LYNNE MOSER, LCSW

LICENSED CLINICAL SOCIAL WORKER

917.605.1006

## Initial Evaluation/Client Demographics

Date:_____

Client'sName:_____
Address: _____
Phone (Home):_____ Phone (Work): _____
Date of Birth: _____ Social Security #: _____
Guardianship (for children and adults when applicable): _____

**Marital Status:** (check one)

[] Never Married [] Divorced
[] Married [] Separated
[] Widowed [] Cohabiting

Race (optional)

[] White [] Native American
[] African-American [] Asian
[] Hispanic [] Other

**Gender**: [] Male [] Female
Age: _____

**Family Members**:

| Name | Age | Sex | Relationship |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Employer**: _____ **Occupation**: _____
Highest Level of Education: _____
Name of School (for children, and adults when applicable):_____

**Referral Source**: _____

**Insurance Information**:
Insurance Company/HMO: _____ Phone: _____
Member ID# _____ Managed Care Company_____
Claims Address: _____
Phone: _____

THE ATRIUM, 4 TERRY DRIVE, SUITE 11, NEWTOWN, PENNSYLVANIA 18940

**Emergency Information:**
Name of Emergency Contact: _____ Phone: _____
Relationship to Patient: _____

**Presenting Problem:** (include onset, duration, and intensity)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

**Precipitating Event:** (Why are you starting treatment now?)

_____
_____
_____
_____

**Medical History:**
Allergies: (adverse reactions to medications/food, etc.)

_____

PCP Name and Tel. Number: _____
Date of Last Physical Exam: _____
Exam Findings: _____

**Relevant medical conditions:**

_____
_____

Current medications: (Include prescribed dosages and name of prescribing doctor)

_____
_____

Hospitalizations/Surgeries: (include dates, complications, adverse reactions to anesthesia, outcomes, etc.):

_____
_____

Past Psychiatric History: (Mental Health/Chemical Dependency)

Hospitalizations: _____

_____

Prior Outpatient Therapy:

Previous practitioners and dates of treatment: _____

_____

_____

Previous treatment interventions: _____

_____

_____

Response to treatment interventions including medication:

_____

_____

Results of recent lab tests and/or consultation reports:

_____

_____

Family History of Mental Health or Chemical Dependency:

_____

_____

_____

**Psychosocial Information:**

Support Systems: _____

School/Work Life: _____

Marital History: _____

Legal History: _____

Military History: _____

Spiritual Beliefs: _____

**Substance Abuse History:** (clients age 12 and over)

| Substance | Amount | Frequency | First Use | Last Use |
|---|---|---|---|---|
| Caffeine | | | | |
| Nicotine/Tobacco | | | | |
| Alcohol | | | | |

Marijuana

Opioids/Narcotics

Amphetamines

Cocaine

Hallucinogens

Other

**For Children and Adolescents *Only*:**

Developmental History (developmental milestones met early, late, normal):

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Perinatal History (details of labor/delivery):

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Prenatal History (medical problems during pregnancy, mother's use of medications):

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