Counseling Associates of Lake Mary

Yearly Psychiatric Evaluation

Date: _____/_____/_____

Patient's Name: ____

DOB: _____/_____/_____

Age: __________________

Allergies to any medication: ______None or: ____

____

Reason for being seen: ____

____

____

Any Psychiatric Hospitalizations? ______Yes ______No

If yes, how many? ___________

Place and reason for hospitalization? ____

____

____

____

Any Psychiatric Counseling in the past? ______Yes ______No

If yes, with whom? ____

List some of the Psychiatric Medications you were on in the past: ______None or: _________

____

____

List all current Non-Psychiatric Medications: ______None or: _____________________

____

____

List all major surgeries: ______None or: ___________________________________

____

Primary Doctor's name: ____

Social History: Are you (circle 1): single / married / divorced / separated / widowed_

Where were you born? ____

Did you finish High School? ______Yes ______No ______GED

Did you attend College or University? ______Yes ______No

If yes, where? ____

Do you have any children? ______Yes ______No

If yes, how many? ____________

Are your parents still living? ______Yes ______No

If yes, where? ____

Do you have any siblings living? ______Yes ______No

If yes, how many brothers ______, sisters ______, step-brothers ______,

step-sisters ______, half-brothers ______, & half-sisters ______

What is your employment? ____

Do you smoke? ______Yes ______No

If yes, how many per day? ____________

Do you drink alcoholic beverages? ______Yes ______No

If yes, how much per week? ____________

Do you exercise regularly? ______Yes ______No

If yes, what type of exercises? ____

Any current legal problems? ______Yes ______No

If yes, please explain: ____

Any Physical/Emotional/Verbal/Sexual Abuse or Domestic Violence? ______Yes ______No

If yes, please explain: ____

____

Anyone in your family with any Psychiatric diagnosed Disorder? ______Yes ______No

If yes, please explain: ____

____

List one **positive** characteristic about yourself: ____

List one **negative** characteristic about yourself: ____

Clinician's Initials ____________