Psychiatric Visit Information Form

mercy care

Name: **Date of visit:**
Person completing form: **Relationship:**

Target symptoms for medication	**Progress since last visit**

Any new behaviors you feel should be brought to the doctor's attention?

Services the youth has received since his last visit:

Sleep patterns: **Appetite patterns**:

Current grades and functioning at school:

Current functioning with peers at home, school and extra-curricular:

Any change in the way the member is thinking? (For example talking to someone that isn't there or complaining of hearing or seeing things that aren't there, more focused on a specific issue)

Has the patient taken medication consistently? ☐ Y ☐N If no please give details or provide medication record.

Possible Side Effects to medication: (check and /or describe)

☐More frequent or more intense headaches
☐Change in vision
☐Constipation or diarrhea
☐Dry mouth
☐Stiffness in muscles not related to exercise
☐Weight change
☐Other:

☐Stomach upset
☐Change in focus
☐Sedation/ fatigue/ lethargy
☐Restlessness
☐Rash/ itching

Describe: (time of day, severity, any other pertinent issues):

Any suicidal thoughts/ comments or attempts since last visit:

Any aggressive incidences since the last visit:

Any drug or alcohol use since last visit? ☐ Y ☐N

New strengths and skills patient has learned since last visit.

Other comments: