ADULT INITIAL EVALUATION: PATIENT FORM

Patient: _____ **DOB:** _____ **Referred by:** _____ **Date:** _____

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:

_____
_____
_____
_____
_____
_____

Use the scale below to rate the occurrence of each of the following. Provide comments in the space provided.

1= None or little of the time, 2 = Some of the time, 3 = Most of the time, 4 = All of the time.

During the past week, I:	1	2	3	4
Felt low in energy or slowed down				
Blamed myself for things going bad				
Felt hopeless				
Felt blue or sad				
Felt worthless				

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Had trouble falling asleep, staying asleep or sleeping too much				
Had trouble concentrating or making decisions				
Had thoughts about suicide				
Had thoughts of harming others				
Felt irritable				
Had racing thoughts				
Was hyperactive or impulsive				
Found my appetite increased or decreased				
Had crying spells				
Was not motivated				
Had no interest in doing anything				
Had thoughts or did cutting or self-harm				
Felt overly happy or full of confidence				

Comments about the section above:

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Use the same scale to rate the occurrence of each of the following:

During the past week, I:	1	2	3	4
Felt moments of fear				
Felt anxious, worried, or nervous				
Felt the worst things were going to happen				
Felt sweaty, heart pounding, tight breathing				
Felt afraid of losing control				
Sought reassurance from others due to worry				
Felt tense, edgy, restless, or unable to relax				
Was unable to make decisions				
Avoided situations because of feeling nervous				
Feared being rejected, humiliated, embarrassed, or ridiculed by others				
Avoided social situations because I was afraid of embarrassing myself				
Had attacks of anxiety or panic				
Had periods of stuck thoughts or behaviors				
Had uncomfortable or intrusive thoughts				
Restricted food intake				
Exercised excessively				
Had episodes of bingeing or purging				
Was afraid of driving or leaving home				
Found it hard to trust people				
Was overly angry or aggressive				

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Comments about the section above :

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Official Use Only

Use the same scale to rate the occurrence of each of the following:

During the past week, I:	1	2	3	4
Had "flashbacks" or a sense reexperiencing an old event				
Felt numb or empty thinking about or being triggered by an old event				
Felt overwhelmed, agitated, or upset thinking about or being triggered by an old event				
Felt "super alert," on guard, or constantly on the lookout for danger				
Was easily startled by unexpected noise				

Comments about the section above:

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Have you ever been a victim or offender of abuse or trauma?

Emotional **Yes** ☐ **No** ☐
Sexual: **Yes** ☐ **No** ☐
Physical: **Yes** ☐ **No** ☐

Comments about the section above:

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Use the table below to list the people in your current living situation:

Name	Relation to Yourself	Age	Education/ Occupation

Comments about the family life, relationships, or people identified above:

_____

_____

_____

_____

_____

Do any of the people listed above have a mental health, alcohol or drug problem? If yes, please describe.

_____

_____

_____

_____

Describe your current employment and financial situation:

_____

_____

_____

_____

Describe any relevant legal issues:

_____

_____

_____

_____

Describe any other relevant stressors:

_____

_____

_____

_____

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Use the table below to list your parents, siblings, or other people who lived with you growing up:

Name	Relation to Yourself	Age	Education/ Occupation

Comments about the family life, relationships, or people identified above:

_____

_____

_____

_____

_____

Do any of the people listed above have a history of mental health, alcohol, or drug problems? If yes, please describe.

_____

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_____

Who is your Primary Care Doctor? _____

Date of your most recent visit: _____

Any medical issues, past or present, relevant to treatment:

_____

_____

_____

_____

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 @ First Use	Use Last 30 Days	Average Quantity Per Use	Last Used	Amount Used
Alcohol					
Sedatives/Barbituates					
Heroin (Opioids)					
Cocaine					
Other Stimulants					
Marijuana					
Halucinagenics					

☐ 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 about the section above:

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