

PT ID or DOB _____

Cigna Adult Assessment

					<input type="checkbox"/>		<input type="checkbox"/>		
Patient Name					Date of Birth		M F		
Age		Ethnicity		Marital Status		Occupation			
Chief Complaint									
History of Present Illness									
Past Psychiatric History									
Family Psychiatric History									
Pertinent Medical/Surgical History									
Pertinent Social History (stressors, current living circumstances, highest grade attended, spiritual, legal and trauma history)									
Advanced Medical Directive		<input type="checkbox"/> Yes		<input type="checkbox"/> No		<input type="checkbox"/> N/A			
Current Medications									
Allergies		<input type="checkbox"/> Yes		<input type="checkbox"/> No		If Yes, What			
Pregnant		<input type="checkbox"/> Yes		<input type="checkbox"/> No		Contraceptive		<input type="checkbox"/> Yes <input type="checkbox"/> No	

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Substance Abuse History (this section must be completed for patients 12 years and older)										<input type="checkbox"/> N/A	
Smoker		<input type="checkbox"/> Yes		<input type="checkbox"/> No		If yes, How Much					
Drugs Used (Alcohol, illicit, prescribed, OTC)				Frequency/Quantity & Route of Admin				Last Use			
Mental Status Examination											
1. General		<input type="checkbox"/> Well-groomed		<input type="checkbox"/> unkempt		<input type="checkbox"/> Relaxed		<input type="checkbox"/> Tense			
		<input type="checkbox"/> Other:									
2. Sensorium		<input type="checkbox"/> Alert		<input type="checkbox"/> Responsive		<input type="checkbox"/> Attentive		<input type="checkbox"/> Inattentive		<input type="checkbox"/> Confused	
		<input type="checkbox"/> Other:									
3. Behavior		<input type="checkbox"/> Cooperative		<input type="checkbox"/> Interested		<input type="checkbox"/> Anxious		<input type="checkbox"/> Agitated		<input type="checkbox"/> Guarded	
		<input type="checkbox"/> Hostile		<input type="checkbox"/> Passive		<input type="checkbox"/> Apathetic					
Eye Contact		<input type="checkbox"/> Good		<input type="checkbox"/> Fair		<input type="checkbox"/> Poor					
		<input type="checkbox"/> Other:									
4. Speech		<input type="checkbox"/> Normal		<input type="checkbox"/> Monotone		<input type="checkbox"/> Verbose		<input type="checkbox"/> Unspontaneous		<input type="checkbox"/> Slurred	
		<input type="checkbox"/> Loud		<input type="checkbox"/> Soft		<input type="checkbox"/> Rapid		<input type="checkbox"/> Pressured		<input type="checkbox"/> Mute	
		<input type="checkbox"/> Other:									
5. Thought Process		<input type="checkbox"/> Coherent		<input type="checkbox"/> Goal Directed		<input type="checkbox"/> Rambling		<input type="checkbox"/> Blocking		<input type="checkbox"/> Perservative	
		<input type="checkbox"/> Loose Assoc		<input type="checkbox"/> Circumstantial		<input type="checkbox"/> Tangential				<input type="checkbox"/> Flight of Ideas	
		<input type="checkbox"/> Other:									
6. Thought Content		<input type="checkbox"/> Relevant		<input type="checkbox"/> Preoccupation		<input type="checkbox"/> Obsessions		<input type="checkbox"/> Phobias		<input type="checkbox"/> Grandiose	
		<input type="checkbox"/> Jealous		<input type="checkbox"/> Religious		<input type="checkbox"/> Somatic		<input type="checkbox"/> Paranoid			
		<input type="checkbox"/> External Influence		<input type="checkbox"/> Ideas of Reference		<input type="checkbox"/> Delusions (Mood congruent/Mood incongruent)					
		<input type="checkbox"/> Other:									
7. Mood/Affect		<input type="checkbox"/> Appropriate		<input type="checkbox"/> Euthymic		<input type="checkbox"/> Depressed		<input type="checkbox"/> Hopeless		<input type="checkbox"/> Constricted	
		<input type="checkbox"/> Labile		<input type="checkbox"/> Anxious		<input type="checkbox"/> Irritable		<input type="checkbox"/> Hostile		<input type="checkbox"/> Elated	
		<input type="checkbox"/> Euphoric		<input type="checkbox"/> Sullen							
		<input type="checkbox"/> Other Comments:									
8. Sensory Perception		<input type="checkbox"/> Illusions		<input type="checkbox"/> Derealizing		<input type="checkbox"/> Depersonalization					
		<input type="checkbox"/> Hallucinations		<input type="checkbox"/> Auditory		<input type="checkbox"/> Visual		<input type="checkbox"/> Tactile		<input type="checkbox"/> Olfactory	
		<input type="checkbox"/> Gustatory									
		<input type="checkbox"/> Comments									
9. Suicidal		Plans		<input type="checkbox"/> Yes		<input type="checkbox"/> No		Means		<input type="checkbox"/> Yes	
										<input type="checkbox"/> No	
Homicidal		Plans		<input type="checkbox"/> Yes		<input type="checkbox"/> No		Means		<input type="checkbox"/> Yes	
										<input type="checkbox"/> No	
10. Cognitive Functions		Orientation				<input type="checkbox"/> Time		<input type="checkbox"/> Person		<input type="checkbox"/> Place	

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	Immediate	<input type="checkbox"/> Intact	<input type="checkbox"/> Impaired	<input type="checkbox"/> Comment
	Short-Term	<input type="checkbox"/> Intact	<input type="checkbox"/> Impaired	<input type="checkbox"/> Comment
	Long-Term	<input type="checkbox"/> Intact	<input type="checkbox"/> Impaired	<input type="checkbox"/> Comment
Attention & Concentration	Ability to Pay Attention	<input type="checkbox"/> Intact	<input type="checkbox"/> Impaired	<input type="checkbox"/> Comment
	Ability to Do Simple Math	<input type="checkbox"/> Intact	<input type="checkbox"/> Impaired	<input type="checkbox"/> Comment
Intelligence (Vocabulary, Educational Level, Fund of Information, etc.)				
	<input type="checkbox"/> Above Average	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Needs Further Evaluation
	Abstract Thought Ability	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
	Good Judgment Capacity	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
	Insight	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
	Comments			
Diagnostic Impression (DSM IV)				
Axis I				
Axis II				
Axis III				
Axis IV				
Axis V				
Treatment Plan/Recommendations (objective measurable goals and time frames)				
Pt agrees to treatment plan				
	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Pt strengths/limitations in achieving treatment goals				
Discussed with pt side effects/benefits of medication		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Pt gives informed consent		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Next Appointment				
Signature				Date