Hillarie Budoff, M.D.
983 Park Avenue
New York, NY 10028
(646) 391-6499

Patient Name: _____ Provider Name/Degree: _____

Patient DOB: _____ Age: _____

Dates of Evaluation/Consultation: _____ Follow-up Date: _____

Reason for Consultation and/or Presenting Problems: _____

History of Presenting Problems: _____

Academic History: _____

Past Psychiatric History (include treatment, provider name and outcome): _____

Medical History/Problems: _____

Current Medication and Dose: _____

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Family Psychiatric History (include treatment and outcome): _____

_____

_____

_____

_____

Drug/Alcohol History (include treatment and outcome): _____

_____

_____

Social History: _____

_____

_____

_____

_____

_____

_____

_____

Trauma/Legal: _____

_____

_____

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Current Mental Status Evaluation (rate all areas)

Affect: ___Neutral ___Labile ___Expansive ___Constricted ___Blunted ___Other:_____

Mood: ___Euthymic ___Depressed ___Anxious ___Euphoric ___Other:_____

Appearance: ___Well-groomed ___Disheveled ___Bizarre ___Other_____

Motor Activity: ___Calm ___Hypoactive ___Hyperactive ___Agitated ___Tremors/Tics:_____

Orientation: ___A to X3 ___Other:_____

Speech: ___WNL ___Other:_____

Thought: ___Intact ___Circumstantial ___Tangential ___Loose Associations ___Other_____

Hallucinations: ___None ___Auditory ___Visual ___Olfactory ___Command

Delusions ___None ___Persecutory ___Grandiose

Memory: ___Intact ___Impaired:_____

Judgment: ___Intact ___Impaired:_____

Suicidality: ___Not Present ___Ideation ___Contemplation ___Plan ___Action

Homicidality: ___Not Present ___Ideation ___Contemplation ___Plan ___Action

Insight: ___Intact ___Impaired:_____

Additional observations:_____

Diagnosis: Axis I: _____ _____ _____

Axis II: _____ _____ _____

Axis III: _____ _____ _____

Axis IV: _____ _____ _____

Axis V: Current: _____ Highest in past year: _____

Recommended Treatment Plan:

___Individual ___Couple ___Primary Care Physician Coordination:_____

___Family ___Inpatient ___Psychiatrist/ARNP Referral ___Community Resources:_____

___Other:_____

___Medication: _____ Instructions: _____ Target:_____

___Medication: _____ Instructions: _____ Target:_____

___Medication: _____ Instructions: _____ Target:_____

Problem/Goals: Strategy:

_____ _____

_____ _____

_____ _____

Patients/parents concur(s) with treatment plan: ___Yes ___No

Provider (Printed Name): _____(Degree)_____

Provider (Signature): _____(Degree)_____