PATIENT: _____

Initial Evaluation

DOB: _____

DATE: _____

Past Psychiatric History

Current Providers: ❑ No ❑ Yes
Therapist:

Psychiatrist:

Past Providers: ❑ No ❑ Yes
Therapist:

Psychiatrist:

Psychological/IQ Testing done ❑ No ❑ Yes; If Yes: when and what where the results
_____

Inpatient Psychiatric Hospitalizations: ❑ No ❑ Yes; If Yes: detail when, where, and why
1._____
2._____
3._____

Day Treatment Hospitalizations: ❑ No ❑ Yes; If Yes: detail when, where, and why
1._____
2._____
3._____

Suicide Attempts ❑ No ❑ Yes; If Yes: detail when, method of attempt, and if medical treatment was sought/ received
1._____
2._____
3._____

Substance Use/ Abuse/ Dependence (Current/Past): ❑ No ❑ Yes
❑ Nicotine ❑ Alcohol ❑ Cocaine ❑ Marijuana ❑ Opiates (Heroin, ect.) ❑ Prescription drugs ❑ IV Drugs ❑ Other _____

_____Uses Per Week: _____ Date of First Use: _____ Date of Last Use: _____ Withdrawal Symptoms: ❑ No ❑ Yes
_____Use Per Week: _____ Date of First Use: _____ Date of Last Use: _____ Withdrawal Symptoms: ❑ No ❑ Yes
_____Use Per Week: _____ Date of First Use: _____ Date of Last Use: _____ Withdrawal Symptoms: ❑ No ❑ Yes
_____Use Per Week: _____ Date of First Use: _____ Date of Last Use: _____ Withdrawal Symptoms: ❑ No ❑ Yes
_____Use Per Week: _____ Date of First Use: _____ Date of Last Use: _____ Withdrawal Symptoms: ❑ No ❑ Yes
_____Use Per Week: _____ Date of First Use: _____ Date of Last Use: _____ Withdrawal Symptoms: ❑ No ❑ Yes

Substance Abuse/ Dependence Treatment (Current/Past): ❑ No ❑ Yes; If Yes: detail when and where
_____
_____

Past Medication Trials:
Antidepressants: ❑ No ❑ Yes ❑Unsure (Ex: Prozac, Zoloft, Celexa, Paxil, Lexapro, Effexor(XR), Wellbutrin(SR/XL), Remeron, Cymbalta,Pristiq ect)
_____
_____
_____
_____
_____

Antipsychotic: ❑ No ❑ Yes ❑Unsure (Ex: Risperdal, Zyprexa, Seroquel, Abilify, Geodon, Haldol ect)
_____
_____
_____
_____

Mood Stabilizers: ❑ No ❑ Yes ❑Unsure (Ex: Lithium, Depakote, Trileptal, Tegretol, Lamictal ect)
_____
_____
_____
_____

Stimulants/ other ADHD medications: ❑ No ❑ Yes ❑Unsure (Ex: Ritalin, Concerta, Adderall (XR), Vyvanse, Daytrana, Focalin(XR), Strattera ect)
_____
_____
_____
_____

Antianxiety: ❑ No ❑ Yes ❑Unsure (Ex: Xanax, Ativan, Klonopin, Valium ect)
_____
_____
_____
_____

Sedatives: ❑ No ❑ Yes ❑ Unsure (Ex: Ambien (CR), Lunesta, Rozerem, Sonata ect.)
_____
_____

Initial Evaluation

List ALL Current Medications- including herbal, supplements, over the counter	Dose	Frequency	Route
Who has been prescribing the above medications?			

Developmental History

Birth History: ❑Unknown/ Adopted; Planned pregnancy ❑ No ❑ Yes

Alcohol ,drug, and/or nicotine use during pregnancy ❑ No ❑ Yes specify which:_____

❑ Full Term ❑ Preterm (weeks): _____ Birth Weight: _____ Length of Stay in hospital after delivery: _____

Prenatal (During pregnancy) Problems: ❑ No ❑ Yes If Yes, please explain: _____

Neonatal (after delivery) Problems: ❑ No ❑ Yes If Yes, please explain: _____

Age of Developmental Milestones: ❑Unknown ❑ Sat: _____ ❑ Walked: _____ ❑ Spoke: single words by:_____ short sentences by:_____

Social Interactions: affectionate with others (hugs/kisses): ❑ No ❑ Yes; played with other children of same age: ❑ No ❑ Yes; engaged in make believe play (imaginative): ❑ No ❑ Yes

Temperment: happy baby: ❑ No ❑ Yes; slow to warm up/ shy/ inhibited: ❑ No ❑ Yes; difficult (feeding/ sleeping patterns) baby ❑ No ❑ Yes

Toilet Training issues as a child: ❑ No ❑ Yes specify: _____

Past Medical History

Medication Allergies ❑ No ❑ Yes If yes, please list with reaction: _____

Major Medical Illnesses

Head Trauma ❑ No ❑ Yes If yes, explain: _____

Seizure Disorder ❑ No ❑ Yes If yes, type: _____

Asthma ❑ No ❑ Yes _____

Heart Problems ❑ No ❑ Yes If yes, explain: _____

Diabetes ❑ No ❑ Yes _____

High Blood Pressure ❑ No ❑ Yes _____

Thyroid Problems ❑ No ❑ Yes If yes, explain: _____

Cholesterol Problems ❑ No ❑ Yes If yes, explain: _____

Cancers/Radiation/Chemo ❑ No ❑ Yes If yes, explain: _____

Repeated ear infections ❑ No ❑ Yes If yes, explain: _____

Any birth defects ❑ No ❑ Yes If yes, explain: _____

Fainting ❑ No ❑ Yes If yes, explain: _____

Chest pain ❑ No ❑ Yes If yes, explain: _____

Irregular heart beats ❑ No ❑ Yes If yes, explain: _____

Liver disease ❑ No ❑ Yes If yes, explain: _____

Kidney disease ❑ No ❑ Yes If yes, explain: _____

Other ❑ No ❑ Yes If yes, explain: _____

Hospitalizations ❑ No ❑ Yes If yes, explain: _____

_____

Operations ❑ No ❑ Yes If yes, explain: _____

Hearing Tested ❑ No ❑ Yes If yes, results:_____ **Vision Tested** ❑ No ❑ Yes If yes, results: _____

PATIENT: _____

Initial Evaluation

DOB: _____

DATE: _____

Last Physical Exam: _____ **Blood work in past year** ❑ No ❑ Yes If yes, when and results: _____

Current Primary Care Physician Name: _____ **Last Seen:** _____

Family History

(Disorders present in ANY BLOOD RELATIVE of the patient- specify who has the disorder)

Medical Disorders

Heart Problems ❑ No ❑ Yes If yes, explain: _____
Sudden Death ❑ No ❑ Yes If yes, explain: (Unknown cause of death prior to 40) _____
Seizures ❑ No ❑ Yes If yes, explain: _____
Diabetes ❑ No ❑ Yes If yes, explain: _____
High Blood Pressure ❑ No ❑ Yes If yes, explain: _____
Thyroid ❑ No ❑ Yes If yes, explain: _____
Asthma ❑ No ❑ Yes If yes, explain: _____
Cholesterol Problems ❑ No ❑ Yes If yes, explain: _____
Cancers ❑ No ❑ Yes If yes, explain: _____
Glaucoma ❑ No ❑ Yes If yes, explain: _____

Others ❑ No ❑ Yes If yes, explain: _____

Psychiatric Disorders

Anxiety disorder ❑ No ❑ Yes If yes, explain: _____
Bipolar Disorder ❑ No ❑ Yes If yes, explain: _____
Depression ❑ No ❑ Yes If yes, explain: _____
Anorexia/Bulimia ❑ No ❑ Yes If yes, explain: _____
Drug Problems ❑ No ❑ Yes If yes, explain: _____
Alcohol Problems ❑ No ❑ Yes If yes, explain: _____
Mental Retardation ❑ No ❑ Yes If yes, explain: _____
Learning disorder ❑ No ❑ Yes If yes, explain: _____
Dyslexia ❑ No ❑ Yes If yes, explain: _____
Schizophrenia ❑ No ❑ Yes If yes, explain: _____
Completed Suicide ❑ No ❑ Yes If yes, explain: _____
ADHD ❑ No ❑ Yes If yes, explain: _____
Autism ❑ No ❑ Yes If yes, explain: _____
OCD ❑ No ❑ Yes If yes, explain: _____
Other ❑ No ❑ Yes If yes, explain: _____

Social History

❑Single ❑ Married: Yrs____, # of marriages____ ❑ Divorced ❑ Separated ❑ Never Married ❑ In Relationship

Number of children, ages, & gender:_____

Were you Adopted: ❑ No ❑ Yes; If Yes; Age at time of adoption: _____

Were you in Foster Care ❑ No ❑ Yes; If Yes, What Age: _____

Current Living Status: ❑ House ❑ Apartment ❑ Shelter ❑ Other: _____

Persons living in household currently (number & relationship to patient): _____

Biological Parents: ❑ Married ❑ Divorced ❑ Separated ❑ Deceased (which parent) _____ ❑ No contact _____ ❑ Unknown

Step Parents: ❑ No ❑ Yes; if yes, explain: _____

Siblings: ❑ No ❑ Yes; age of each: _____

Highest Education Level Achieved and overall performance: _____

Employment type/ title: _____

Hobbies: ❑ No ❑ yes; if yes, list: _____

Friends/Social support system: ❑ No ❑ Yes; if yes, explain _____

Child Protective Service Involvement: ❑ No ❑ Yes; if yes, reason & current status of investigation: _____

Physical/ Sexual/ &/or Emotional Abuse (Specify which) ❑ No ❑ Yes ❑ Victim ❑ Perpetrator ❑Legal action taken/pending? ❑ No ❑ Yes

_____

Any Legal charges (current/ past) ❑ No ❑ Yes; If yes, explain (misdemeanor, felony, DWI, ect)_____

Probation ❑ No ❑ Yes; If yes, explain _____

_____