Initial Evaluation

Client's Name:_____ Age:____ Sex: M F Marital Status:_____

Occupation:_____ Education:_____ Primary Physician:_____

Others Living in the Home:_____ Nearest Relative:_____

Presenting Problem(s): Please describe the reasons for seeking counseling:

_____
_____

Please Indicate how the following symptoms/problems are effecting you (leave blank if no effect). And use the following scale: 1) Little effect 2) Some effect 3) Much effect 4)Significant effect:

___Eating habits/Appetite: eating more, eating less, weight change_____, binge/purge.

___Sleep: trouble falling asleep, trouble staying asleep, trouble waking up,

Average # of hours of sleep/night_____ Naps____

___Decreased energy/fatigue.

___Sexual functioning.

___Loss of interest in activities.

___Hopelessness/Helplessness.

___Decreased ability to concentrate.

___Memory: Long term; short term.

___Difficulty making decisions.

___Difficulty planning ahead.

___Anger outbursts.

___Impulse control.

___Mood changes.

___Anxious/Nervous.

___Worry/Fear

___Stealing

___Lying

___Truancy

___Fire setting

___Police/Probation Involvement

___Spending sprees

___Rapid heartbeat

___Phobia

___Sweating

___Trouble breathing

___Flashbacks of traumatic event

___Nightmares

___Suicidal thoughts

___Racing thoughts

___Hearing voices

___Seeing things that are not there

Substance Abuse History

Coffee (#_____cups/daily) Cigarettes (#_____per day) Alcohol (#_____drinks/weekly) Date last drank_____

Street Drugs: Type:_____ Amount:_____ Frequency:_____ Date last used:_____

Prescription Drugs: Type:_____ Amount:_____ Frequency:_____ Date last used:_____

Describe impact of substance abuse on your life: _____
_____

Past treatment for substance abuse:_____

Family history of substance abuse:_____

Please rate how the problems/symptoms are impacting the following areas using the following scale:

1) Mild 2) Moderate 3) Severe

___Marriage/Relationship

___Work/School

___Family

___Friendships

___Financial Situation

___Physical Health

___Spirituality

___Social Interests

___Leisure Activities

___Clubs/Group Memberships

___Legal Issues

___Housing

___Attending to daily living activities (i.e. shower, self care)

___Other_____

What do you see as your strengths?_____

What do you see as your weaknesses?_____

Goals for treatment?_____

Motivation for treatment?_____

Past Treatment History

Medical History:_____

Current Medications (dosage, frequency, M.D. prescribing)_____

_____

Over the Counter Medications:_____

Allergies:_____

Significant family medical history:_____

Primary Care Provider Name:_____ Phone #_____

Psychiatrist Name:_____ Phone #_____

Other Provider Name:_____ Phone #_____