Pre-Evaluation Client History

NAME:	
DATE:	**THERAPIST:**

IDENTIFYING DATA

Birthdate:	Age: Sex: M F	Education:
Race:	Marital Status:	Language Barrier?
Referral Source:		

PRESENTING PROBLEM: Using your own words, what is your current problem/reason for seeking an evaluation?

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_____

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HISTORY OF PRESENTING PROBLEM: Please check the symptoms that you are currently experiencing or have experienced in the PAST TWO WEEKS.

☐ Mostly depressed mood	☐ Elevated mood	☐ Excessive worry	☐ Feeling of unreality or of being detached from self
☐ Little interest in activities	☐ Grandiosity	☐ Trouble controlling worries	☐ Fear of losing control
☐ Change in appetite	☐ Decreased need for sleep	☐ Feeling restless and on-edge	☐ Thoughts of going crazy
☐ Change in sleep	☐ More talkative	☐ Easily fatigued	☐ Chill or hot flashes
☐ Restless	☐ Racing thoughts	☐ Blank mind	☐ Suicidal thoughts
☐ Sluggish	☐ Easily Distracted	☐ Irritability	☐ Homicidal thoughts
☐ Fatigue	☐ Increase in goal-directed activity	☐ Muscle tension	
☐ Feeling worthless	☐ Risky but pleasant activities	☐ Sleep disturbance or nightmares	
☐ Unable to concentrate	☐ Delusions	☐ Pounding heart	
☐ Eating too much	☐ Hallucinations	☐ Sweating	
☐ Eating too little	☐ Numbness or tingling	☐ Shortness of breath	
☐ Sleep too much	☐ Disorganized speech	☐ Shaking	
☐ Sleep too little		☐ Feeling of choking	
☐ Low energy		☐ Chest pain	
☐ Low self-esteem		☐ Nausea or stomach pain	
☐ Feeling hopeless		☐ Dizzy, lightheaded	

STRESSORS & SYMPTOMS: Please provide a summary of current stressors and symptoms that prompted the evaluation.

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_____

_____

_____

NAME:	DOB:

PSYCHIATRIC HISTORY

Hospitalizations: ☐ Yes ☐ No	Number:	Hospitals & Dates: First:
Others:		
Previous therapy or counseling? ☐ Yes ☐ No If yes, where? Therapist/counselor name: Was treatment helpful? ☐ Yes ☐ No If no, why not?		
Current Psychiatric Medications:		
Psychiatric Medications Previously Used:		
Family History of Mental Illness:		

RISK ASSESSMENT

Suicide:	thoughts	impulses	plans	
Violence / Homicide:	thoughts	impulses	plans	
Comments:				

CLIENT'S STRENGTHS/LIMITATIONS: Please provide a list of personal strengths and limitations.

_____

_____

_____

_____

CLIENT'S GOALS & DESIRES: Please provide a few personal goals and desires for the future.

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_____

_____

_____

NAME:	CASE NO:

SUBSTANCE USE HISTORY

A=Currently Using B=History of Use	Alcohol	Marijuana	Cocaine	Heroin	Rx Drugs	Other:
Order of Preference						
Age at First use						
Amount Used						
Frequency of Use						
Oral, **S**nort, **I**nject, S**m**oke						
Longest Abstinence						
Last Usage						
*Adverse Reactions						

* 1=black outs 2=withdrawal 3=overdose 4=paranoia 5=chest pain 6=symptoms

Ever worried about drinking or drug habit? ☐ Yes ☐ No If yes, why?

Relationship between alcohol/drug use and criminal history:

IMPACT	
Family:	
Health:	
Legal:	
Social:	
Work:	

Treatment (current):

Treatment (past):

NAME:	CASE NO:

MEDICAL INFORMATION

Check all of the following that apply:

Current	History		Medications	Current	History		Medications
		Anemia				High Blood Pressure	
		Head Injury				Hepatitis	
		Cancer				Thyroid Problem	
		Diabetes				Kidney Problem	
		Stomach Ulcers				AIDS	
		Seizures				Tuberculosis	
		Cardiac Problems				Other:	
		Pregnancy				Pre/Post Natal Care	

Height:	Weight:	Recent significant weight change?
Name of Physician:		Last Gynecological exam (month/year):
Most Recent Contact with Physician (month/year):		
Current Physical Medications:		
Allergies/Adverse Reaction to Medications:		
History of Medical Hospitalizations/Surgery:		
Current Medical Problems:		

CHILDHOOD & DEVELOPMENT

Problems in Early Development? If yes, explain:
Place of Birth, Parents/Siblings Names & Ages:
Ethnic and Religious Background:
Problems in School? If yes, explain:
History of childhood abuse or recent abuse? If yes, explain:
Relationship and Marital Situation:
Children:

NAME:	CASE NO:

CURRENT LIFE INFORMATION

Activities of Daily Living:
Living Arrangements:
Social/Emotional Status:
Social Relationships/Support:
Formal or Informal Group/Organization/Club participation:
Current Employment Status:

LEGAL & CRIMINAL HISTORY

Legal Status: Current charges ☐ Yes ☐ No If yes, list:
Number of Arrests/Convictions:
Number and length of jail/prison sentences served:
Probation/Parole Violations:
Values and attitudes supportive of crime? ☐ Yes ☐ No
History of unfavorable attitude toward conventional norms & values? ☐ Yes ☐ No

_____
Client Printed Name

_____ _____
Client Signature Date Completed

FOR OFFICE USE ONLY

_____ _____
Date Received Therapist Signature/Credentials