrolytes		
Thyroid Functions		
Anticonvulsant Levels		

Neurodiagnostics	Results	Date
CAT Scan		
MRI		
EEG		

Assessment & Plans: _____ is a _____ year-old with the following DSM IV diagnoses:

Axis I: Major Psychiatric Illnesses:

1. _____
2. _____
3. _____
4. _____

Axis II: Cognitive and Personality Disturbances:

1. _____
2. _____

Axis III: Medical Problems:

1. _____
2. _____
3. _____
4. _____

Axis IV: Social Problems:

1. _____
2. _____

Axis V: Global Assessment Score: _____ **Highest Functioning (in the last year):** _____

Discussion: _____

Patient Name: _____

**Triangle Neuropsychiatry
Psychopharmacology Evaluation**

Medication Decisions: _____

- The complexity of diagnosis, medication choices, and drug interactions was reviewed in detail.
- Every effort is being made to employ the least number of medications at the lowest effective dose(s).
- Potential Side effects were discussed in detail including suicide ideation, agitation, sedation, metabolic problems, aspiration, laboratory abnormalities and potential adverse events.

Behavioral Strategies (Consider limit setting, rewards, relaxation procedures, anger management):

Lifestyle Considerations (Consider exercise, diet, social supports, financial concerns & potential unhealthy habits):

Treatment Planning (Complimentary interventions, collaborations with other health professionals, medical concerns, psychotherapy, laboratory work, Neurodiagnostics and referrals were discussed):

Communication Strategies (The uncertainty of the information process was considered. A strategy for this individual patient will be developed as we get to know the patient better.) :

Specific Safety Considerations:

- Suicidality, homicidality, substance abuse, the potential for victimization, and the reliability of the information sources were assessed.

Signature

Date

Follow- up Appointment: _____

Patient Name: _____