Initial Evaluation Template

Demographic Information

(Please complete all questions on this form)

Date:_____

Name:_____

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: _____

School (for children, and adults when applicable): _____

Referral Source: _____

Insurance Information:

Insurance Company/HMO: _____Phone: _____

Member ID# _____ Managed Care Company_____

Claims Address: _____Phone: _____

Emergency Information:

Name of Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

Advance Directives:

I have an Advanced Directive/Instruction for Mental Health Treatment. ____YES ____ NO

Initial Evaluation Template

Patient's Name/ID#: _____

Previous Medical History:
Allergies (adverse reactions to medications/food/etc.): _____

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

Any relevant medical conditions (diabetes, hypertension, head traumas, cardiac problems, asthma or other breathing problems, cancer, etc.): _____

_____

Current medications (Include prescribed dosages, dates of initial prescription and refills, and name of doctor prescribing medication):

_____

_____

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

_____

Past Psychiatric History (Mental Health and Chemical Dependency):
Hospitalizations: _____

_____

Prior Outpatient Therapy

Previous practitioners and dates of treatment: _____

_____

_____

Previous treatment interventions: _____

_____

_____

Response to treatment interventions including medications: _____

_____

_____

Results of recent laboratory tests and consultation reports:

_____

_____

Family Mental Health or Chemical Dependency History: _____

_____

_____

Initial Evaluation Template

Patient's Name/ID#: _____

Psychosocial Information:

Support Systems: _____
School/Work Life: _____
Marital History: _____
Legal History: _____
Military History: _____
Spiritual Beliefs: _____

Risk Assessment

Ideations	None Noted	Thoughts Only	Plan (describe)	Intent (describe)	Means (describe)	Attempt (describe)	Able to Contract for Safety
Suicidal Ideation							
Homicidal Ideation							

***If significant risk was found (checklist) :**

___Assessed for diminishing access to weapons/lethal means
___Developed a plan for maintaining sobriety and discussing the role of substance (if applicable)
___Involved family/other support system members in suicide management plans
___Documented actual family/support system involvement

Assessment of Risk Factors (check all that apply):

_____ Non-compliance with treatment
_____ AMA/elopement potential
_____ Prior behavioral health inpatient admissions
_____ History of multiple behavioral diagnosis
_____ Suicidal/Homicidal ideation
_____ Debilitating illness/Advanced age/Gender in seniors
_____ Gender identity disorder in teens
_____ History of violence
_____ Insomnia
_____ Substance abuse
_____ Anxiety
_____ Other (describe)

Substance Abuse History (*complete for all patients age 12 and over*)

Substance	Amount	Frequency	Duration	First Use	Last Use
Caffeine					
Nicotine/Tobacco					
Alcohol					
Marijuana					
Opioids/ Narcotics					
Amphetamines					
Cocaine					
Hallucinogens					
Others:					

Drew Alikakos, M.S.

DATE: _____ CLIENT: _____

Are you seeing a medical Doctor? Yes _____ No_____

MEDICAL ISSUES

Height: _____ Weight: _____ Recent Weight Changes: _____

Health Issues:_____

New Health Issues: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Side Effects of Medication: _____

CIRCLE ALL THAT APPLY:

Drug abuse Alcohol abuse DUI Obsessive spending Gambling
Loss of appetite Demisted sex drive Increased sleep Irritability Decreased sleep
Increased sex drive Hallucinations Hearing voices Horrible thoughts
Obsessing Nightmares Molested Physically Abused

FAMILY HISTORY
CIRCLE ALL THAT APPLY:
In 1st. cousins, siblings, parents, grandparents

Alcoholism Depression Bipolar Disorder Schizophrenia Suicides

Drew Alikakos, M.S.
Licensed Psychologist

811 West Chester Pike
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Date: _____ **Name:** _____

bad good

Depression on a scale of 1----------10, please circle

1 2 3 4 5 6 7 8 9 10

hopeless level elated

Sleep, circle best that apply

Early morning awakenings Not sleeping N/A

Mood Swings, circle best that apply

None middle down top to bottom

Medication compliance, circle yes no

Side effects: write in _____

Anger, circle yes no **Hallucinations,** circle yes no

Substance Abuse, circle yes no not sure

Racing Thoughts, circle yes no **Suicidal Thoughts,** circle yes no

Obsessing, please circle

Illnesses hurting self hurting others revisiting conversations revisiting situations
hoarding things making list horrible thoughts rereading rewriting
obsessing about body obsessing about hair obsessing about face
ultra moralistic perfectionism procrastination my way or the highway
no gray area panic attack tightness in chest heart racing

Progress Note: _____

DEPRESSION SCALE

Name _____ Date _____

INSTRUCTIONS
This questionnaire includes questions about symptoms of depression. For each item please indicate how well it describes you during the PAST WEEK, INCLUDING TODAY. Circle the number in the columns next to the item that best describes you.

RATING GUIDELINES
0=not at all true (0 days)
1=rarely true (1-2 days)
2=sometimes true (3-4 days)
3=often true (5-6 days)
4=almost always true (every day)

During the PAST WEEK, INCLUDING TODAY....

1	I felt sad or depressed	0	1	2	3	4
2	I was not as interested in my usual activities	0	1	2	3	4
3	My appetite was poor and I didn't feel like eating	0	1	2	3	4
4	My appetite was much greater than usual	0	1	2	3	4
5.	I had difficulty sleeping	0	1	2	3	4
6.	I was sleeping too much	0	1	2	3	4
7.	I felt very fidgety, making it difficult to sit still	0	1	2	3	4
8.	I felt physically slowed down, like my body was stuck in mud	0	1	2	3	4
9.	My energy level was low	0	1	2	3	4
10.	I felt guilty	0	1	2	3	4
11.	I thought I was a failure	0	1	2	3	4
12.	I had problems concentrating	0	1	2	3	4
13	I had more difficulties making decisions than usual	0	1	2	3	4
14.	I wished I was dead	0	1	2	3	4
15.	I thought about killing myself	0	1	2	3	4
16.	I thought that the future looked hopeless	0	1	2	3	4

17. Overall, how much have symptoms of depression interfered with or caused difficulties in your life during the past week?
    0) not at all
    1) a little bit
    2) a moderate amount
    3) quite a bit
    4) extremely

18. How would you rate your overall quality of life during the past week?
    0) very good, my life could hardly be better
    1) pretty good, most things are going well
    2) the good and bad parts are about equal
    3) pretty bad, most things are going poorly
    4) very bad, my life could hardly be worse

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