Welcome to Psych and Psych Services. In order to most efficiently use your face to face time with your therapist we ask that you complete this form. This information will enable your therapist to understand and help you. If there are any questions you do not wish to answer, please draw a line through them and initial the item(s).

ADULT INITIAL EVALUATION: Patient Form

Date: _____

Patient: _____DOB: Referred by: _____

Name of Person completing this form if not patient: _____

Relationship to Patient: _____

Briefly describe the events that led to this appointment:

_____

_____

_____

What do you wish to accomplish through your involvement in therapy?

_____

_____

Has there been any previous mental health treatment? List the reason for treatment, what treatment was provided, who provided it and dates.

_____

_____

Did you feel it was helpful? Why?

_____

_____

Check off any symptoms/problems that give you concern:

□ Sadness
□ Hopelessness
□ Loss of Interest
□ Too much energy
□ Impulsivity
□ Racing thoughts
□ Memory problems
□ Decreased Sex Interest/activity
□ Thoughts of harming myself
□ Anxious
□ Specific fears
□ Trusting others
□ Social Phobia
□ Sexual performance
□ Fatigue
□ Guilt
□ Irritability
□ Too little energy
□ greif issues
□ Obsessive/Compulsive concerns
□ Excessive Sex Interest/activity
□ Sleep problems
□ Thoughts of harming others
□ Panic attacks
□ Anger control
□ Eating habits
□ Cutting yourself
□ Relationship issues

Other Symptoms not listed: _____

Do any of the people in your current living situation have a mental health, alcohol or drug problem?

☐ Yes ☐ No

Highest Education Level Completed:_____ Occuptaion: _____

During your school years were you identified as having a learning disability? YES / NO Did you have an Individualized Education Plan (IEP) YES / NO If yes, explain:_____

Who lives with you in your home?

Name	Relation to Yourself	Age	Education	Occupation

Please check any of the following issues that apply:

☐ Blood Pressure Problems ☐ Diabetes ☐ Childhood Sexual physical abuse ☐ Sexual/Physical abuse as an adult ☐ Domestic violence in child-hood home

☐ Thyroid ☐ Heart ☐ Mental Illness in family members ☐ Alcohol/drug abuse

☐ Lungs ☐ Kidney ☐ Seizures ☐ Domestic Violence

☐ Stomach ☐ Cancer ☐ Divorce _____

☐ Headaches ☐ Neurological ☐ Other - including disabilities and disorders – List below:

_____

How have you adjusted socially to your disability and/or disorder? _____

_____

Have you been a victim of abuse, neglect, sexual assault or other trauma? Yes ___ No ____ Have you witnessed trauma? Explain the trauma and tell when it was experienced.

_____

_____

Legal Involvement: Past: _____ Present:_____

Please check if any of the following existed in your childhood home: ☐ Poor relationship with parents | ☐ Parent(s) with substance abuse problems | ☐ Legal problems | ☐ Involvement of Child Protective Services | ☐ neglect/abuse | ☐ Incest | ☐ Poor relationship with siblings

Are you currently pregnant? Yes___ No ___ N/A ___ If yes, are you receiving prenatal care? _____

Who is your Primary Care Doctor? _____

Have you had a recent physical? _____ If yes, when_____

List any ongoing medical conditions

_____

_____

List all current medications and identify if the medications helped reduce your symptoms:

_____

Allergies (include allergies to medication):_____

Are you in need of any type of assistive technology (i.e. hearing impaired, autism, dyslexia, etc?) _____

Are you interested in information for social support in regards to your current situation? Yes_____ No _____

Do you have any concerns regarding use of drugs/alcohol?

_____

_____

Do you use tobacco products? Yes ___ No ___If yes, how often do you use the tobacco product? _____

Are you able to read and write English? Yes _____ No _____

Employment history _____

_____

Present Occupation:_____ ☐ Full time ☐ Part time ☐ Retired ☐ Disabled

List your abilities and interests_____

List your personal strengths _____

_____

_____

_____

Identify any preferences you have for your therapy

_____

_____

_____

_____

Do you use supplemental health approaches such as acupuncture, supplements or holistic medicine? Yes ___
No____ If yes, list the supplemental health approaches you use.

_____

Optional Questions:
Do you have any cultural or spiritual beliefs that your therapist should be aware of? _____

_____

_____

What is your Sexual Orientation? _____Gender Expression? _____

~Thank you~