ADULT INITIAL EVALUATION: Patient Form

Date: _____

Patient: _____ DOB: _____ Referred by: _____

Name of Person completing this form if not patient: _____

Briefly describe the events that led to this appointment.

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Have there been any previous mental health contacts? If yes, list these contacts and approximate dates of treatment (include hospitalization dates). List any past psychiatric medications.

_____
_____
_____
_____

Please check any of the following symptoms or complaints that apply to your situation. Add comments if necessary:

- ☐ Sad Mood _____
- ☐ Low Energy/Fatigue _____
- ☐ Hopelessness _____
- ☐ Worthlessness _____
- ☐ Crying Spells _____
- ☐ Guilt _____
- ☐ Decreased Motivation _____
- ☐ Loss of Interest in Usual Activities _____
- ☐ Irritability _____
- ☐ Hyperactivity _____
- ☐ Impulsiveness _____
- ☐ Elevated Mood _____
- ☐ Racing thoughts _____

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- ☐ Concentration/Memory Difficulties _____
- ☐ Increased Sexual Interest _____
- ☐ Decreased Sexual Interest _____
- ☐ Decreased Appetite _____
- ☐ Increased Appetite _____
- ☐ Difficulty Falling Asleep _____
- ☐ Early Morning Awakening _____
- ☐ Difficulty Staying Asleep _____
- ☐ Excessive Sleeping _____
- ☐ Suicidal Thoughts _____
- ☐ Thoughts of Harming Others _____
- ☐ Anxious/Worried _____
- ☐ Panic Attacks _____
- ☐ Fear of Leaving the House _____
- ☐ Fear of Driving _____
- ☐ Fear of Specific Situations or Things _____
- ☐ Fear of Embarrassing Oneself in Public _____
- ☐ Intruding, Uncomfortable, Upsetting Thoughts _____
- ☐ Repetitive Thoughts or Behaviors _____
- ☐ Excessively Orderly and Perfectionistic _____
- ☐ Periods of "Lost" Time _____
- ☐ Excessive Anger / Aggressiveness _____
- ☐ Difficulty Trusting Others _____
- ☐ Binging/Purging _____
- ☐ Rebelllous/Defiant _____
- ☐ Victim of Abuse or Trauma: _____
  - ☐ Emotional _____
  - ☐ Sexual _____
  - ☐ Physical _____
- ☐ Offender of abuse: _____
  - ☐ Emotional _____
  - ☐ Sexual _____
  - ☐ Physical _____

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Do any of the people in your current living situation have a mental health, alcohol or drug problem? If yes, please list and describe.

Use the table below to describe the people in your current living situation.

Name	Relation to Yourself	Age	Education/ Occupation	Personal Style

Describe your current employment and financial situation:

Describe any relevant legal issues:

Describe any other relevant stressors:

Do any of the people in your family of origin currently or in the past have a history of mental health, alcohol, or drug problems? If yes, please list and describe.

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Use the table below to describe the people in your family of origin.

Name	Relation to Yourself	Age	Education/ Occupation	Personal Style

Please check any of the following medical issues that apply to your situation. Add comments if necessary:

- ☐ Blood Pressure Problems _____
- ☐ Diabetes _____
- ☐ Thyroid _____
- ☐ Heart _____
- ☐ Lungs _____
- ☐ Kidney _____
- ☐ Stomach _____
- ☐ Seizures _____
- ☐ Headaches _____
- ☐ Other _____

Who is your Primary Care Doctor? _____

Date of your most recent physical? _____

Date of your most recent blood work? _____

Ever had EEG, CT, MRI, of the head? _____

Any abnormal findings?

_____
_____
_____

List all current medications:

_____
_____

Allergies (include medication allergies):

_____
_____

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Please complete the following table and answer the questions below. Add comments if necessary:

Substance Use:

Substance	**Age of First Use**	**Most Recent Pattern of use and Duration** *How much you use, how often, and do you need more or less to get the same effect?*	**Date of last use and time**	**History of Withdrawal** *Describe symptoms*	**Method of Use** *(oral, smoked, snort, IV, etc)*
Alcohol					
Sedatives/Barbituates					
Heroin (Opioids)					
Cocaine					
Other Stimulants					
Marijuana					
Halucinagenics					
Nicotine					
Caffeine					
Meth/Amphetamines					
Inhalants					
Benzos					
Synthetics (ex. PCP/ecstasy/spice/flakka, bath salts)					
Rx Medications					
Over-the-Counter Drugs					
Other					

What are your triggers for use?

_____

_____

_____

☐ No ☐ Yes Someone in the biological family has or has had a serious substance abuse problem.

_____

_____

_____

☐ No ☐ Yes In the past two years, there has been one or more episodes of memory loss due to substance abuse.

☐ No ☐ Yes There are personality changes due to the use of substances.

☐ No ☐ Yes In the past 5 years, there has been one or more arrest with a B.A.L. of .16% or higher.

☐ No ☐ Yes Someone close to you thinks you may have a serious substance use problem.

☐ No ☐ Yes In the past year there has been an out of control experience due to substance use.

☐ No ☐ Yes There is a history of serious problems with the use of substances.

☐ No ☐ Yes There is a history of substance abuse treatment (may include 12-step program).

Comments: