



Psychiatric Assessment Report

Protected when completed.

Family name:	Given name(s):
Date of birth: (yyyy-mm-dd):	VAC No./Service No.:
Client identification including: <ul style="list-style-type: none">- Legal status:- Work status:	
Reason for referral:	
Presenting Problem: <ul style="list-style-type: none">- Personal medical history:	
History of Presenting Problem: <ul style="list-style-type: none">- Triggering factor(s): - Family medical history:	
Personal psychiatric history:	
Family psychiatric history:	
Habits (alcohol and drug use, gambling, etc.):	
Detailed current medical problems and treatment:	
Detailed current and prior pharmacological treatment:	



Other perpetuating factor(s) influencing current illness (financial, job loss, relationships, family illness/death, medical illness, legal or pending trial, etc.) Please elaborate:

Mental Status examination:

Results of psychiatric scales utilized (BDI II, BAI, PTSD Checklist), if pertinent:

Multi-axial diagnosis based on current DSM:

Clinical opinion on the following:
Nature, duration and severity (mild, moderate, severe) of functional limitation(s):

Link, if present, between service and current clinical presentation:

Current treatment:

Treatment recommendations:

Additional investigations, ie. referrals to specialists, laboratory tests, psychometric testing:

Pharmacological interventions:

Psychosocial interventions: (e.g., individual psychotherapy, group psychotherapy, couple therapy, occupational therapy, social services)

Other interventions:

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Professional title:	Professional corporation:		
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