Behavioral Health and Education Specialists

Psychiatric Follow-Up Form

Patient Name:		**Date:**	
Provider Name:		**Date Of Birth:**	

1. Compared to your last visit, how would you describe the way you feel?

- ❑ Very Much Improved
- ❑ Much Improved
- ❑ Minimally Improved
- ❑ No Change
- ❑ Minimally Worse
- ❑ Much Worse
- ❑ Very Much Worse

2. Rate how you feel today between 1 and 10; 1 = the worst you have ever felt and 10= the best you have ever felt: _______

3. Indicate how the symptoms below have changed since your late visit:

Symptom	Worse	Better	No Change	Not Applicable
Anger				
Anxiety				
Appetite				
Concentration				
Crying				
Dreaming				
Fatigue				
Insomnia				
Memory				
Mood				

Symptom	Worse	Better	No Change	Not Applicable
Mood Swings				
Motivation				
Obsessing				
Pain				
Sex				
Sedation				
Sleep				
Suicidality				
Sweating				
Weight				

4. Please list all allergies that you have:

❑ **I have no known drug or other allergies**

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5. **List any new medication side-effects or psychiatric symptoms you have experienced since your last visit:**

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6. **List any medication changes (started or stopped medications or dosage changes) since you last session (all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin and diet supplements. Also, list any medications you take only on occasion (such as Viagra, Albuterol, Nitroglycerin, etc):**

Medication	Dose	How Often Do You Take The Medication	Prescriber	Date Started

7. **List any additional questions or comments you would like your psychiatrist to be aware of for this session:**

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