

# PREMIER PSYCHOLOGICAL CENTER

## ADULT FORM (18 and older)

\*\*\*\*\*PLEASE PRINT\*\*\*\*\*

The following information is very important 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 disability 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**

**List** the reasons why you are unable to work **AND** describe them 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 your 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.

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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:

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**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 \_\_\_\_\_

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Have you ever been placed in a psychiatric hospital?  No  Yes If Yes, when? \_\_\_\_\_ **Explain why:**

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**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:

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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**

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

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**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:**