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?

_____

_____

_____

Legal Involvement: Past: _____ Present: _____

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

_____

_____

Do you feel it was helpful? Why?

_____

_____

List any symptoms you are experiencing:

_____

_____

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

☐ Yes ☐ No

Highest Education Level Completed:

_____

Who lives in your home?

Name	Relation to Yourself	Age	Education	Occupation

Please check any of the following medical issues that apply:

☐ Blood Pressure Problems ☐ Diabetes

☐ Thyroid ☐ Heart

☐ Lungs ☐ Kidney

☐ Stomach ☐ Seizures

☐ Headaches ☐ Other _____

Have you been a victim of abuse, neglect or trauma? Yes ____ No ____ Have you witnessed trauma? Yes____ No ____

Are you currently pregnant? _____ If yes, are you receiving prenatal care? _____

Who is your Primary Care Doctor? _____

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

If you answered yes please list any abnormalities that may have come up during the physical_____

_____

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? _____

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

_____

_____

Do you use tobacco products? Yes _____ No _____ Are you able to read and write English? Yes _____ No _____

List employment history _____

_____

List your abilities and interests_____

_____

Optional Question:

Do you have any cultural or spiritual beliefs that the therapist should be aware of? _____

_____