INITIAL EVALUATION



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

 Client Name:_____

**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:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____
Client/Legal Representative Signature Date