PREMIER PSYCHOLOGICAL CENTER

ADULT FORM (18 and older)

*****PLEASE PRINT *****

The following information is <u>very important</u> and needed to fully complete your evaluation. Please answer each question thoroughly and provide specific details when necessary. If there are any questions, please ask our staff.

Client Full Name: _____Birth Date: _____ Age: _____

Address: _____

City _____Race/Cultural Group: _____

Home Phone: _____ Cell: _____ Work: _____

Sex: (please circle) Male Female Height? _____ Weight? _____

Circle Marital Status: Single (never-married) Married Separated Divorced Widowed Living with someone

Spouse's Name: _____ Age: _____ Date Married? _____

Do you have children? [ ] No Yes [ ] If yes, how many? _____

Do any of your children receive disability funds? [ ] No Yes [ ] If yes, how many? _____ For what reason?

_____

_____

Do any of your immediate family members (i.e. mother, father, siblings) receive disabilty funds? If Yes, who? _____

For what reason? _____

_____

Driver's License: [ ] Current [ ] Suspended [ ] ID Only If suspended, why?:

_____

Do you have your own transportation? [ ] No [ ] Yes If yes, do you drive yourself to places you need to go? If not, why?

_____

How did you get to this appointment today? [ ] Drove [ ] Driven/Dropped Off [ ] Public Transportation

[ ] Walked/Bicycle

Did anyone accompany you today? [ ] No [ ] Yes

If yes, what is their **name** and relationship to you? Name _____ Relationship_____

Do you want them to provide the examiner with additional information? [ ] No [ ] Yes

Purpose of Visit

What are the concerns for which you are seeking Assistance? Please describe in detail

Developmental:
Do you have any **childhood** medical or emotional issue that is currently affecting your **mental health**? No [ ] Yes [ ]

If yes, **HOW** is it affecting you? **Describe** in DETAIL.

Living Situation

Where do you live? [ ] Apartment [ ] Single Family Home [ ] Mobile Home [ ] Rooming House [ ] Halfway house

Do you rent or own? Rent [ ] Own? [ ] Does anyone help you financially? No [ ] Yes [ ] If yes, who?

_____

How long have you lived at your present address? _____

*If less than a year, where and with whom did you previously live? _____

Why did you move? _____

Are you capable of living independently? No [ ] Yes [ ] If not, why? _____

_____

Please list ALL current household members:

NAME	AGE	SEX	RELATIONSHIP TO CLIENT

Have you ever been homeless? If so, please answer the following questions:

When? Why are/were you not able to stay with family or friends?
Where do/did you stay when it was too hot or cold to stay outdoors?
How do/did you get money for transportation, medicine, etc.?

Education
What is your last grade completed? _____

Did you repeat a grade? [ ] No [ ] Yes If yes, what grade(s)? _____

What were your typical grades? _____

Special education classes? [ ] No [ ] Yes If yes, for what reason? (Learning/ Behavior?)

_____

School suspensions? [ ] No [ ] Yes If yes, for what?

_____

_____

Employment
Are you employed? [ ] No [ ] Yes **If yes**, Where do you work?

How long have you been working there? _____

What is your job title? _____ what are you job duties? _____

_____

Are there any problems noted on the job? [ ] No [ ] Yes If Yes, Describe in detail:

_____

_____

Do you get along with coworkers/supervisors? [ ] No [ ] Yes If Not, describe in detail:

_____

_____

If unemployed,

Date when last employed? _____ How long were you there? _____

Where did you work? _____

What was your job title? _____ What were your job duties? _____

_____

Were there any problems noted on the job? [ ] No [ ] Yes If yes, please describe.

Did you get along with coworkers/supervisors? [ ] No [ ] Yes If No, describe in detail:

Reason for leaving?

List other jobs in the **past 10 years**:

Job Name and your position	Dates Worked	Reasons for Leaving	Any Social Problems? Describe.

Do you have any income? No [ ] Yes [ ] If yes, from where? _____

How much per month? _____

Mental Health

Have you been **diagnosed** with a mental health issue? [ ] No [ ] Yes If Yes, what was your diagnosis? _____

_____

When were you diagnosed? _____ By whom? _____

Are you currently experiencing any significant emotional distress (i.e. depression?) [ ] No [ ] Yes If Yes, describe **in detail**:

Are you currently having suicidal thoughts? [ ] No [ ] Yes If Yes, please Explain.

Have you ever done anything to harm or kill yourself? No [ ] Yes [ ] If yes, when? _____ **Please explain in detail:**

Are you currently having thoughts or plans to harm someone else? [ ] No [ ] Yes If Yes, please Explain.

Do you or have you ever had hallucinations (for example, hear voices or see things that others do not see)? No [ ] Yes [ ]
If yes, please explain.

Do you experience panic attacks (sudden attacks of fear or anxiety)? No [ ] Yes [ ]

If yes, please describe what happens when you have panic attacks.

How often do panic attacks occur? _____ How long do they last? _____

When did they begin? _____

Do you **often** find yourself angry or irritable? If yes, **how** do you **act** when you're angry? Describe

Do you physically fight others? No [ ] Yes [ ] If yes, **when** was the last time you fought and **explain** what happened.

Has your anger affected your relationships with others? No [ ] Yes [ ] If yes, please explain .

Family History of mental health problems:

Do you have family members with mental health or substance abuse problems?

[ ] No [ ] Yes If yes, explain who and what type of problems:

_____

_____

Mental Health Treatment: Are you currently receiving any mental health treatment? [ ] No [ ] Yes If yes, for what reason?

Where are you receiving treatment? _____

When did you begin treatment? _____ How often are your appointments? _____

If you are not currently receiving mental health treatment, have you ever received counseling/mental health treatment in the past?

[ ] No [ ] Yes If Yes, **when?** _____

What was the reason? Explain in detail _____

_____

Have you ever been placed in a psychiatric hospital? [ ] No [ ] Yes If Yes, when**? _____ Explain why:**

_____

_____

_____

Medical

Please list any medical issues (i.e. Diabetes,) and when you were **diagnosed** with each. ***Do not** list mental health issues here, such as depression or anxiety****

Medical Issues/Symptoms	Date Diagnosed

Do these medical (physical) issues affect your ability to work? [ ] No [ ] Yes If yes, describe in detail:

_____

_____

Please list all **MEDICATIONS**.

Name of Medication	Dosage	Is medication helpful? No or Yes; If yes, explain how it helps (i.e. helps to sleep better)

Substance Use

1. Do you drink alcohol?

If yes, **If No, did you drink in the past?** ? [ ] No [ ] Yes

How often do you drink (i.e. once a week)?	How often did you drink (i.e. once a week)?
How much do you drink each time? (i.e a 6 pk)	How much did you drink each time?
When was your last alcoholic drink?	Why did you stop drinking?

2. Do you use drugs (i.e. marijuana, cocaine, methamphetamine)? [ ] No [ ] Yes

If yes, **If No, did you use drugs in the past?**

What type of drug(s)?	What type of drug(s)?
How often (i.e. once a week)?	How often (i.e. once a week)? How much each time?
How much each time?	When did you last use any drugs?
When did you last use any drugs?	Why did you stop using drugs?

3. Have you ever been in a substance abuse program (e.g. drug or alcohol)? [ ] No [ ] Yes If yes, **where and when**?

_____

Legal

Have you ever had a legal charge related to alcohol or other drugs (i.e. DUI)? [ ] No [ ] Yes If yes, When? _____

Please explain what happened? _____

_____

Have you ever been in jail or prison? [ ] No [ ] Yes If yes,

List charges/convictions: **Dates incarcerated**

Are you currently on probation or parole? [ ] No [ ] Yes If yes, for what charge?

Daily Activities

Do you have sleep problems? [ ] No [ ] Yes If yes, please explain.

Do you nap during the day? [ ] No [ ] Yes

Do you have appetite problems? [ ] No [ ] Yes If yes, please explain.

Have you had any weight gain or weight loss over the past six months? No [ ] Yes [ ] If yes, Please explain:

INFORMATION ABOUT YOUR DAILY ACTIVITIES

Do you have difficulty doing any of the following? (Please **EXPLAIN** any "Yes" answers.)
Bathing/Dressing □ No □ Yes
Taking medicine □ No □ Yes
Preparing meals (Cooking) □ No □ Yes
Feeding self □ No □ Yes
Doing chores (inside/outside house) □ No □ Yes
Do you have your own Transportation? □ No □ Yes If no transportation, how do you get around?
Shopping for clothes or groceries □ No □ Yes
Seeing, hearing, or speaking □ No □ Yes If yes, does this affect your daily living? No[ ] Yes [ ] If yes, explain:

Do you have difficulty with any of the following? (Please explain any "Yes" answers.)	
Managing money (Pay bills, buy clothes, etc.)	□ No □ Yes
Concentrating	□ No □ Yes
Memory	□ No □ Yes
Understanding/following directions	□ No □ Yes

Social Functioning

How do you spend your morning and afternoons (for example, watch TV, talk to friends, clean house)?

What are your hobbies (movies, dining out, etc.)? Describe in detail.

How often do you participate in hobbies?

If you do not participate in hobbies, why not? Describe in detail.

Do you have friends? [ ] Yes [ ] No

*If yes, how often do you spend time with them?

What do you do with them?

If you do not have friends, please explain why.

Do Not write below this line. For Official Use Only.

Affect:

Orientation:

Reasoning:

Physical D:

Express:

R/R Memory:

Receptive:

Gross/Fine Motor:

Effort:

Insight & Jud:

Reliability:

Attention:

Est. Intell.

Additional Notes:

Initial Dx:
I
II
III
IV
V

Anaylsis: