Initial Evaluation Form

Name: _____

History of present Illness

1. What is the reason you decided to seek treatment or consultation at this time?

_____
_____
_____

2. How long has your particular difficulty been going on and approximately when did it start? (We will talk a lot about this question during the actual session)

_____
_____

3. Are you currently seeing a therapist? If so, please provide the name, address and phone number.

_____
_____

4. Do I have permission to communicate with your therapist? Yes_____ No_____
Please sign here indicating your permission_____

5. Have you been feeling depressed, sad or blue? _____

6. Have you recently experienced difficulty sleeping? If so, when did it start? Problems falling asleep, staying asleep or waking early? _____

7. Has there been a change in your appetite lately? If so, have you lost or gained weight, how much and over what period of time?_____

8. Has there been a change in your level of energy? No____ Increase_____ Decrease_____

9. Is it harder to motivate yourself to do things that you need to do? Yes_____ No_____

10. Has there been a change in your level of interest in what you usually enjoy?
Yes_____ No_____

11. Have you been more irritable that usual? Yes_____ No_____

12. Are you concentrating as well as you usually do? Yes_____ No_____

13. Have you been crying more than usual or more easily? Yes_____ No_____

14. Have you had thoughts of hurting yourself **lately**? If yes, please describe:

_____
_____
_____

15. Have you had thoughts of hurting anyone else? If so, please describe:

_____
_____

16. Has there been any changes in your sexual interest recently? Yes_____ No_____

17. Have you had trouble with your memory recently? Yes_____ No_____

18. Have you been avoiding other people lately? Yes_____ No_____

19. Have you suffered any of the anxiety symptoms listed below? Indicate frequency of each:

	FREQUENCY
Shortness of breath	_____
Pounding chest	_____
Difficulty breathing	_____
Tight Chest	_____
Rapid heart beat	_____
Sweating	_____
Hot or cold feelings	_____
Fearful feelings	_____
Light headed or dizzy feelings	_____
Nausea	_____
Desire to flee	_____
Diarrhea	_____

20. Are you **currently** taking any medications to treat a psychiatric disorder? If so, please list medication, dosage, number of times per day for each. Please include past tried medications.

_____
_____
_____
_____

Social History

1. Please indicate your marital status.

Single_____ Widowed_____
Married_____ (length of time)_____ Separated_____(length of time)_____
Divorced_____(length of time)_____
*If more than one, please detail here:

_____

2. If married, spouse's name and what work does he/she do?_____

3. Do you have children? No_____ If so, please list names and ages. Where do they live?

_____
_____
_____

4. Whom do you live with? _____

5. Do you work at home or outside the home? If outside, where, for how many hours per week and for how long you've been at that particular job? If shift work, please indicate that shift.

_____

_____

6. How much education have you had? _____

Alcohol and Drug History

1. Do you consume alcohol? If so, kind, how much and how often (day/week). Incr/Decr use.

_____

2. Have you had a problem with alcohol in the past?

_____

3. Have you ever used/abused marijuana, cocaine, barbiturates or any other recreational drug?

_____

4. Have you ever had a difficulty with abuse of prescription medication?

_____

5. Are you currently participating in an alcohol or drug treatment program?

_____

6. Do you drink caffeinated coffee, tea, soda? How many, how often?

_____

7. Do you smoke cigarettes? How many, how often?_____

Past Psychiatric History

1. Have you ever had a serious episode of depression in your life? If so, when, what was the trigger (if known), and what kind of treatment did you receive?

   _____

   _____

   _____

2. Have you ever had a serious problem with anxiety in your life? If so, when, what was the trigger (if known) and what kind of treatment did you receive?

   _____

   _____

   _____

3. Have you ever received treatment in a psychiatric hospital in the past?_____

_____

_____

4. Have you ever threatened or injured someone during a violent outburst? If so, whom?

_____

5. Have you ever attempted suicide in the past? If so, what was the circumstance and method?

_____

_____

6. Have you ever experienced having a vision of a person or animal when there was no one there? If so, when?

_____

_____

7. If you have experienced any of the symptoms below, please indicate when and how long they lasted:

	When	Duration
Difficult time controlling thoughts	_____	_____
Elevated energy	_____	_____
Elevated mood	_____	_____
Rapid speech	_____	_____
Decreased need for sleep	_____	_____
Taking on too many projects	_____	_____
Spending too much money	_____	_____

8. Have you ever had the following paranoid feelings? If so, indicate when they occurred.

People were trying to hurt, harm or spy on you _____
Paranoid feelings _____
People were plotting against you _____
People were out to get you _____

9. Have you ever had the experience of the following? If so, indicate when they occurred.

You felt you were outside your body _____
You weren't really you _____
Things around you did not appear to be real _____
You were outside your body looking at yourself _____

10. Have you ever had a problem with the following? If so, when and where?

Performing repetitive actions (ie:washing hands) _____
Having to triple check things (doors/appliances) _____
Counting rituals _____
Cleaning compulsively _____
Afraid of contamination (germs/dirt/disease) _____
Repetitive thoughts you cannot get out of head _____
Difficultly spending money _____
Hoarding _____

11. Have you ever had an eating disorder? Gained or lost excessive amounts of weight (excessive exercise, laxatives or dieting), or binged frequently and felt the need to purge? If so, please describe your symptoms and details.

_____
_____
_____

12. Have you ever experienced the following symptoms suggestive of attention disorders. If so, when did you first experience these problems?

Easily distractible	_____
Disorganized	_____
Difficulty paying attention	_____
Forgetfulness	_____
Lose things frequently	_____
Can't relax or sit still	_____
Restlessness	_____
Impulsivity	_____
Feeling wired or hyper	_____

13. Have you ever experienced difficulty in sexual functioning?

_____

14. Have you ever been physically, sexually or mentally abused? If so, at what age and by whom?

_____
_____
_____
_____

Medical History

1. What regular over-the-counter medications do you use? Include vitamins, birth control, etc.

_____

2. Do you have any allergies to medications or foods?

_____

3. Have you had any surgery in the past? If so, indicate what type and when it was performed.

_____
_____

4. Please list any ongoing medical problems from which you are suffering.

_____
_____

5. When was your last physical exam, who preformed it and what were the results?

_____
_____

6. Please write the name, address and phone number of your primary physician:

_____

_____

7. Do I have permission to communicate with your physician? Yes_____ No_____

8. At your most recent physical exam was an electrocardiogram or thyroid function test performed? Yes_____ No_____ If so, results_____

9. Do you have difficulty with your vision other than wearing corrective lenses?

_____

10. Do you have hearing impairment? _____

11. Have you had problems with your skin? _____

12. Have you had problems with your heart, including heart attack, abnormal heart rhythm, frequent palpitations, high blood pressure or heart failure?

_____

13. Have you had problems with your lungs, including shortness of breath, frequent cough, pneumonia, bronchitis or asthma?_____

14. Have you had problems with your stomach, including ulcer disease, frequent constipation or diarrhea, IBS problems?_____

15. Have you had any problems urinating recently or in the past?_____

16. (*Women*) Have you had any recent gynecological problems?

_____

17. (*Men*) Have you had any prostate problems?

_____

18. Have you ever had a head trauma? If so, at what age and did you lose consciousness?

_____

19. Have you ever had a seizure? If so, please describe. When did it happen?

_____

_____

Family History

Please answer these questions as they pertain to parents, grandparents, aunts, uncles, brothers, sisters, cousins or children.

1. Has anyone in your family suffered from depression? If so, who (in relationship to you)?

_____

_____

2. Has anyone in your family suffered from anxiety, including panic disorder?

_____

_____

3. Has anyone in your family had a psychotic disorder?

_____

_____

4. Has anyone in your family ever made a suicide attempt or been hospitalized for a psychiatric disorder? If so, what was the method and how old were you when this happened?

_____

_____

5. Is there a history of alcohol or substance abuse in your family? If so, please indicate the type or difficulty and who had it.

_____

_____

_____

_____

_____ _____

Signature Date