



Psychiatric Evaluation Form

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date of appointment: \_\_\_\_\_

**DSM-IV Diagnosis:**

Axis I \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Axis II \_\_\_\_\_  
\_\_\_\_\_

Axis III \_\_\_\_\_  
\_\_\_\_\_

Axis IV \_\_\_\_\_  
\_\_\_\_\_

Axis V GAF= \_\_\_\_\_

**Medication(s) Prescribed:**

Medication #1 Name: \_\_\_\_\_ Total Dosage: \_\_\_\_\_

Time medication dispensed and dosage amount each time: \_\_\_\_\_

Medication #2 Name: \_\_\_\_\_ Total Dosage: \_\_\_\_\_

Time medication dispensed and dosage amount each time: \_\_\_\_\_

Medication #3 Name: \_\_\_\_\_ Total Dosage: \_\_\_\_\_

Time medication dispensed and dosage amount each time: \_\_\_\_\_

Reason for medication change or dosage adjustment, if applicable: \_\_\_\_\_

Recommendations: \_\_\_\_\_

Next appointment needed by: \_\_\_\_\_

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Address and Phone Number: \_\_\_\_\_