

INITIAL EVALUATION

Page 1 of 3

Client's Name: \_\_\_\_\_ Age: \_\_\_ D.O.B. \_\_\_\_\_ Sex: M F Marital Status: \_\_\_\_\_

Client's Address: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone#: \_\_\_\_\_ OK to leave messages? Y N

Occupation: \_\_\_\_\_ Education: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Others living in the home: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_ Phone#: \_\_\_\_\_

**PRESENTING PROBLEM(S)**

Please describe the reasons for seeking counseling (include date/month the problem started):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HISTORY OF PRESENT ILLNESS**

Please indicate how the following symptoms/problems/complaints are affecting you: (leave blank if no effect)

1) Little effect 2) Some effect 3) Much effect 4) Significant effect

- \_\_\_ Eating habits/Appetite: eating more; eating less; weight change \_\_\_; binge; purge.
- \_\_\_ Sleep: trouble falling asleep; trouble staying asleep; trouble waking up; average #hours sleep\_\_\_; #naps
- \_\_\_ Decreased energy/Fatigue
- \_\_\_ Sexual functioning
- \_\_\_ Loss in interest in activities
- \_\_\_ Tearfulness
- \_\_\_ Hopelessness/Helplessness
- \_\_\_ Decreased attention span
- \_\_\_ Inattentive/Distractible
- \_\_\_ Memory; long term; short term
- \_\_\_ Difficulty planning ahead
- \_\_\_ Opposition
- \_\_\_ Anger outbursts
- \_\_\_ Impulse control; difficulty controlling physical behavior/hyperactive
- \_\_\_ Mood changes
- \_\_\_ Anxious/nervous
- \_\_\_ Worry/fear
- \_\_\_ Stealing
- \_\_\_ Lying
- \_\_\_ Truancy
- \_\_\_ Fire setting
- \_\_\_ Police/probation involvement
- \_\_\_ Spending sprees
- \_\_\_ Rapid heartbeat
- \_\_\_ Phobia
- \_\_\_ Sweating
- \_\_\_ Trouble breathing
- \_\_\_ Flashbacks of traumatic event
- \_\_\_ Nightmares
- \_\_\_ Racing thoughts
- \_\_\_ Hearing Voices
- \_\_\_ Seeing things that are not there

\_\_\_\_\_  
Client/Legal Representative Signature

\_\_\_\_\_  
Date

**HISTORY OF SUBSTANCE USE**

-Coffee (#\_\_ cups/daily) -Cigarettes (#\_\_ per day) -Alcohol (#\_\_ drinks /weekly) Date last drank: \_\_\_\_\_

**Street Drugs:**

Type: \_\_\_\_\_ Amount: \_\_\_\_\_ Frequency: \_\_\_\_\_ Date last used: \_\_\_\_\_

**Prescription Drugs:**

Type: \_\_\_\_\_ Amount: \_\_\_\_\_ Frequency: \_\_\_\_\_ Date last used: \_\_\_\_\_

Describe impact of substance abuse/use on your life:

\_\_\_\_\_

\_\_\_\_\_

Past treatment for substance use:

\_\_\_\_\_

\_\_\_\_\_

Family history of substance use:

\_\_\_\_\_

\_\_\_\_\_

**PSYCHOSOCIAL HISTORY/FUNCTIONING**

Rate how the problems/symptoms/complaints are impacting areas of functioning:

1) Mild 2) Moderate 3) Severe

\_\_\_ Marriage/Relationship

\_\_\_ Work/School

\_\_\_ Family

\_\_\_ Friendships

\_\_\_ Financial Situation

\_\_\_ Physical Health

\_\_\_ Social Interests

\_\_\_ Leisure activities

\_\_\_ Housing

\_\_\_ Attending to daily living activities (i.e. shower, grooming, self-care, etc.)

\_\_\_ Spirituality

\_\_\_ Current Stressors

Other \_\_\_\_\_

WHAT DO YOU SEE AS STRENGTHS: \_\_\_\_\_

WHAT DO YOU SEE AS WEAKNESSES: \_\_\_\_\_

GOALS FOR TREATMENT: \_\_\_\_\_

GOALS AND EXPECTATIONS OF SIGNIFICANT OTHERS: \_\_\_\_\_

\_\_\_\_\_

MOTIVATION FOR TREATMENT: \_\_\_\_\_

\_\_\_\_\_

Client/Legal Representative Signature

\_\_\_\_\_ Date

**PAST TREATMENT HISTORY**

Psychiatric or psychological treatment of any kind before? YES \_\_\_ NO \_\_\_

If Yes, please answer the following:

What type of care was received? Inpatient \_\_\_ Outpatient \_\_\_ Both \_\_\_

When was the treatment? \_\_\_\_\_

How long was the treatment? \_\_\_\_\_

Name of the therapist or doctor? \_\_\_\_\_

Was there prescribed medication at that time? YES \_\_\_ NO \_\_\_ NOT APPLICABLE \_\_\_

If yes, what was prescribed (include dosages if known)? \_\_\_\_\_

Family history of psychiatric treatment:

\_\_\_\_\_  
\_\_\_\_\_

Family members currently in psychiatric treatment: \_\_\_\_\_

**MEDICAL HISTORY**

Any past/current medical problems/surgeries:

\_\_\_\_\_  
\_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

Current Medications/Remedies: (Dosage, frequency, and M.D./Practitioner prescribing) \_\_\_\_\_

Over the Counter Medications: \_\_\_\_\_

Client Allergies: \_\_\_\_\_

Significant family medical history and allergies: \_\_\_\_\_

Authorization to communicate with current/previous providers: YES \_\_\_ NO \_\_\_

Provider Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Provider Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Provider Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Other information you would like me to know:

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\_\_\_\_\_

\_\_\_\_\_  
Client/Legal Representative Signature

\_\_\_\_\_  
Date