CONFIDENTIAL

ADULT INITIAL EVALUATION

PART I: PATIENT INPUT:

Patient Name:_________________________________ Today's Date: _______________

Date of Birth: __________________ Age: _____ Sex: M F

Address:____

Telephone #_______________________ SS# ______________

Address ____

Telephone number(s): (H)_________________________ (C)_______________________

Marital status Married/Together Divorced Separated/Never Married

Employer ____ Phone __________

PEOPLE WHO LIVE IN THE HOME:

Name	Age	Relationship	Name	Age	Relationship

Please describe why you wish to be seen for an appontment and the problem(s) or symptoms(s) your currently having:

____

____

____

____

____

____

Name: ______________________________ Date: ______________

PATIENTS CURRENT PSYCHIATRIC HISTORY:
Has you received any psychiatric services or medications? Y N
(if not, please skip to the next section)

Psychiatrist(s) /date(s) started: ______________________________

CURRENT MEDICATIONS :

Name of med.	Dose	Times of day taken	Who prescribes	When started	lowest/highest dose ever taken

PREVIOUS DIAGNOSES: ______________________________

Other Behavioral/Mental Health Services:

Name: ______________________________ Date: ________________________________

Psychologist/Therapist/Counselor: ____

Issues Addressed and Response to Treatment: ______________________________________

____

____

Medical/DEVELOPMENTAL HISTORY

BIRTH: Birth weight______________ Did any of the following occur?

- ☐ emergency delivery
- ☐ trouble breathing
- ☐ incubator use
- ☐ premature
- ☐ C -section
- ☐ induced delivery (pitocin)

INFANCY: Did any of the following occur?

- ☐ poor responsiveness
- ☐ excessive crying
- ☐ feeding problems
- ☐ difficult baby
- ☐ poor eye contact
- ☐ sleeping problems
- ☐ hard to comfort
- ☐ seemed not able to hear
- ☐ other _____________

TODDLER: Did any of the following occur?

- ☐ Did not start talking at 12-18 months
- ☐ Did not walk around 12 months of age
- ☐ Did not point to indicate interest in something
- ☐ Was not toilet trained by 3.5 yrs old
- ☐ Played with toys in unusual ways
- ☐ Never played "pretend"

Name: ______________________________ Date: _________________________________

PATIENTS MEDICAL HISTORY: (check all that apply)

___allergy to medication(s) ____

- ☐ asthma
- ☐ ear infections
- ☐ seizures/epilepsy
- ☐ headaches
- ☐ stomach aches
- ☐ head injury
- ☐ chronic pain
- ☐ diabetes
- ☐ heart problem
- ☐ liver problem
- ☐ kidney problem
- ☐ chronic diarrhea
- ☐ problems sleeping
- ☐ genetic testing
- ☐ vomiting
- ☐ loss of consciousness
- ☐ greater than “normal” weight gain or loss recently
- ☐ EEG
- ☐ brain imaging
- ☐ other special test(s)

☐ other (specify)____

☐ serious accident(s): ____

☐ hospitalization(s): ____

☐ serious illness(es): ____

☐ evaluation by neurologist (who/when): ____

Name: ______________________________ Date: _________________________________

Comments: ____

____

____

____

Physician ______________________________________ tel. # ________________________

FAMILY MEDICAL AND SOCIAL HISTORY:

Occupation(s) __________________________ ________________________

Current stressors relevant to the family:

- ☐ financial
- ☐ legal
- ☐ occupational
- ☐ deaths/losses
- ☐ housing
- ☐ safety
- ☐ recent birth/marriage
- ☐ abuse
- ☐ marital conflict
- ☐ violence
- ☐ illness/health care
- ☐ legal custody issues
- ☐ CYF (CYS) involvement: ___ current ___ in the past
- ☐ other stressor(s) ____

Are any family members medically ill at present? _____________________________________

____

Any significant family medical history (seizures, heart problems, thyroid problems, genetic problems, etc.)?

____

Have you received previous psychological testing? ____ Yes _____ No

Name: ______________________________ Date: _________________________________

If yes: Where? _________________________________ When?____________________

* Please bring copy of previous testing results with you.

FAMILY PSYCHIATRIC HISTORY: Have any members of your family had any of the following problems?

Problem	Family member(s)	Problem	Family member(s)
☐ Anxiety	__________________________	☐ Depression	_____________________________
☐ Suicide	__________________________	☐ Bipolar/Manic	__________________________
☐ Schizophrenia	_____________________	☐ ADHD	_______________________________
☐ Learning problem	_________________	☐ Autism Spectrum	________________________
☐ Mental retardation	_________________	☐ Speech problem	_________________________
☐ Alcohol abuse	____________________	☐ Drug abuse	_____________________________
☐ temper problem	___________________	☐ Abusive	______________________________
☐ Legal problems	___________________	☐ jail/prison	______________________________
☐ Psychiatric hospitalization	___________	☐ Institutionalized	_________________________
☐ Personality Disorder	________________	☐ Other	__________________________________

____ ___________________

Signature /Legal Guardian Completing this form Date

____

Printed Name

Thank_ you for taking the time to complete this form.

Name: ______________________________ Date: _________________________________