New Patient Self-Evaluation

Name: _____ DOB: _____ Date Completed: _____

A. REASON FOR SEEKING TREATMENT (list current diagnoses, problems or symptoms):

_____

_____

_____

_____

_____

_____

CURRENT LIFE STRESSORS

In the past 6 months, have there been problems with (check all that apply):

- ☐ Marital Conflicts
- ☐ Medical illness or problems
- ☐ Chronic Pain
- ☐ Recent move
- ☐ Serious problems in school
- ☐ Parent/Child conflicts
- ☐ Recent death
- ☐ Sexual/physical assault
- ☐ Legal problems
- ☐ Financial problems
- ☐ Personal use or abuse of Drugs/alcohol
- ☐ Drug/alcohol use or abuse by family member
- ☐ Conflicts at work

Are there any other important events currently affecting you? ☐ Yes ☐ No List: _____

_____

_____

_____

Have you ever attempted suicide? ☐ Yes ☐ No When? _____

How? _____

B. HISTORY OF TREATMENT FOR MENTAL HEALTH PROBLEMS

Psychiatric Hospitalizations _____

_____

_____

Substance Abuse Treatment _____

_____

_____

Counseling/Therapy (How long? With whom? What are you working on? Is it helpful?)_____

_____

_____

Psychiatric Medications _____

_____

Medication	Dose	Length of time taken	Response	Side Effects

Name: _____

C. CHILDHOOD HISTORY

General description and significant events

_____

_____

_____

_____

_____

_____

When you were growing up, where your parents: ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed

Number of Siblings (including yourself) _____ Occupation of Father _____

Your place in birth order _____ Occupation of Mother _____

Age Range of Siblings (including yourself) _____

Other comments: _____

_____

Were you ever abused:		When?	By Whom?
Emotionally?	☐ Yes ☐ No		
Physically?	☐ Yes ☐ No		
Sexually?	☐ Yes ☐ No		

D. RELATIONSHIP HISTORY

Marriage #	Date Married	Date Divorced	Current Ages of Children	Reasons for Divorce (if applies)
1				
2				
3				

If never married, what has been the duration of your longest intimate relationship? _____

Did you live together? ☐ Yes ☐ No

Are any of the children living in your home from a previous relationship?

☐ Yes ☐ No ☐ N/A If yes, are they your ☐ Children ☐ Stepchildren ☐ Both

Do you have a close confiding relationship with your spouse/partner? ☐ Yes ☐ No ☐ N/A

Do you have a close confiding relationship with someone else?

☐ Yes ☐ No If yes, with whom? _____

Other comments: _____

_____

_____

E. LIFESTYLE and OTHER:

1. Education or Last Grade Completed: _____
2. Military History: _____
3. Employment: _____

_____

4. Legal History or Current Legal Issues: _____

_____

Name: _____

F. SUBSTANCE ABUSE or ADDICTIVE BEHAVIOR

Have you ever smoked? ☐ Yes ☐ No ☐ I smoke currently

If yes, how long? _____, Packs per Day _____ Did you quit? _____ When? _____

Do you use street drugs, alcohol or non-prescription substances for recreation or other purposes? ☐ Yes ☐ No

If yes, how often do you take this drug/drink alcohol? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other_____

Do you have a drug of choice? List: _____ ☐ Yes ☐ No

Have you ever felt that you should cut down on your drinking/drug use? ☐ Yes ☐ No

Have people annoyed you by criticizing your drinking/drug use? ☐ Yes ☐ No

Have you ever felt bad or guilty about your drinking/drug use? ☐ Yes ☐ No

Have you ever taken a drink/drug first thing in the morning to steady your nerves? or to get rid of a hangover? ☐ Yes ☐ No

Have you tried to quit using? ☐ Yes ☐ No

Have you successfully quit using drugs/alcohol? ☐ Yes ☐ No

If yes, how long have you been sober? _____

G. CURRENT SYMPTOMS

1. Have you ever had a period of <u>one month or more</u> when most of the time you felt <u>worried and anxious?</u> ☐ Yes ☐ No
2. In your lifetime, have you ever had <u>two weeks or more</u> when nearly every day you felt <u>sad, blue or depressed?</u> ☐ Yes ☐ No
3. Has there ever been <u>two weeks or longer</u> when you <u>lost interest in most things,</u> like work, hobbies, or things you usually liked to do for fun? ☐ Yes ☐ No
4. Have you ever had <u>two years or more</u> in your life when you felt <u>depressed or sad most days</u>, even if you felt okay sometimes? ☐ Yes ☐ No
5. Has there ever been a period of <u>at least two day</u> when you were so <u>happy or excited</u> that you got into trouble, or your family or friends worried about you, or a doctor said you were manic? ☐ Yes ☐ No
6. Has there ever been a period of <u>several days</u> when you <u>were so irritable</u> that you threw things or broke things, started arguments, shouted at people or hit someone? ☐ Yes ☐ No
7. Have you ever had a spell or attack when all of a sudden you felt <u>frightened, anxious or very uneasy</u> in situations when most people would not be afraid or anxious? ☐ Yes ☐ No
8. Some people have such an <u>unreasonably strong fear</u> of being in a crowd, leaving home alone, traveling on buses, cars or trains, or crossing a bridge that they always get very upset in such a situation or <u>avoid it altogether</u>. Did you ever go through a period when being in any of these (or other similar) situations <u>always</u> frightened you? ☐ Yes ☐ No
9. Is there anything you are <u>afraid</u> to do or feel <u>uncomfortable doing in front of other people</u>, like speaking, eating, writing or using public bathrooms? ☐ Yes ☐ No
10. Are there any other <u>things you are especially afraid of</u>, such as flying, heights, seeing blood, closed places, or certain kinds of animals or insects? ☐ Yes ☐ No
11. Have you ever been bothered by <u>thoughts that didn't make any sense</u>, and kept coming back to you even when you tried not to have them? ☐ Yes ☐ No
12. Was there ever <u>anything you had to do over and over again</u> and couldn't resist doing, like washing your hands again and again, counting up to a certain number, or checking something several times to make sure that you had done it right? ☐ Yes ☐ No
13. Have you ever been preoccupied with dieting or weight, been significantly below average for your height, or used vomiting or laxatives for weight control? ☐ Yes ☐ No
14. How often do you diet? ☐ never ☐ rarely ☐ sometimes ☐ often ☐ always