Psychiatric Diagnostic Evaluation Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · July 2026

A psychiatric diagnostic evaluation is the comprehensive initial assessment that establishes a mental health diagnosis and treatment plan: psychiatric, medical, family, and social history, a mental status exam, and a risk assessment. US payers bill it as CPT 90791, or 90792 when medical services are included. A typical evaluation runs 500 to 1,200 words.

Identification & referral who, from whom, and why now
Do: record the referral source and the chief complaint in the patient's own words. **Pitfall:** paraphrasing the complaint into clinician language; the patient's words anchor medical necessity.

History of present illness onset, course, severity, impact
Do: date the onset and describe course and functional impact. **Pitfall:** symptoms listed without how long they have existed; reviewers expect the length of existence of the problems.

Past psychiatric history what has already been tried
Do: capture prior episodes, treatment and response, hospitalizations, past suicide attempts. **Pitfall:** skipping treatment response; the next clinician repeats what already failed.

Medical history & medications required of every evaluator
Do: list significant conditions, current medications with doses, and allergies. **Pitfall:** therapists leaving this out because they do not prescribe; the element list applies to the evaluation, not the credential.

Substance use name the substances
Do: document current and past use, amounts, last use, prior treatment. **Pitfall:** a bare "denies substance use"; an unspecified denial reads as an unasked question.

Family & social history context the plan depends on
Do: record family psychiatric history, living situation, work or school, stressors. **Pitfall:** "noncontributory" one-liners; an absence with no content reads as not assessed.

Mental status exam a listed element, and the top audit gap
Do: document all elements: appearance through insight and judgment. **Pitfall:** "MSE within normal limits" with no elements.

Risk assessment explicit, even when negative
Do: address suicidal and homicidal ideation, self-harm, means, protective factors. **Pitfall:** no line when risk is negative; the record must show risk was assessed, not assumed absent.

Strengths & liabilities the element clinicians skip most
Do: note supports, motivation, insight, and the barriers working against treatment. **Pitfall:** leaving it out; it is on the contractor's expected-element list and it makes the plan realistic.

Diagnostic impression & treatment plan where the evaluation earns its keep
Do: give the DSM-5-TR diagnosis with ICD-10-CM code, rule-outs, methods, anticipated length, measurable goals, and willingness to participate. **Pitfall:** a diagnosis the findings do not support, or a plan with no measurable goals.

Before you sign

- [ ] Every expected element present, including medical history and current medications
- [ ] MSE documented element by element, not "WNL"
- [ ] Risk has an explicit finding with protective factors, even when negative
- [ ] Diagnosis supported by documented duration, criteria, and impact
- [ ] Plan goals measurable and time-anchored; participation statement included
- [ ] Signed with credentials, dated promptly

Drafting with AI

Capture 30 seconds of bullets after the interview: presenting problem, key history, MSE findings, scores, risk status, diagnosis, plan.

> *"Draft a psychiatric diagnostic evaluation from these interview notes; adult, first-episode moderate depression, 90791: …"*

Never paste patient-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.

500–1,200 words	30–60 min by hand	At the start of care	Care team · payers · auditors
typical length	clinical team estimate	when it's written	who reads it

Full guide, sample note, and compliance notes:
bastiongpt.com/template/psychiatric-diagnostic-evaluation

Psychiatric Diagnostic Evaluation Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

Patient (initials): | DOB / age: | Date of evaluation: | Type: ☐ 90791 ☐ 90792

Referral source & reason (if applicable): | Interpreter / other participants:

Chief complaint

The reason for the evaluation, in the patient's own words

History of present illness

Onset, duration, course, severity, and impact on functioning

Past psychiatric history

Prior diagnoses, treatment and response, hospitalizations, past suicide attempts or self-harm

Medical history & current medications

Significant conditions, medications with doses, allergies

Substance use

Current and past use, amounts, last use, prior treatment

Family & social history

Psychiatric conditions in the family; living situation, work or school, relationships, legal, stressors

Mental status exam

Appearance · behavior · speech · mood · affect · thought process · thought content · perception · cognition · insight · judgment

Risk assessment

Suicidal / homicidal ideation, self-harm, access to means, protective factors; document even when negative

Strengths & liabilities

Supports, motivation, insight; barriers working against treatment

Diagnostic impression

DSM-5-TR diagnosis with ICD-10-CM code(s), rule-outs, and the findings that support it

Treatment plan & participation

Methods, frequency, anticipated length, measurable goals, referrals or labs; patient's ability and willingness to participate

Clinician signature / credentials: | Date signed: