

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)

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	Intent	<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	Intent	<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