

Initial Evaluation

** Please complete all questions on this form **

Date: _____

Demographic Information

Name: _____

Address: _____

E-Mail: _____

Phones: Home: _____ Work: _____ Cell: _____

Date of Birth: _____

Social Security #: _____

Age: _____

Gender: Male Female

Marital Status: Never Married Divorced
 Married Separated
 Widow Cohabiting

Race (optional): White Native American
 Asian African American
 Hispanic Other

Number of Years Married: _____

Family Members (including parents, siblings or close relatives):

Name	Age	Gender	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Employment

Employer: _____ Occupation: _____

School (when applicable): _____

Referral Source or How You Located Me: _____

Emergency Information

Primary Care Physician: _____ Phone: _____

Fax: _____

Psychiatrist: _____ Phone: _____

Fax: _____

Emergency Contact Name: _____ Phone: _____

Relationship to Patient: _____

Medical History

Allergies (adverse reactions to medications/food/etc.) _____

Date of Last Physical Exam: _____

Findings from Exam: _____

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

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

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

Mental Health and Chemical Dependency History

In-patient Hospitalization/s (include dates of treatment): _____

Family Mental Health or Chemical Dependency History: _____

Psychosocial Information: (use as much space as you need)

Support Systems:

School/Work Life:

Marital History:

Legal History:

Military History:

Spiritual Beliefs:

Cultural Background:

Community Resources Currently Utilized:
