ADULT EVALUATION QUESTIONAIRE

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Today's Date _____ **Drug Allergies** _____

Name, Address and Phone number of Pharmacy _____

NAME: _____
Last **First** **Middle**

Address: _____
Street **City** **State** **Zip**

Home Phone _____ **Cell Phone** _____

Age _____ **Date of Birth** _____

Marital Status _____ **Height** _____ **Weight** _____

Occupation: _____ **Email Address:** _____

Company/School/Education _____

Work Phone _____ **Social Security #** _____
(For Office Use only)

Wife/Husband/ Significant Other's Name _____

Age _____ **Occupation** _____

Cell Phone # _____ **Work Phone #** _____

Mother's Name _____ **Age** _____ **Occupation** _____

Cell Phone # _____ **Work Phone #** _____

Father's Name _____ **Age** _____ **Occupation** _____

Cell Phone # _____ **Work Phone #** _____

Children (Include names, ages/marital status/occupation/grandchildren) _____

_____

_____

Siblings (Include names, ages/marital status/occupation/nieces or nephews)_____

_____

_____

Please list referral source: (PLEASE DO NOT LEAVE THIS OUT.)

_____ _____

Referral Source **Phone Number of Referral Source**

EMERGENCY CONTACT

Name_____**Relationship to you**_____

Daytime Phone: _____**Cell Phone**_____

Evening Phone_____

Answer the following with respect to the symptoms that bring you here today.
IF "1" IS THE WORST YOU EVER FELT AND "10" IS THE BEST, WHERE ARE YOU TODAY?

1----------2----------3----------4----------5----------6----------7----------8----------9----------10

CHIEF COMPLAINT

Describe the reason for this visit and the symptoms that you are currently experiencing.

_____

_____

_____

_____

_____

_____

_____

HISTORY OF THE PRESENT ILLNESS

Describe when your current symptoms began and if they have changed over time.

_____

_____

_____

_____

Are you currently in psychotherapy? Yes_____ No_____

If yes, how long have you been in treatment with your current therapist?_____

If yes, what is the name and phone number of your therapist?

Name_____Phone Number_____

<u>List all Medications you are currently taking (including psychiatric, medical and over the counter)</u>:

DRUG	DOSE	START DATE	CONDITION BEING TREATED
• _____			
• _____			
• _____			
• _____			
• _____			
• _____			
• _____			
• _____			
• _____			
• _____			

What are the names and phone numbers of the physicians who are prescribing the medications?

Name_____Phone Number_____

Which Medications?_____

Name _____Phone Number _____

Which Medications?_____

Please describe if there are side effects (even if you are not sure if they are side effects):

_____

_____

_____

_____

List all past psychiatric medications and how you responded to them:

_____

_____

_____

_____

_____

_____

PAST PSYCHIATRIC HISTORY

Describe past psychiatric history and other treatments for psychiatric symptoms and dates of treatment (include what diagnoses you were told that you had in the past and/or presently have now):

_____

_____

_____

_____

_____

Have you ever been hospitalized for a psychiatric illness? If yes, list the hospitals and dates of admission and discharge.

_____

_____

FAMILY HISTORY

Is there a family history of psychiatric disorder, drug dependency and/or alcoholism? (Include parents, siblings, aunts, uncles and cousins)

PSYCHO - SOCIAL HISTORY – WORK HISTORY

Friends- Relationships – Education - Employment – Most recent Living Situation – Drug and/or Alcohol History:

DEVELOPMENTAL HISTORY

Significant events in your life since childhood other than covered in Social History:

_____

_____

_____

ANY ADDITIONAL PERSONAL HISTORY OR RELEVANT INFORMATION
You Feel Might Be Helpful:

_____

_____

_____

_____

_____

Are you currently having suicidal thoughts? No_____Yes_____

If yes, do you have a plan? No_____Yes_____

Have you ever attempted suicide? No_____Yes_____

If yes, please explain circumstances._____

_____

_____

_____

How much coffee, tea or caffeine-containing beverages do you drink a day?

_____

_____

Do you smoke? Yes_____No_____ Number of cigarettes per day: _____

Do you use recreational drugs? Yes_____No_____ If yes, which ones and how often?

_____

Do you drink? Yes_____No_____ Specify number of glasses or bottles per week. _____

Please specify where beer, hard liquor or wine._____

Do you use Motrin, Advil, Aleve, Ibuprofen or other drugs for pain or inflammations?

Yes_____No_____Which ones?_____.

MEDICAL HISTORY

Primary Care Physician_____Phone Number _____

Address_____Date of most recent Physical Exam._____

Have you ever been treated for any of the following:

	YES	*NO*	**COMMENTS (*TO BE ENTERED BY PSYCHIATRIST ONLY)**
Heart Disease			
High Blood Pressure			
Stroke			
Endocrine (including Diabetes)			
Arthritis or Other Bone Problems			
Neurological Problem/Parkinson's			
Cataracts/other eye problems			
Nose/Mouth/Throat			
Hearing Problems			
Lung/Respiratory Diseases			
Skin Diseases			
Urinary Problems			
Gastro-Intestinal			
Growths/Cancer			
Hospitalizations			
Major Operations			
Sexually Transmitted Diseases			
Kidney Disease			
Liver Disease			
Gynecologic Problems			
Muscular Problems			
Sexual Problems (incldg., STDs)			
Other Medical Problems			

Have you had?

Blackouts			
Convulsions or Seizures			
Headaches			
Tremors			
Dizziness			
Forgetfulness			
Major Weight Loss/Gain			

BRIEFLY DESCRIBE ANY CURRENT MEDICAL PROBLEMS _____

_____

Has anyone in your family been treated for?

	YES	*NO*	**COMMENTS (*TO BE ENTERED BY PSYCHIATRIST ONLY)***
Heart Disease			
High Blood Pressure			
Stroke			
Endocrine (including Diabetes)			
Arthritis or Other Bone Problems			
Neurological Problem/Parkinson's			
Cataracts/other eye problems			
Nose/Mouth/Throat			
Hearing Problems			
Lung/Respiratory Diseases			
Skin Diseases			
Urinary Problems			
Gastro-Intestinal			
Growths/Cancer			
Hospitalizations			
Major Operations			
Sexually Transmitted Diseases			
Kidney Disease			
Liver Disease			
Gynecologic Problems			
Muscular Problems			
Sexual Problems (incldg., STDs)			
Other Medical Problems			

Have you had?

Blackouts			
Convulsions or Seizures			
Headaches			
Tremors			
Dizziness			
Forgetfulness			
Major Weight Loss/Gain			

Does anyone in your family have a history of:

Drug Abuse_____

Alcohol Abuse_____

Briefly describe any current medical problems._____

_____

_____

Briefly describe any unusual childhood illnesses: (please give age)_____

_____

_____

Briefly describe any serious adult illnesses: (please give approx. age)_____

_____

_____

Briefly describe any hospitalizations or surgeries _____

_____

_____

_____

_____

For women of child bearing age, please record date of last menstrual period: _____