CLIENT EVALUATION FORM

Date: _____ Client Name:_____
Gender: ☐male ☐female Age: _____ Date of Birth: _____
Preferred phone: _____ ☐ cell ☐ home ☐ work
May I leave detailed messages on this phone? ☐ yes ☐ no
Preferred Mailing Address: _____
Preferred Email address_____

Medications:
Current medications and past medications, and whether or not you are currently taking these medications:

_____
_____
Allergies to medications _____

Parent/Guardian Information (if client is under 18):

Name _____ Age_____
Street Address_____
Cell Phone_____ email address_____
Name _____ Age _____
Cell Phone_____ email address_____
Street Address_____

Emergency Contact Information:

Name: _____
Phone/email: _____
Address:_____
_____

How/ by whom were you referred to us? _____
Phone: _____

Preferred Pharmacy: _____ Phone: _____

Address: _____

Goals of Consultation: Please describe current symptoms and what you hope to achieve through this consultation.

Current School and/or Place of Employment:

Please check off any prior or current modalities of treatment:

☐ Individual therapy
☐ Family Therapy
☐ Medication
☐ Hospitalization
☐ Day treatment
☐ Residential program

Please list names and approximate dates of treatment of prior psychiatrists or therapists.

Birth Complications? (C-section, emergency delivery, prolonged hospital stay, illness)

History of early intervention services (check all that apply):

☐ Speech and Language Therapy
☐ Physical or Occupational Therapy
☐ Special Education Classes/504 plan/IEP
☐ None, but did have delays in walking/talking or learning difficulties
☐ None

Describe any social difficulties in childhood:

Level of physical activity in childhood:
☐ Low
☐ Average
☐ High

Childhood or lifetime history of physical/sexual/emotional abuse:
☐ Yes
☐ No

Preschool: Summary of performance & relationship with teachers and peers:

Elementary School: Summary of performance & relationship with teachers and peers:

Middle School: Summary of performance & relationship with teachers and peers:

High School: Summary of performance & relationship with teachers and peers:

College: Summary of performance & relationship with teachers and peers:

Choose all substances you have tried at least once:
☐ Alcohol
☐ Cigarettes
☐ Marijuana
☐ Cocaine
☐ Heroin
☐ Hallucinogens
☐ Other: _____

For the above substances you have tried, please describe your current and past use:

Describe any disciplinary action/legal involvement (school suspensions, arrests, charges, jail/prison, probation, etc.):

Check off any symptoms that have been experienced in past or present. We will discuss in more detail during consultation.

☐ Depressed mood
☐ Difficulty sleeping
☐ Overeating
☐ Decreased appetite
☐ Difficulty concentrating
☐ Low Energy
☐ Low self-esteem
☐ Thoughts of self-harm
☐ History of self-harm
☐ Premenstrual symptoms
☐ Mood swings
☐ Unusually high energy
☐ Excessive risk-taking/frequent impulsive decisions
☐ Difficulty controlling anger
☐ Wanting to harm others
☐ Hearing things that may not be there
☐ Seeing things that may not be there
☐ Feeling panicked or worried
☐ Phobias
☐ Fear/discomfort in social situations
☐ Fear of being sick
☐ Fear of dying
☐ Physical pain
☐ Doing things over and over
☐ Having same thoughts over and over again
☐ Difficulty with memory
☐ Losing things/leaving things places and forgetting where they are
☐ Mind wandering/not paying attention to conversation at times when someone is speaking

☐ Interrupts people when talking or doing something
☐ Lying
☐ Physical fights
☐ Excessive reaction to noise
☐ Overreacts to touch
☐ Compulsive rituals
☐ Unusual interests
☐ Situationally inappropriate emotions
☐ Motor tic
☐ Vocal tics
☐ Difficult to follow speech/tangential speech
☐ Little interest in socializing outside of family
☐ Initiates or terminating interactions inappropriately
☐ Excessive reaction to change in routine
☐ Feeling detached from others
☐ Sexual difficulties
☐ Fear of being overweight
☐ Vomiting/purging
☐ Addictive behaviors

List any medical illnesses, prior need for medications, surgeries, and/or traumatic injuries:

Family Medical History: Please check any diagnosis or symptoms that biologically related family members have experienced:
☐ Medical Illnesses
☐ Substance Abuse
☐ Anxiety
☐ Depression
☐ Bipolar Disorder
☐ Schizophrenia/Psychosis/Hallucinations/Delusions/Paranoia
☐ Sudden decline in function leading to disability
☐ Suicide Attempts

Please indicate which family members experienced above symptoms and describe types of symptoms:

Thank you for taking the time to complete these forms. We look forward to meeting you. If there is anything else we should know in advance, please explain below. You may also fax any other documents you want us to review to 1(888) 396-3996.