MARSH LANDING BEHAVIORAL GROUP

Adult Evaluation

Please complete ENTIRE form and return at least 48 hours prior to your appointment.

Name Date

Who referred you?

What are the circumstances leading you to seek treatment at this time?

When did the issues start?

How often do these issues happen?

How long do they last?

What makes them better?

What makes them worse?

What symptoms are most concerning to you?

What do you hope to accomplish during treatment?

How has your mood been lately?

Do you sleep well? (yes/no)

If not, please describe your typical sleep routine:

Bedtime:

Time to fall asleep:

TV/Phone use in bed?

Does anything cause you to wake in the night or before you would like to rise?

Estimate your total number of hours of sleep

What things do you like to do in your free time?

Any feelings of guilt or worthlessness? (y/n)

If so, about what?

How is your energy level?

How is your appetite?

What do you do to cope when you're not feeling well?

Who or what are your sources of strength and support?

Do you ever have daily worry that gets out of control? (y/n)

If so, about what?

Have you ever been the victim of abuse or suffered a major traumatic life event? (y/n)

If so, please briefly describe:

Have you ever had such a "high" or irritable mood that it caused you to do impulsive or reckless things?(y/n)

If so, please describe:

Have you ever had so much energy that you needed little or no sleep for several days or weeks straight?(y/n)

If so, please describe:

Have you ever had eating disordered behavior, such as bingeing, purging, or restricting food? (y/n)

Have you ever had excessive worry about weight or appearance?

Do you have any recurring, intrusive, unwanted thoughts? (y/n)

If so, please describe:

If so, do you ever have any behaviors or rituals that you feel compelled to complete to alleviate these thoughts? (y/n)
If so, please describe:

Do you ever have difficulty with concentration or forgetfulness so much so
that it causes you to have problems at work, school, or home? (y/n)
If so, please describe each:

Do you ever hear things that other people cannot hear? Or see things other people cannot see? (y/n)

If so, please describe:

Do you have any fears or special beliefs that most people would consider strange? (y/n)

If so, please describe:

Do you ever drink alcohol? (y/n)

If so, how often?

If so, how many drinks each time?

Do you ever need to drink again to keep from getting tremors or other symptoms of withdrawal?(y/n)

If so, please describe:

Describe any periods where you had heavier alcohol use than you currently do:

Have you ever had to get treatment for alcohol or drug abuse/dependence? (y/n)

If so, please describe:

Do you use any substances (legal or not) for recreational purposes? (y/n)

If so, please describe:

Do you use any medications for reasons ***other*** than as prescribed? (y/n)

If so, please describe:

Please describe any tobacco use: (What type, how much, how often)

Please describe any caffeine intake: (What type, how much, how often)

Please describe any other substance use: (What type, how much, how often)

Please list any prior psychiatric diagnoses and the date of diagnosis:

Please list any prior psychiatric care: (What hospital/practice, dates of care, Names of Physicians/ Therapists seen)

Please list any prior suicide attempts: (Date, method, treatment required)

Please list any prior NON-suicidal self-injurious behavior: (Date, method, treatment required)

Please list any history of violence:

Please list **ALL** PRIOR psychiatric medications: (Name, dates of use, dose range, efficacy, side effects, reasons for stopping)

Please list all medical diagnoses or conditions:

Please list any surgical history:

Please describe any history of severe head injuries:

Please describe any history of seizures:

Who is your primary care physician?

If you see any Specialists, please list, incl. reason for seeing:

Please list **ALL** CURRENT medications: (Name, dose, frequency, Date started, prescribing physician, reason for taking)

Are you sexually active?

What forms of protection do you use?

What forms of contraception do you use?

For Women: When was your last menstrual cycle?

For Women: Who is your OBGYN?

For Women: When was your last exam/ PAP/ Mammogram?

For Women: How many Pregnancies? Miscarriages? Abortions? Births?

For Women: Please list any pregnancy related complications:

For Women: Please list any post-partum symptoms:

For Women: Please list any infertility treatments:

Please list any major medical illnesses in your immediate (parents/siblings) family: (Who has what?) Please list any mental health diagnoses in your immediate (parents/siblings) family: (Who has what?) Please list any learning disabilities in your immediate (parents/siblings) family: (Who has what?)

Please list any substance abuse or addiction issues in your immediate (parents/siblings) family: (Who has what?)

Please list any close family members who died by suicide: (*relation, not name)*

Please list any complications with your mother's pregnancy or delivery of you:

Were you born at full term? Or how many weeks early?

Did you meet your milestones (walking/talking/etc.) at a normal time?

Where are you from?

How would you describe your childhood?

Please list any siblings/ages

Are your parents still together?

How long have you been living in the area?

What is your living situation?

Are you in a relationship?

How long have you been together?

Please list any children/ages:

What is your highest level of education?

What schools did you attend?

What areas did you study?

Do you hold any degrees or certificates?

Please describe any educational difficulties:

What is your current occupation?

What is your occupation/work history?

Please describe any current or historical legal issues (such as DUI, arrest, or imprisonment):

Please describe any religious or faith background:

Please describe any notable diet practices:

Please describe any regular exercise: