Initial Evaluation

Patient Report:

Name: _____

Date: _____

Please write your answers under each question.

What is the main reason for your visit?

Have you been bothered by these problems? Please circle the ones that apply to you:

Syndrome A

Down, sad, irritable, unable to enjoy, unmotivated, poor concentration, forgetful, indecisive, worthless, failure, helpless, hopeless, suicidal, tired, change in appetite, change in sleep, decreased sexual drive

Syndrome B

Worry, anxiety, muscle tension, palpitations, sweating, dry mouth, nausea, agitation, irritability, fatigue, concentration difficulty, sleep disturbance

Syndrome C

Feeling "High", mood liability, racing thoughts, distractibility, increased self-confidence, decreased need to sleep, increased energy and sexual drive, restless, talkative, start multiple projects, increased socializing, risk taking

Syndrome D

Hearing voices, being spied on, others could read your mind, things seem especially arranged for you, having great abilities, seeing visions

Specialist Report:

Have your problems that you circled on the previous page affected your functioning? Please circle what applies to you:

Marriage/Relationship/Family
Job/School Performance
Friendship/Peer Relationships
Financial Situation
Hobbies/Interests/Play Activities
Physical Health
Activities of daily living (personal hygiene, bathing, etc.)
Anything else?
_____
_____

Have you experienced any of these life events? Please circle what applies to you.

Death in the family
Serious injury or illness
Serious troubles at work
Serious financial problems
Serious relationship problems
Significant traumatic events
Physical abuse
Sexual abuse
Emotional abuse
Anything else?
_____
_____

Please list all medications you are currently taking (including over the counter medications, vitamins, etc.)

Please list any allergies to medications:

Specialist Report:

List any physical health problems and pertinent family health history:

Did you ever receive treatment from mental health professionals? Have you ever been hospitalized for mental health issues? Please describe:

Have you ever attempted suicide or self-injury? Please describe:

Did or are you abusing alcohol or other drugs including prescription medication? Please describe.

Do you have family members who are diagnosed with mental health disorders? Please list

Do you gamble?

Are there guns in your home?

List your current support system:

List the 3 most important events that affected Your life:

1.)

2.)

3.)

Specialist Report: