

# Psychiatric Review of Systems

Patient Name:

Date:

Mood	Yes	No
Depressed mood:	<input type="checkbox"/>	<input type="checkbox"/>
Elevated mood:	<input type="checkbox"/>	<input type="checkbox"/>
Irritable mood:	<input type="checkbox"/>	<input type="checkbox"/>
Mood swings:	<input type="checkbox"/>	<input type="checkbox"/>

Sleep	Yes	No
Difficulty falling asleep	<input type="checkbox"/>	<input type="checkbox"/>
Frequent awakenings:	<input type="checkbox"/>	<input type="checkbox"/>
Early morning awakenings:	<input type="checkbox"/>	<input type="checkbox"/>
Non-restorative sleep:	<input type="checkbox"/>	<input type="checkbox"/>

Anxiety	Yes	No
Excessive worry:	<input type="checkbox"/>	<input type="checkbox"/>
Restlessness:	<input type="checkbox"/>	<input type="checkbox"/>
Irritability:	<input type="checkbox"/>	<input type="checkbox"/>

Difficulty concentrating:	<input type="checkbox"/>	<input type="checkbox"/>
Physical symptoms (e.g., racing heart, sweating):	<input type="checkbox"/>	<input type="checkbox"/>

<b>Psychosis:</b>	<b>Yes</b>	<b>No</b>
Hallucinations (visual, auditory, tactile):	<input type="checkbox"/>	<input type="checkbox"/>
Delusions:	<input type="checkbox"/>	<input type="checkbox"/>
Disorganized thinking:	<input type="checkbox"/>	<input type="checkbox"/>

<b>Obsessions and Compulsions:</b>	<b>Yes</b>	<b>No</b>
Obsessive thoughts:	<input type="checkbox"/>	<input type="checkbox"/>
Compulsive behaviors:	<input type="checkbox"/>	<input type="checkbox"/>

<b>Dissociative Symptoms:</b>	<b>Yes</b>	<b>No</b>
Detachment or numbness:	<input type="checkbox"/>	<input type="checkbox"/>
Out-of-body experiences:	<input type="checkbox"/>	<input type="checkbox"/>
Loss of memory:	<input type="checkbox"/>	<input type="checkbox"/>

<b>Trauma History:</b>	<b>Yes</b>	<b>No</b>
Exposure to traumatic events:	<input type="checkbox"/>	<input type="checkbox"/>
PTSD symptoms (e.g., flashbacks, nightmares):	<input type="checkbox"/>	<input type="checkbox"/>

<b>Body Image Disturbances:</b>	<b>Yes</b>	<b>No</b>
Preoccupation with appearance:	<input type="checkbox"/>	<input type="checkbox"/>
Dissatisfaction with body image:	<input type="checkbox"/>	<input type="checkbox"/>
Engaging in weight control behaviors (e.g., excessive dieting, purging):	<input type="checkbox"/>	<input type="checkbox"/>

<b>Substance Abuse:</b>	<b>Yes</b>	<b>No</b>
Alcohol use:	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco use:	<input type="checkbox"/>	<input type="checkbox"/>
Illicit drug use:	<input type="checkbox"/>	<input type="checkbox"/>

<b>Cognitive Symptoms:</b>	<b>Yes</b>	<b>No</b>
Memory problems:	<input type="checkbox"/>	<input type="checkbox"/>
Concentration difficulties:	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty making decisions:	<input type="checkbox"/>	<input type="checkbox"/>

<b>Suicidal Ideation:</b>	<b>Yes</b>	<b>No</b>
Thoughts of suicide:	<input type="checkbox"/>	<input type="checkbox"/>
Suicide plan:	<input type="checkbox"/>	<input type="checkbox"/>

**Additional Notes:**