INITIAL EVALUATION

PAPTIENT REPORT:

NAME:____________________________

DATE:____________________________

PLEASE WRITE IN THE *LEFT* COLUMN ONLY

What is the main reason for your visit?
Please briefly describe:

Have you been bothered by these problems lately? Please circle 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, starts multiple projects, increased socializing, risk-taking, intrusive, demanding, assaultive

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:

PLEASE WRITE IN THE *LEFT* COLUMN ONLY

Have your problems, which 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 that has affected you
Serious injury or illness
Serious troubles at work
Serious financial problems
Serious relationship (marital) problems
Significant traumatic events
Physical abuse
Sexual abuse
Emotional abuse
Anything else?
____
____
____

Please list all medication you currently take (include OTC, vitamins, herbs, etc.)

Allergies to medications:

SPECIALIST REPORT

PLEASE WRITE IN THE _LEFT_ COLUMN ONLY

SPECIALIST REPORT

List any physical health problems and pertinent Family health history:

Did you ever receive treatment by mental health professionals? Have you ever been hospitalized for mental health issues?

Did you ever attempt suicide, violence 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?

Do you gamble? Please describe:

Are there guns in your home?

Do you have any pending legal issues?

Have you ever served in the armed forces?

List your current support system:

List three most important events that affected you and your life:

1)
2)
3)