NEW PATIENT EVALUATION

Patient Name: Date:

Date of Birth:	**Age:**	**Referring Professional (Name/Ph #/Fax):**

Address:	**Home Phone:** **Work Phone:** **Cell phone:**	**Please check the most correct statement:** _______ I decided to come to this evaluation on my own. _______ I was encouraged to come in by ___________________. _______ I was required to come by ________________________.

Marital Status *(please circle one)* Single Engaged Married Divorced Living with a partner Widowed Separated	**How long have you been in your current relationship?**	**Spouse's Name:**

Please list your children's names, ages, genders, and locations:

Psychotherapist Name/Number:	**Primary Care Facility**:	**Primary Care Manager's Name** *(if known):*

Briefly describe the events that led to this visit today:

CONTINUE HERE

II. Primary Concern

Briefly describe the problems/concerns that brought you here.

____

____

What led to your decision to seek help now?

____

____

How upsetting is the problem to you? ☐ Mild ☐ Moderate ☐ Severe

What makes the problem worse? ____

____

What makes the problem better? ____

____

What has changed in your life because of your primary concern? (for example, relationships with family and friends, your desire to have fun):

____

____

Emotions/Behaviors

Please rate the extent to which each item below has been a problem for you over the **past month**.

	No Problem	Mild Problem	Moderate Problem	Extreme Problem
S: Sleeping too much				
Difficulties falling asleep				
Difficulties staying asleep				
Waking earlier than desired				
I: Loss of interest in pleasurable activities				
G: Excessive guilt				
Feeling worthless				
E: Decreased energy				
Increased energy				
C: Difficulties with concentration/memory				
A: Increased appetite				
Decreased appetite				
P: Unable to sit still				
Moving so slowly others notice				
S: Changes in sexual interest				
Mood swings				
Feeling sad or depressed				
Feeling nothing or feeling numb				
Anger				
Temper outbursts				
Regretting some behaviors (e.g., spending too much)				
Irritability				
Anxiety or fear				
Worry about social or performance situations				
Avoiding places, people, or situations				
Inability to stop worrying				
Seeing things that others may not see				
Hearing things that others may not hear				

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Risk Assessment
Please check all that apply.

	Currently (in last week)	**Recently** (in last 6 months)	**Previously** (+6 months ago)	**Never**
Recurrent thoughts about death				
Recurrent thoughts about killing yourself				
Recurrent thoughts about killing others				
Engagement in self-harming behaviors, such as cutting or burning yourself, without intent to die				
Thinking out a plan to kill yourself				
Thinking out a plan to kill others				
Active preparation to kill yourself (e.g., writing goodbye letter, purchasing pills, obtaining a weapon)				
Active preparation to kill others				
Attempting to kill yourself				
Attempting to kill others				
Believing that others would be "better off" if you die				
Feeling hopeless about your life and future				
A family member or close friend completing suicide				
Voices telling you to hurt or kill yourself or others				
Being more physically or verbally aggressive than you intended with your spouse or children				
A physical altercation in which you caused injury				
Throwing or breaking things when angry				
Arrest for physical violence				

Physical Symptoms
Please check the physical symptoms that have been a problem for you over the **past month**.

	Dry mouth		Chills/Hot flashes		Trembling/Shaking
	Constipation		Urinary problems		Excessive snoring
	Sweating		Shortness of breath		Taking medication to sleep
	Fatigue		Choking sensation		Fainting or dizzy spells
	Nightmares		Rapid heart beat		Unexplained weight loss
	Constant pain		Muscle tension		Unexplained weight gain
	Nausea		Difficulty urinating		Changes in hearing or vision
	Diarrhea		Restless legs		Numbness in extremities
	Blackouts		Stomach problems		Other:
	Headaches		Swollen ankles		
	Chest pain		Tics/Twitches		

Are you currently being seen or receiving any type of treatment for any physical problems? (If yes, please explain):

____
____
____

III. Medical

Medication

Please list any medications you are currently taking or have taken within the last year (include aspirin, laxatives, birth control pills, and alternative or herbal medicines)

Medication	Dosage	For what condition?

Medical History

Please describe your lifelong history of medical problems, conditions, diagnoses, treatments, hospitalizations, injuries, etc.

____
____
____
____

Allergies

Are you allergic to any medications? YES NO

Are you allergic to any foods? YES NO

If YES to either of the above, please give details.

Substance:	Response:
Substance:	Response:
Substance:	Response:
Substance:	Response:

Are you seeing a physician on a regular basis to deal with a medical problem? YES NO If yes what condition?
Do you experience physical pain on a regular basis? YES NO
If yes, what is the usual level of that pain? 0 1 2 3 4 5 6 7 8 9 10 (0 = No pain) (10 = Extreme pain)
When was your last physical?
Are you satisfied with your current level of sexual functioning? YES NO
Do you desire to learn more about safe sexual practices? YES NO
FEMALES ONLY: Are you pregnant? YES NO Possibly pregnant? YES NO
Last Menstrual period:

IV. History

Mental Health History

Please check any of the following that apply to you at **any time in your life**

	Had an emergency room evaluation for emotional or behavioral issues		Had a substance abuse evaluation or treatment
	Had a evaluation or treatment at an inpatient Mental Health hospital		Saw a religious leader for counseling
	Saw a school counselor for counseling		Saw a psychiatrist, psychologist, social worker, or counselor for assessment or treatment (on or off base)
	Saw a physician for a mental health problem		Was given medication for a mental health problem

Family Medical History

Please check the medical conditions or treatments that apply to any members of your family. Please enter the appropriate letter(s) to indicate which family member after the condition (M=Mother, F=Father, S=Sister, B=Brother, A=Aunt, U=Uncle, GP=Grandparents).

	Heart disease or condition		Anemia		AIDS or HIV positive
	High blood pressure		Headaches		Huntington's disease
	Stroke		Ulcers		Seizures
	Diabetes		Pancreatitis		Cancer
	Tuberculosis (TB)		Cirrhosis		Arthritis
	Thyroid Disease		Hepatitis		Other:

Family Mental Health History

Please check the mental health conditions or treatments that apply to any members of your family. Please enter the appropriate letter(s) to indicate which family member after the condition (M=Mother, F=Father, S=Sister, B=Brother, A=Aunt, U=Uncle, GP=Grandparents).

	Learning Disability		Attention Deficit Hyperactivity Disorder or Attention Deficit Disorder
	Psychosis (such as schizophrenia)		Bipolar Disorder or Manic Depressive Illness
	Alcohol or Drug Abuse		Anxiety Disorder (such as panic disorder, phobia, or very excessive worry)
	Mental Retardation		Hospitalized for Mental Health Problem
	Depression		Other:

Family Background:

Where did you grow up? ____

Who was your parent figure? ____

Where is your "parent figure" now and what is your relationship? ____

____

Who did you grow up with? ____

Are you having family problems? ____

Please check any of the following events that applied to you as a child, adolescent, or adult:

	Abusive Relationship		Rape		Happy Childhood
	Experienced physical abuse		Miscarriage		Unhappy Childhood
	Experienced emotional abuse		Abortion		Death of parent
	Experienced sexual abuse		Crime victim		Death of someone close
	Witnessed physical abuse		War		Filed for bankruptcy
	Witnessed emotional abuse		Poverty		Natural disaster
	Witnessed sexual abuse				

<u>V. Occupation</u>

Occupation: ____

Describe your duties at work: ____

What is your current experience with your job? (like/dislike? Difficulties/trouble? with coworkers? positive experiences?)

____

____

How has your current problem/concern affected your work? ____

____

Briefly describe your work history: ____

Do you travel due to work related duties? Y N

If so, how often / how long?____

What will you be doing? ____

Do you have any concerns about your work related travel? Y N

____

Will you relocate in the next year? Y N If yes, when ____

Are you planning to separate from your current employer? Y N

If yes, when and why?_______________ ____

<u>VI. Current Living Situation</u>

Briefly describe your current living situation (e.g., with whom you currently live)

____

Are you currently having any problems at home? (If yes, describe)

____

Are your relationships physically and emotionally safe?

____

VII. Legal/Financial

Are you currently experiencing any legal difficulties? Yes No
If yes, please explain: ____

Is your current concern related to legal difficulties? Yes No

Are you currently experiencing any financial difficulties? Yes No
If yes, please explain: ____

Is your current concern related to financial difficulties? Yes No

VIII. Learning/Education

Is English your primary language? YES NO If no, please explain:			
Do you have any difficulty reading and writing? YES NO If yes, please explain:			
Are you motivated to learn new skills/techniques to deal with your problems? YES NO			
Check any of the following that apply to how you learn best:			
	Listening to others speak		Watching someone else do something
	Reading on my own		Watching someone else then doing it myself
	Talking to my peers		

Please check any of the following that applied to you during your education (grade school, high school, and/or college)

	Low grades		Being involved in activities		Skipping a grade
	High grades		Being held back a grade		Few friends
	Truancy		Being suspended or expelled		Many friends

IX. Coping

Who do you talk to about your problems?______________________________
What do you do when you're sad? ______________________________
What do you do when you're angry? ______________________________
What do you do when you're afraid/worried?______________________________
How do you spend your free time?______________________________

What activities are fun for you?______________________________

Are you doing them?______________________________

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X. Religion/Spirituality

When you make decisions in your everyday life, how often do you ask a higher power for help with the decisions?
1. never 2. seldom 3. sometimes 4. often 5. very often

To what extent is the direction of your life influenced by some religious goal or purpose?
1. not at all 2. to a small extent 3. to a moderate extent
4. to a large extent 5. to a very large extent

How often have you attended religious worship services during the last year?
1. never 2. a few times a year 3. once or twice a month 4. weekly 5. more than once a week

How would you describe the nature of your relationship to a higher power?
1. no relationship 2. distant relationship 3. intermediate relationship
4. close relationship 5. very close relationship

What religion to you practice? ______________________________

XI. Substance Use

Tobacco/Caffeine:

Do you use tobacco products? Yes No If yes, what kind? ______________________
How much (e.g., packs per day)? ______________________

Do you use caffeinated products (e.g., coffee, tea, soda, tablets, energy drinks)? Yes No
If yes, what kind? ______________________

How much (e.g., servings per day)? ______________________

Drugs/Addictive Behaviors:

Have you overused/overdone any prescription or over-the-counter drug or behavior?
Have you used any illegal drugs now or in the past?
Have you ever taken drugs by IV?
Have you ever been in treatment for drug or addictive use/behavior?

If yes, list year, type, frequency, and reason:

____

Alcohol:

Do you drink alcohol now or have you in the past?
How many days out of the **month** do you drink?
How much do you usually drink when you do drink? Wine ______ Beer _______ Hard alcohol ______
How often do you drink to get drunk or to get away from stressors per **month**? ________________
Has your alcohol use increased in the past month?
Have you had problems in your relationships with friends or family due to alcohol use?
Have you had problems at work or at home due to alcohol use?
Have you blacked out in the past from drinking alcohol?
Have you ever been in treatment for use of alcohol?
Have you had trouble with the law due to alcohol use?
Do you drive after drinking alcohol?

Marijuana:

Do you use now or have you in the past?
First Use - Last Use -
How many days out of the **month** do you use?
How Often do you usually use when you do use? Daily ______ Week _______ Month ______
How much do you use when you use?
Has your Marijuana use increased in the past month?
Have you had problems in your relationships with friends or family due to Marijuana use?
Have you had problems at work or at home due to Marijuana use?
Have you ever been in treatment for Marijuana use?
Have you had trouble with the law due to Marijuana use?

Amphetamines:

Do you use now or have you in the past?
First Use - Last Use -
How many days out of the **month** do you use?
How Often do you usually use when you do use? Daily ______ Week _______ Month ______
How much do you use when you use?
Has your Amphetamine use increased in the past month?
Have you had problems in your relationships with friends or family due to Amphetamine use?
Have you had problems at work or at home due to Amphetamines use?
Have you ever been in treatment for Amphetamine use?
Have you had trouble with the law due to Amphetamine use?

Benzodiazepines:

Do you use now or have you in the past?
First Use - Last Use -
How many days out of the **month** do you use?
How Often do you usually use when you do use? Daily ______ Week _______ Month ______
How much do you use when you use? _________________
Has your Benzodiazepine alcohol use increased in the past month?
Have you had problems in your relationships with friends or family due to Benzodiazepine use?
Have you had problems at work or at home due to Benzodiazepine use?
Have you ever been in treatment for Benzodiazepine use?
Have you had trouble with the law due to Benzodiazepine use?

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Opiates:

Do you use now or have you in the past?
First Use - Last Use -
How many days out of the **month** do you use?
How Often do you usually use when you do use? Daily ______ Week _______ Month ______
How much do you use when you use?
Has your Opiate use increased in the past month?
Have you had problems in your relationships with friends or family due to Opiate use?
Have you had problems at work or at home due to Opiate use?
Have you ever been in treatment for Opiate use?
Have you had trouble with the law due to Opiate use?

Methamphetamines:

Do you use now or have you in the past?
First Use - Last Use -
How many days out of the **month** do you use?
How Often do you usually use when you do use? Daily ______ Week _______ Month ______
How much do you use when you use?
Has your Methamphetamine use increased in the past month?
Have you had problems in your relationships with friends or family due to Methamphetamine use?
Have you had problems at work or at home due to Methamphetamine use?
Have you ever been in treatment for Methamphetamine use?
Have you had trouble with the law due to Methamphetamine use?

Ecstasy:

Do you use now or have you in the past?
First Use - Last Use -
How many days out of the **month** do you use?
How Often do you usually use when you do use? Daily ______ Week _______ Month ______
How much do you use when you use?
Has your Ecstasy use increased in the past month?
Have you had problems in your relationships with friends or family due to Ecstasy use?
Have you had problems at work or at home due to Ecstasy use?
Have you ever been in treatment for Ecstasy use?
Have you had trouble with the law due to Ecstasy use?

Suboxone:

Do you use now or have you in the past?
First Use - Last Use -
How many days out of the **month** do you use?
How Often do you usually use when you do use? Daily ______ Week _______ Month ______
How much do you use when you use?
Has your Suboxone use increased in the past month?
Have you had problems in your relationships with friends or family due to Suboxone use?
Have you had problems at work or at home due to Suboxone use?
Have you ever been in treatment for Suboxone use?
Have you had trouble with the law due to Suboxone use?

Synthetic Drugs, Please List:____________________________

Do you use now or have you in the past?
First Use - Last Use -
How many days out of the **month** do you use?
How Often do you usually use when you do use? Daily ______ Week _______ Month ______
How much do you use when you use?
Has your Synthetic drug use increased in the past month?
Have you had problems in your relationships with friends or family due to this use?
Have you had problems at work or at home due to this use?
Have you ever been in treatment for Synthetic drug use?
Have you had trouble with the law due to this use?

Other Drugs, Please List:____________________________

Do you use now or have you in the past?
First Use - Last Use -
How many days out of the **month** do you use?
How Often do you usually use when you do use? Daily ______ Week _______ Month ______
How much do you use when you use?
Has your use increased in the past month?
Have you had problems in your relationships with friends or family due to this use?
Have you had problems at work or at home due to this use?
Have you ever been in treatment for drug use?
Have you had trouble with the law due to this use?

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XII. Nutrition

How many meals do you eat per day?		
Have you had any of the following eating difficulties: problem chewing or swallowing, loss of appetite for greater than 5 days, taste changes, getting filled up quickly?	YES	NO
Do you have trouble eating a well-balanced diet including foods from all four food groups?	YES	NO
Are you on a special diet? If yes, please state type:___________________________________	YES	NO
Are you dependent on nutritional support?	YES	NO
Do you have dietary or food limiting practices?	YES	NO
Do you use dietary supplements excessively?	YES	NO
Do you want to learn more about proper nutrition?	YES	NO
Do you have a need for general nutritional education?	YES	NO
Do you have inadequate financial resources for food?	YES	NO
Do you have poor nutritional intake/involuntary weight loss?	YES	NO
Are you a Vegan or do you have a restriction of all animal origin products?	YES	NO

Are you now or have you ever been on the weight management program? YES NO

Is weight a concern for you? YES NO

If so, how are you dealing with the problem?

Weight: Height:

Do you exercise? YES NO

Type/Frequency/Duration?

How do you describe your weekly activity level and fitness?

Poor Marginal Good Excellent

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XIII. GOALS FOR TREATMENT

What do you want to change about yourself?

1. ____

____

2. ____

____

3. ____

____

Specific Goals

In coming to this center, I would like to concentrate on……(check any that apply).

Note the 3 most important goals with **1, 2, & 3**.

	Feeling less depressed		Improving family relationship
	Feeling less anxious/fearful		Improving marital relationship
	Feeling less angry		Improving work relationship
	Better managing my temper		Improving communication skills
	Feeling more self-confident		Improving relationship with….(complete the goal)
	Feeling less guilt		Improving my sexual relationship
	Better managing my health or pain		Reducing my sensitivity to criticism
	Doubting myself less		Controlling my eating or weight
	Better tolerating my mistakes		Learning how I come across to others
	Having more fun		Receiving medication help
	Better accepting a loss/death		Adjusting better to a recent change
	Talking out a pending decision		Discussing thoughts of harming self
	Discussing desire for separation/discharge		Allowing myself to express feelings more
	Learning how to relax		Not taking disappointments so hard
	Thinking more positively		Learning problem-solving techniques
	Not reacting so emotionally		Learning how to improve friendships
	Improving my sleep		Adjusting better to a past incident
	Worrying less about….. (complete the goal)		Discussing thoughts of harming others
	Better tolerating my mistakes		Controlling my use of alcohol or drugs
	Expressing myself more assertively		

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