

PSYCHIATRIC EVALUATION - MEDICATION EVALUATION

OFFICE USE :

Date of Eval: _____ Time:(start)_____ (end)_____ CPT _____
Referred by: _____ DSM DX _____

SECTION I: TO BE COMPLETED BY PATIENT/PARENT/GUARDIAN

Directions: Answer questions the best you can. If unsure just leave blank. Where appropriate just place an "X" in the

Name of person completing form: _____ Self YN Legal Guardian YN
(Copy of Legal Custody Papers are Required to be o file in this office) Y N Relationship to patient: _____

PATIENT LEGAL NAME _____

Nickname _____ **AGE** _____ **DOB** _____ **SS# (last 4 digits)** _____

Complete Address _____ **Zip Code** _____

Cell Phone _____ **Email** _____

Do you give permission to call/text YN; email you YN (*note: neither text nor email can insure confidentiality)

Are you here for Meds Only Y N **Meds and Therapy** Y N **Therapy Only** Y N **Second Opinion** Y N

Employment of Parent if patient is minor (title/where/how long): _____

Employment of Patient if appropriate _____

Do you feel you are currently being successful in workplace? Y N Not applicable

Problematic Issues _____

School (where, grade, major) _____

Do you feel you are currently being successful in school? Yes ___ No ___ Problematic Issues _____

Do you need any special accommodations (Ex: extended test times etc) _____

Relationship Status (how many times married/divorced/significant other) _____

Spouse/partner's name? _____

Sexual Preference _____ Gender Identification _____ Preferred Pronoun: _____

| CHILDREN: NAME(S) <input type="checkbox"/> NONE | Age | | Primary Residence |
|---|-----|---|-------------------|
| | | Biological <input type="checkbox"/> Y <input type="checkbox"/> N Adopted <input type="checkbox"/> Y <input type="checkbox"/> N at age _____ | |
| | | Biological <input type="checkbox"/> Y <input type="checkbox"/> N Adopted <input type="checkbox"/> Y <input type="checkbox"/> N at age _____ | |
| | | Biological <input type="checkbox"/> Y <input type="checkbox"/> N Adopted <input type="checkbox"/> Y <input type="checkbox"/> N at age _____ | |

| SIBLINGS: NAME(S) <input type="checkbox"/> NONE | Age | | Residence |
|---|-----|---|-----------|
| | | Biological <input type="checkbox"/> Y <input type="checkbox"/> N Adopted <input type="checkbox"/> Y <input type="checkbox"/> N at age _____ | |
| | | Biological <input type="checkbox"/> Y <input type="checkbox"/> N Adopted <input type="checkbox"/> Y <input type="checkbox"/> N at age _____ | |
| | | Biological <input type="checkbox"/> Y <input type="checkbox"/> N Adopted <input type="checkbox"/> Y <input type="checkbox"/> N at age _____ | |

Others living in the home: _____

Primary Healthcare Provider's Name _____ Phone _____

Approximate Date Last Physical: _____ Date of last lab work? _____

Do you have a release of information on file with your current therapist or healthcare provider to speak with me or share information electronically? Y N N/A ROI signed today Y N for _____

*****PRENATAL AND DEVELOPMENTAL HISTORY (IF PATIENT IS A MINOR)*****

Planned pregnancy Y N Prenatal care Y N Problems during pregnancy or delivery Y N
Specify _____ Apgars ____/____ Unsure

During pregnancy did you experience more than usual stress or any physical or emotional trauma? Y N Specify if Yes _____
Cigarettes Y N Alcohol Y N Drug use Y N Specify _____
Between birth and age 3, were you or others concerned about your child's development? Yes No Unsure
If "Yes", please describe: _____

Does/Is your child:

Walk without holding on? Y Age learned ____; N Use single words? Y Age learned ____; N
Use phrases to talk? Y Age learned ____; N Toilet trained? Y Age learned ____; N

Did your child ever lose skills he or she once had (for example, learned words then stopped talking)? Yes No; If Yes please describe: _____

Why are you here today? (Chief Complaint) _____

What made you decide to seek help for this problem NOW? _____

What are your goals for this appointment today? _____

Regarding the reason you came today, please answer the items below the best you can.

Onset: When did this problem first start? _____

Location: Is there any particular place you feel this in your body Y N (i.e. chest, neck, stomach, head?) _____

Duration: How long has this problem been going on? _____ Have you ever had this problem before? Y N

Characteristics or Aggravating Factors: Are there any certain qualities to this problem or things that make it feel worse? Y N Specify _____

Relieving Factors: Is there anything that makes it feel better? Y N Specify _____

Time: How long does this problem usually last? _____ Is it off and on Y N OR there all the time Y N
Is there any time of day it is better or worse? (Be as specific as possible) _____

Severity of Symptoms: On a scale of 1-10 with "1" being the best or least problematic and "10" being the worst or most problematic: How would you rate **this problem/discomfort today?** 1-10 _____

How would you rate it over the **past 2-3 weeks?** 1-10 ____ How would you rate it over the **past 3 months?** 1-10 _____

| PSYCHIATRIC SYMPTOMS CHECKLIST | N= NEW O=OLD C=CONTINUOUS R=RECURRING |
|--|---|
| <input type="checkbox"/> Anxiety <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> C <input type="checkbox"/> R | <input type="checkbox"/> Fidgety <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> C <input type="checkbox"/> R |
| <input type="checkbox"/> Fears <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> C <input type="checkbox"/> R | <input type="checkbox"/> Paranoia <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> C <input type="checkbox"/> R |
| <input type="checkbox"/> Worries <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> C <input type="checkbox"/> R | <input type="checkbox"/> Too much energy <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> C <input type="checkbox"/> R |
| <input type="checkbox"/> Panic Attacks <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> C <input type="checkbox"/> R | <input type="checkbox"/> Too little energy <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> C <input type="checkbox"/> R |
| <input type="checkbox"/> Depressed <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> C <input type="checkbox"/> R | <input type="checkbox"/> Sleep too much <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> C <input type="checkbox"/> R |
| <input type="checkbox"/> Moodiness <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> C <input type="checkbox"/> R | <input type="checkbox"/> Attention problems <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> C <input type="checkbox"/> R |
| <input type="checkbox"/> Obsessions <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> C <input type="checkbox"/> R | <input type="checkbox"/> Lack of Pleasure <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> C <input type="checkbox"/> R |
| <input type="checkbox"/> Compulsions <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> C <input type="checkbox"/> R | <input type="checkbox"/> Sexual Concerns <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> C <input type="checkbox"/> R |
| <input type="checkbox"/> Agitation <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> C <input type="checkbox"/> R | Other: _____ <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> C <input type="checkbox"/> R |
| <input type="checkbox"/> Irritability <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> C <input type="checkbox"/> R | Other: _____ <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> C <input type="checkbox"/> R |
| <input type="checkbox"/> Insomnia <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> C <input type="checkbox"/> R | |

Have you been treated in the past or are currently treated for this symptom? Y N If past, how long ago? _____

Have you had a positive or negative experience with therapy in the past? _____

Past therapist Y N Name: _____ Phone _____ ROI Y N

Current Therapist Y N Name: _____ Phone _____ ROI Y N

Overall, on a scale of 1(low or worst)-10 (high or best) - **in general** how would you rate your **“overall sense of well being”** today __, over past 2-3 weeks __, 2-3months __, past year? ____

When was the last time you felt “good”? _____

What has changed since then and when? _____

If you went to sleep tonight and woke up tomorrow and a **“Miracle”** happened that fixed everything for you, what would your life look like for you? What would be different?

If I had a magic wand what **ONE problem or symptom** would you like me to “fix or change for you **TODAY**?”

If you had **any 3 wishes** what would they be?

***Please be as specific as possible on the Medical and Psychiatric Family History Sections.**

Family Medical History: (i.e. heart disease, diabetes, high blood pressure, high cholesterol, cancer, asthma etc.)

*Please note age and if still living. Directions: **Put an X in the box and specify under appropriate column**

| MEDICAL HISTORY: FAMILY | CHILDREN | SIBLINGS | MATERNAL FAMILY (MOTHER, GRANDMOTHER, GRANDFATHER, AUNTS UNCLER, COUSINS) | PATERNAL FAMILY (FATHER, GRANDMOTHER, GRANDFATHER, AUNTS UNCLER, COUSINS) |
|--|----------|----------|---|---|
| <input type="checkbox"/> Diabetes | | | | |
| <input type="checkbox"/> High Blood Pressure | | | | |
| <input type="checkbox"/> High Cholesterol | | | | |
| <input type="checkbox"/> Heart Attack | | | | |
| <input type="checkbox"/> Stroke | | | | |
| <input type="checkbox"/> Cancer | | | | |
| <input type="checkbox"/> Other | | | | |

Family Mental Health History: (i.e. depression, anxiety, panic, PTSD, alcoholism, drug addiction, bipolar (manic depression), schizophrenia, obsessive compulsive, dementia,alzheimer’s, other) *Please note age and if still living. *(If you need more room please use back of this page)

| PSYCHIATRIC HISTORY: FAMILY | CHILDREN | SIBLINGS | MATERNAL FAMILY (MOTHER, GRANDMOTHER, GRANDFATHER, AUNTS UNCLER, COUSINS) | PATERNAL FAMILY (FATHER, GRANDMOTHER, GRANDFATHER, AUNTS UNCLER, COUSINS) |
|--|----------|----------|---|---|
| <input type="checkbox"/> Depression | | | | |
| <input type="checkbox"/> Anxiety | | | | |
| <input type="checkbox"/> Panic attacks | | | | |
| <input type="checkbox"/> Bipolar | | | | |
| <input type="checkbox"/> Schizophrenia | | | | |

| PSYCHIATRIC HISTORY: FAMILY | CHILDREN | SIBLINGS | MATERNAL FAMILY (MOTHER, GRANDMOTHER, GRANDFATHER, AUNTS UNCLAS, COUSINS) | PATERNAL FAMILY (FATHER, GRANDMOTHER, GRANDFATHER, AUNTS UNCLAS, COUSINS) |
|--|----------|----------|---|---|
| <input type="checkbox"/> ADHD | | | | |
| <input type="checkbox"/> PTSD | | | | |
| <input type="checkbox"/> OCD | | | | |
| <input type="checkbox"/> Eating Disorders | | | | |
| <input type="checkbox"/> Schizophrenia | | | | |
| <input type="checkbox"/> Asperger's | | | | |
| <input type="checkbox"/> Autistic Spectrum | | | | |
| <input type="checkbox"/> Addiction <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Dependence <input type="checkbox"/> Borderline | | | | |
| <input type="checkbox"/> Other | | | | |
| <input type="checkbox"/> Hospitalized | | | | |

Personal Health: Psychiatric and General Medical Conditions and Medication History

| CURRENT OR PAST PSYCHIATRIC CONDITIONS/DIAGNOSIS | 1.HAVE YOU EVER: BEEN HOSPITALIZED FOR PSYCH CONDITION Y <input type="checkbox"/> N <input type="checkbox"/> 2.DONE IOP FOR PSYCH CONDITION(S) Y <input type="checkbox"/> N <input type="checkbox"/> MORE THAN ONCE? Y <input type="checkbox"/> N <input type="checkbox"/> #TIMES _____ WHERE _____ DATE(S) _____ HOW LONG _____ VOLUNTARY Y <input type="checkbox"/> N <input type="checkbox"/> | PERSONALITY DISORDERS OR TRAITS |
|---|--|---|
| <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Panic attacks <input type="checkbox"/> Agoraphobia <input type="checkbox"/> Bipolar <input type="checkbox"/> Post-partum dep <input type="checkbox"/> ADHD Tested for ADHD Y <input type="checkbox"/> N <input type="checkbox"/> by: _____ Other: _____ _____ _____ | <input type="checkbox"/> PTSD <input type="checkbox"/> OCD <input type="checkbox"/> Anorexia <input type="checkbox"/> Bulimia <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Psychotic disorder <input type="checkbox"/> Asperger's <input type="checkbox"/> Autistic Spectrum <input type="checkbox"/> Special learning needs <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> _____ Accommodations <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> IEP <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> 504Plan <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> <input type="checkbox"/> Addiction/Substance Abuse/Dependence <input type="checkbox"/> Conduct disorder <input type="checkbox"/> Oppositional defiant <input type="checkbox"/> Reactive attachment | <input type="checkbox"/> Borderline <input type="checkbox"/> Narcissistic <input type="checkbox"/> Avoidant <input type="checkbox"/> Dependent <input type="checkbox"/> Paranoid <input type="checkbox"/> Histrionic <input type="checkbox"/> Antisocial <input type="checkbox"/> Schizoid <input type="checkbox"/> Schizotypal <input type="checkbox"/> Obsessive compulsive <input type="checkbox"/> Personality change due to medical condition <input type="checkbox"/> Other _____ _____ |

History of Seizures Y N Head Injuries Y N Loss of Consciousness Y N Migraines Y N _____

Eating Disorders (i.e. anorexia, bulimia etc.) Y N _____ Specify: _____

ALLERGIES/SENSITIVITIES: Are you allergic or sensitive to any medications that you know of Y N

List any medication(s) you are **allergic or sensitive** to: _____
 Reaction(s) _____ Other allergies Y N _____ Latex Y N Epi-pen Y N

Vital Signs if indicated: Height _____ Weight _____ BMI _____ Waist Circumference _____ Pulse _____ B/P _____

| REVIEW OF SYMPTOMS | | |
|---|--|--|
| General Health- <input type="checkbox"/> No Problems <input type="checkbox"/> Weight loss or gain <input type="checkbox"/> Fatigue <input type="checkbox"/> Weakness <input type="checkbox"/> Fever or chills <input type="checkbox"/> Trouble sleeping | Eyes- <input type="checkbox"/> No Problems <input type="checkbox"/> Vision Loss/Changes <input type="checkbox"/> Glasses or contacts <input type="checkbox"/> Pain <input type="checkbox"/> Redness <input type="checkbox"/> Flashing lights <input type="checkbox"/> Specks <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataracts <input type="checkbox"/> Blurry or double vision | Endocrine- <input type="checkbox"/> No Problems <input type="checkbox"/> Head or cold intolerance <input type="checkbox"/> Sweating <input type="checkbox"/> Frequent urination <input type="checkbox"/> Thirst <input type="checkbox"/> Change in appetite |
| Head & Neck- <input type="checkbox"/> No Problems <input type="checkbox"/> Headache <input type="checkbox"/> Head injury <input type="checkbox"/> Neck Pain <input type="checkbox"/> Lumps <input type="checkbox"/> Pain <input type="checkbox"/> Stiffness <input type="checkbox"/> Swollen glands | Neurologic- <input type="checkbox"/> No Problems <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Seizures <input type="checkbox"/> Weakness <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Tremor | Skin- <input type="checkbox"/> No Problems <input type="checkbox"/> Rashes <input type="checkbox"/> Lumps <input type="checkbox"/> Itching <input type="checkbox"/> Dryness <input type="checkbox"/> Color changes <input type="checkbox"/> Hair and nail changes |
| Ears- <input type="checkbox"/> No Problems <input type="checkbox"/> Decreased hearing <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Earache <input type="checkbox"/> Drainage | Nose- <input type="checkbox"/> No Problems <input type="checkbox"/> Stuffiness <input type="checkbox"/> Discharge <input type="checkbox"/> Itching <input type="checkbox"/> Hay fever <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Sinus pain | Hematologic (Blood Issues)- <input type="checkbox"/> No Problems <input type="checkbox"/> Ease of bruising <input type="checkbox"/> Ease of bleeding |
| Throat- <input type="checkbox"/> No Problems <input type="checkbox"/> Bleeding <input type="checkbox"/> Dentures <input type="checkbox"/> Sore tongue <input type="checkbox"/> Dry mouth <input type="checkbox"/> Sore throat <input type="checkbox"/> Hoarseness <input type="checkbox"/> Thrush <input type="checkbox"/> Non-healing sores Breasts- <input type="checkbox"/> No Problems <input type="checkbox"/> Lumps <input type="checkbox"/> Pain <input type="checkbox"/> Discharge <input type="checkbox"/> Self-exams <input type="checkbox"/> Breast-feeding Musculoskeletal- <input type="checkbox"/> No Problems <input type="checkbox"/> Muscle or joint pain <input type="checkbox"/> Stiffness <input type="checkbox"/> Back pain <input type="checkbox"/> Joint Redness <input type="checkbox"/> Swelling <input type="checkbox"/> Trauma | Respiratory- <input type="checkbox"/> No Problems <input type="checkbox"/> Cough <input type="checkbox"/> Sputum <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Painful breathing Cardiovascular- <input type="checkbox"/> No Problems <input type="checkbox"/> Chest pain/discomfort <input type="checkbox"/> Tightness <input type="checkbox"/> Palpitations <input type="checkbox"/> Shortness of breath with activity <input type="checkbox"/> Difficulty breathing lying down <input type="checkbox"/> Swelling <input type="checkbox"/> Sudden awakening from sleep with shortness of breath | Vascular- <input type="checkbox"/> No Problems <input type="checkbox"/> Calf pain with walking <input type="checkbox"/> Leg cramping Gastrointestinal- <input type="checkbox"/> No Problems <input type="checkbox"/> Swallowing difficulties <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Yellow eyes or skin <input type="checkbox"/> Change in appetite <input type="checkbox"/> Change in bowel habits Urinary- <input type="checkbox"/> No Problems <input type="checkbox"/> Frequency <input type="checkbox"/> Urgency <input type="checkbox"/> Burning or pain <input type="checkbox"/> Blood <input type="checkbox"/> Incontinence <input type="checkbox"/> Change in urinary strength |
| Other: | Other: | Other: |
| Past Surgery: Specify type/age | Past Surgery: Specify type/age | Past Surgery: Specify type/age |

| TRAUMA HISTORY & ADVERSE CHILDHOOD EXPERIENCES (ACE) Have you ever experienced any of the traumas listed below? *Please be specific and note age and duration of trauma event and if still occurring. Some of these may be occurring now or when you were a child. | | Agency reports; Name of contact, results, & ref #'s |
|---|--|---|
| Physical Abuse <input type="checkbox"/> Y <input type="checkbox"/> N Age started _____ Duration of Abuse _____ Still Occurring <input type="checkbox"/> Y <input type="checkbox"/> N | | |
| Physical Neglect <input type="checkbox"/> Y <input type="checkbox"/> N Age started _____ Duration of Abuse _____ Still Occurring <input type="checkbox"/> Y <input type="checkbox"/> N | | |
| Emotional Abuse <input type="checkbox"/> Y <input type="checkbox"/> N Age started _____ Duration of Abuse _____ Still Occurring <input type="checkbox"/> Y <input type="checkbox"/> N | | |
| Emotional Neglect <input type="checkbox"/> Y <input type="checkbox"/> N Age started _____ Duration of Abuse _____ Still Occurring <input type="checkbox"/> Y <input type="checkbox"/> N | | |
| Sexual Abuse <input type="checkbox"/> Y <input type="checkbox"/> N Age started _____ Duration of Abuse _____ Still Occurring <input type="checkbox"/> Y <input type="checkbox"/> N | | |
| Bullying <input type="checkbox"/> Y <input type="checkbox"/> N Age started _____ Duration of Abuse _____ Still Occurring <input type="checkbox"/> Y <input type="checkbox"/> N | | |
| Other <input type="checkbox"/> Y <input type="checkbox"/> N Age started _____ Duration of Abuse _____ Still Occurring <input type="checkbox"/> Y <input type="checkbox"/> N | | |
| Experienced or witnessed violence in family <input type="checkbox"/> Y <input type="checkbox"/> N Age started _____ Duration of Abuse _____ Still Occurring <input type="checkbox"/> Y <input type="checkbox"/> N Specifics _____ | | |
| Family Member Incarcerated <input type="checkbox"/> Y <input type="checkbox"/> N Hospitalized <input type="checkbox"/> Y <input type="checkbox"/> N Relationship _____ Age of pt at time _____ Duration of incarceration/hospitalization _____ | | |
| Current relationship <input type="checkbox"/> Y <input type="checkbox"/> N Specify _____ | | |
| Alcohol or drug abuse in household <input type="checkbox"/> Y <input type="checkbox"/> N Age started _____ Duration of Abuse _____ Still Occurring <input type="checkbox"/> Y <input type="checkbox"/> N | | |
| Other: | | |

PAST psychiatric medications (name/dose/how long were you on/for what condition/ who prescribed/ what was positive or negative effects of this med)? _____

All CURRENT Prescribed PSYCH Medications (dose/how long have you been on med/for what condition/ who prescribed/what has been the benefit or adverse effects)? _____

All CURRENT Prescribed NON-PSYCH Medications (dose/how long have you been on med/for what condition/ who prescribed/what has been the benefit or adverse effects)? _____

Current use of herbal remedies/VITAMINS/or dietary supplements (dose/duration/reason for taking) _____

Describe Current Family/Social History: (current living situation, any legal/work/school or other issues) _____

On a scale of 1(low) to 10 (high) how willing are you to take action to change some things in or for yourself in order to feel better? _____ Do you have any ideas what would be helpful to change? _____

Is there anything else you feel is important for the psychiatric provider to know about you or your situation in order to best help you? (Any secrets you have been afraid to share about what is going on with you? Any fears about discussing what is going on with you?) _____

Section II:

Sleep Hygiene: easy to fall asleep Y N; stay asleep Y N; early am awakening Y N; How do you get to sleep (bedtime routine) _____
average number hours of nightly sleep over past two weeks _____; what is norm _____; feel rested upon awakening Y N
What is the longest time you have gone without sleeping and felt OK? _____ When _____ What did you do? _____

Appetite: No problem Intentional Weight Gain Y N; Intentional Weight Loss Y N
 Over what period of time did weight gain or loss occur? _____

Physical Energy: No problem Exhausted (hard to do what needs to be done) High Energy (plenty of energy to get things done) Specify _____

Mental Energy: No problem Exhausted (hard to do what needs to be done) High Energy (plenty of energy to get things done) Specify _____

Pleasure: (what do you do for fun? when is the last time you did something for fun? Do you have best friend/ friends?) _____

Sex: Sexually active Y N; Desire Y N; Pleasurable Y N; Pain with intercourse Y N;
 Ability to orgasm Y N; Masturbate Y N; Any concerns? _____
 Possibly pregnant Y N; Last Period _____ Menopause Y N; PMS Y N; Andropause (males)YN

Cognitive Functioning: Difficulties with concentration Y N; Focus Y N; Memory, Y N;
 Decision making Y N; Reading Y N;

RISK ASSESSMENT: Violence toward self/others/objects/places

| SUICIDE | HOMICIDE/VIOLENCE | SELF HARMING BEHAVIORS |
|---|--|---|
| <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Previous Attempt <input type="checkbox"/> Weapons <input type="checkbox"/> Access <input type="checkbox"/> Passive thoughts of death/dying Specify If you should ever think about suicide what would stop you from acting on it? Comment/quotes: | <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Previous Attempt <input type="checkbox"/> Weapons <input type="checkbox"/> Access Specify <input type="checkbox"/> Assault of another <input type="checkbox"/> Destruction of property Specify If you should ever think about harming someone else what would stop you from acting on it? Comment/quotes: | <input type="checkbox"/> Cutting <input type="checkbox"/> Burning <input type="checkbox"/> Branding <input type="checkbox"/> Other Specify Comment/quotes: |

Have you ever destroyed property of self or someone else? Y N Specify _____

Do you have a safety plan: Y N Specify _____

Resources Available: Family Friends Community Church Spiritual Other _____

Spiritual Beliefs/Religious Affiliation: _____

Therapist's Notes:

SUBSTANCE USE / ABUSE / DEPENDENCE HISTORY - *Current and past use of *non-prescription* or *prescription* drugs/substances (legal or illegal) **FOR ALL USED, LIST AGE STARTED AND STOPPED & IF PAST OR CURRENT USE.** *Mark "X" in the C P by each substance. **Write in any substances used not listed.

| SUBSTANCES - PRESCRIPTION OR NON-PRESCRIPTION | |
|---|--|
| <input type="checkbox"/> NICOTINE (cigarettes, gum, patches) age started ____ amount used/day ____ <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> TOBACCO (other than cigarettes) age started ____ amount used/day ____ <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> ALCOHOL age started ____ amount used/day ____ <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> CAFFEINE (coffee,tea,mountain dew,red bull,energy drinks) age started ____ amount used/day ____ <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> POT (marijuana) age started ____ amount used/day ____ <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> COCAINE age started ____ frequency ____ <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> METH age started ____ amount used/day ____ <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> ECSTASY / <input type="checkbox"/> MDMA age started ____ frequency ____ <input type="checkbox"/> C <input type="checkbox"/> P LSD age started ____ amount used/day ____ <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> MUSHROOMS age started ____ frequency ____ <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> STIMULANTS (speed)/adderall/ritalin/vyvanse/provigil age started ____ amount used/day ____ <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> PAIN PILLS (oxycontin, opana, lortabs, percocets, vicodin) age started ____ amount used/day ____ <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> BENZO'S (xanax-zanni bars/footballs)/ Klonopin (k-pins/valium/ativan/ age started ____ amount used/day ____ <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> SLEEPING PILLS (ambien, restoril) age started ____ amount used/day ____ <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> OTHER SYNTHETICS (spice, kratom, molly, other) age started ____ amount used/day ____ <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> HEROIN <input type="checkbox"/> MORPHINE/ <input type="checkbox"/> DEMEROL <input type="checkbox"/> DILAUDID age started ____ amount used/day ____ <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> METHADONE <input type="checkbox"/> SUBOXONE <input type="checkbox"/> SUBUTEX age started ____ amount used/day ____ <input type="checkbox"/> C <input type="checkbox"/> P | <input type="checkbox"/> COUGH SYRUP age__ amt__ freq__ <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> TRIPLE C age__ amt__ freq__ <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> ROBITUSSIN age__ amt__ freq__ <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> DXM age__ amt__ freq__ <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> NYQUIL age__ amt__ freq__ <input type="checkbox"/> C <input type="checkbox"/> P Other Meds: _____ _____ Related to any past or current use have you experienced any of the following: 1. Ever charged for any drug-related offenses <input type="checkbox"/> Y <input type="checkbox"/> N Specify _____ 2. Served time in jail/prison <input type="checkbox"/> Y <input type="checkbox"/> N Specify _____ 3. Overdosed <input type="checkbox"/> Y <input type="checkbox"/> N Specify _____ 4. Any negative consequences or losses <input type="checkbox"/> Y <input type="checkbox"/> N Specify _____ 5. Have you ever been concerned about your own alcohol or substance use? <input type="checkbox"/> Y <input type="checkbox"/> N Specify _____ 6. Have any friends/family ever told you they were worried about your alcohol or substance use? <input type="checkbox"/> Y <input type="checkbox"/> N Specify _____ 7. Have you ever tried to stop using alcohol or substances? <input type="checkbox"/> Y <input type="checkbox"/> N Specify _____ 8. Hospitalization/Rehab/Detox <input type="checkbox"/> Y <input type="checkbox"/> N (Details) _____ _____ _____ Therapist's notes: _____ _____ _____ |

*****STOP HERE***** The following section will be completed by the evaluator

What question(s) should I have asked that I did not? _____

SCREENING TESTS /SCORES: MDQ Depression:PHQ9 Zung SAD(gero) Edinburgh Post-Natal Yale-Brown OCD Anxiety Panic YMRS ADHD Test taking anxiety PTSD Other _____

Labs- reviewed ordered CBC CMP HbA1C Thyroid w/TPO Lipid Panel Vit D B12 Folate Ferritin CRP Homocysteine Creatinine Beta Hcg PSA Free & Total Testosterone DHEA-S Progesterone Estradiol(E2) Lithium Depakote Tegretol _____ EKG EEG CT SCAN MRI _____ Sleep Study UA UDS 7 12 Panel OTHER _____ Directions for fasting or drug levels given Y N

| <u>MENTAL STATUS EXAM</u> | <u>MENTAL STATUS EXAM</u> | <u>RISK ASSESSMENT SUMMARY</u> |
|---|---|--|
| Appearance- <input type="checkbox"/> Casual dress, normal grooming & hygiene <input type="checkbox"/> Other Attitude/Response to Rapport- <input type="checkbox"/> Calm & cooperative <input type="checkbox"/> Easily engaged <input type="checkbox"/> Hostile <input type="checkbox"/> Uncooperative <input type="checkbox"/> Other Behavior- <input type="checkbox"/> No unusual movements or psychomotor changes <input type="checkbox"/> Other Speech- <input type="checkbox"/> Normal rate/tone/volume/ <input type="checkbox"/> Pressured <input type="checkbox"/> Loud <input type="checkbox"/> Soft <input type="checkbox"/> Monotone <input type="checkbox"/> Slurred <input type="checkbox"/> Poverty <input type="checkbox"/> Tangential <input type="checkbox"/> Other Orientation- <input type="checkbox"/> Oriented X3 <input type="checkbox"/> Other Memory/Concentration- <input type="checkbox"/> Short Term Intact <input type="checkbox"/> Long Term Intact <input type="checkbox"/> Distractible/Inattentive <input type="checkbox"/> Other Insight/Judgment- <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor Impulse Control- <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor | Affective Expression- <input type="checkbox"/> Full range displayed - appropriately <input type="checkbox"/> Mood congruent <input type="checkbox"/> Labile <input type="checkbox"/> Depressed <input type="checkbox"/> Tearful <input type="checkbox"/> Constricted <input type="checkbox"/> Blunted <input type="checkbox"/> Flat <input type="checkbox"/> Superficial <input type="checkbox"/> Other Mood- <input type="checkbox"/> Euthymic <input type="checkbox"/> Anxious <input type="checkbox"/> Irritable <input type="checkbox"/> Angry <input type="checkbox"/> Depressed <input type="checkbox"/> Elevated <input type="checkbox"/> Anhedonic <input type="checkbox"/> Other Thought Process/Form- <input type="checkbox"/> Goal-directed/Logical <input type="checkbox"/> Disorganized <input type="checkbox"/> Other Thought Content- Suicidal ideation <input type="checkbox"/> None <input type="checkbox"/> Passive <input type="checkbox"/> Active If Active: <input type="checkbox"/> Plan <input type="checkbox"/> Intent <input type="checkbox"/> Means Homicidal ideation <input type="checkbox"/> None <input type="checkbox"/> Passive <input type="checkbox"/> Active If Active: <input type="checkbox"/> Plan <input type="checkbox"/> Intent <input type="checkbox"/> Means Specify if Duty to Warn: <input type="checkbox"/> Y <input type="checkbox"/> N _____ <input type="checkbox"/> Delusions <input type="checkbox"/> Paranoia <input type="checkbox"/> Phobias <input type="checkbox"/> Perseveration <input type="checkbox"/> Obsessions/compulsions <input type="checkbox"/> Grandiosity <input type="checkbox"/> Flight of ideas <input type="checkbox"/> Other Perception- <input type="checkbox"/> No hallucinations or delusions during interview <input type="checkbox"/> Dissociation <input type="checkbox"/> Depersonalization <input type="checkbox"/> Other Intelligence- <input type="checkbox"/> Appears WNL for age/education <input type="checkbox"/> Other: _____ Notes: _____ _____ _____ _____ | <input type="checkbox"/> Preoccupations Suicidal Ideation <input type="checkbox"/> None Currently <input type="checkbox"/> Ideation history <input type="checkbox"/> Previous attempt/s <input type="checkbox"/> Current ideation <input type="checkbox"/> Impulsiveness <input type="checkbox"/> Viable plan <input type="checkbox"/> Available means <input type="checkbox"/> Settling of affairs Hostile Intent <input type="checkbox"/> None Currently <input type="checkbox"/> Previous intimidation <input type="checkbox"/> History of violence <input type="checkbox"/> Current intent <input type="checkbox"/> Impulsiveness <input type="checkbox"/> Viable plan <input type="checkbox"/> Available means Other risk factors such as alcohol or substance use: _____ _____ _____ Intervention: _____ _____ _____ |

CURRENT DIAGNOSTIC IMPRESSION/PROVISIONAL DIAGNOSIS/ INCLUDE DIFFERENTIAL DIAGNOSIS:

| | | |
|--|--|--|
| | | |
| | | |

Plan for treatment: (Therapy and Medications): Individual Family Couples Group _____

Currently prescribed any **controlled substance(s)** Y N By other provider Y N **KASPER** Y N _____

Specify: _____

Medication(s) Started/Recommended:

Medication Plan Discussed Y N N/A Usefulness of Medication and Possible Side Effects Reviewed Y N N/A
Handout Given Y N WebMd.com Y N Other _____ Consent for off label (Age) Y

PLAN for next appt: Life event timeline Child self pic Letter writing Past/Present/Future Journal Music
 Photography Collage Art Energy Release None at this time Other _____

Other Referrals Given: Psych Testing PCP/Specialist Other _____

Were goals of this initial appointment met? Y N Follow-up Appt: _____

Therapist's Notes: Miscellaneous: _____

Evaluation Completed By _____ **Date** _____