COGNITIVE THERAPY & CONSULTATION, LLC

INIITIAL EVALUATION **Date:** ___________

Name: ________________________________ Phone**:** **Home** (   ) _____-_________

Age: ____ Birthdate: ____/____/______ **Cell Phone: (   ) ____-__________**

On which phone may I leave a message for you?

______

1. Main reason/s you are seeking this evaluation/treatment**:**
   ____
   ____
   ____
   ____

2. When did you first notice this problem?
   ____
   ____
   ____

3. Please describe any other concerns below**:**
   ____
   ____
   ____

4. When did you first notice this/these problem/s?
   ____
   ____
   ____

5. Please list/describe any other stressors in your family at this time:
   ____
   ____
   ____
   ____

6. Have you been seen by a mental health professional or received psychiatric services in the past?
   No (__) Yes (__) (If yes, please complete grid below.)

Date	By Whom	Findings/Diagnoses	Treatments/Medications

7. Which psychotropic medications do your take or have you taken?

Drug	Dose	When (mo. /yr.)	Did it help?	Side effects?

Family Psychiatric History: (Please circle any of the following that exist on either side of your biological family and specify which family member.)

Biological family members**:**

Alcohol Abuse ___; family member(s): _________________

Anxiety ____; family member(s): _____________________________

Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder____;

family member(s): ______________________________

Bipolar Disorder ___; family member(s):_______________________________

Depression ___; family member(s):_______________________________

Drug abuse __; family member(s): _______________________________

Learning Disorder __; family member(s): _______________________________

Schizophrenia ___; family member(s):_ ______________________________

Suicide Attempt ___; family member(s):_______________________________

Has anyone in your family had previous mental health treatment**?**
No (___) Yes (___) (If yes, please explain):
____
____
____
____

Have you ***or*** *anyone in your family* been hospitalized for a mental illness**?**
No (___) Yes (____) (If yes, please explain):
____
____
____

Do you use any of the following**?**
Caffeine No (___) Yes (___) (If yes, please describe frequency and amount, to your knowledge):
____
Tobacco No (___) Yes (___) (If yes, please describe frequency and amount, to your knowledge):
____
Alcohol No (___) Yes (___) (If yes, please describe frequency and amount, to your knowledge):
Drugs No (___) Yes (___) (If yes, describe)

Pease check if you have had any of the following medical problems:

__ Frequent headaches ___ Seizures ___ Unusual movements/motions
___ Trouble sleeping ___ Poor appetite ___ Vision problems ___Hearing problems
___ Cancer ___ Fainting spells ___ Frequent ear infections
___ High blood pressure ___ Allergies ___ Frequent stomach aches
___ Urine or kidney infection __ Tics or other habits __ Asthma
___ Serious head injury (if yes, please describe):
____
___ Loss of consciousness (if yes, please describe):
____
___ Surgery (if yes, please describe):
____
___ Hospitalization (if yes, please describe):

Are you allergic to anything? No (___) Yes (___) (If yes, please describe):

Please list any medications you are currently taking, including the dose and prescribing physician:

Medication Dose Physician

Your primary physician: Name Telephone Number

______________________________________ (___) ____ _________

Marital status and current living situation (Check both: Marital status & living arrangement)

____ Married ___ Domestic Partnership ___Single ___ Separated ___ Divorced____
____ Widow/er

____ Live alone
____ Live with spouse/partner ___ and children____#___
____ Live with children
____ Live with parents
____ Live with roommate/friend
____ Other (Specify) _____________

Household Composition

Name /Relationship	*Age*	*Name/Relationship*	*Age*

Employment Status: ___ Full time___ Part time ___ Not Working ___ Retired

___ Student ___ Homemaker

If employed, occupation________________________

Education: Highest grade completed ______________

Problem Checklists:

<table>
<tr><th colspan="3">Please circle any of the following problems that you have now.</th></tr>
<tr><td>Shy

Worried

Aloof

Avoid eye contact

Finishing tasks

Distractible

Disorganized

Forgetful

Can't sit still

Impulsive

Interrupt people

Short tempered

Can't control anger</td><td>Use drugs

Specify:

Use alcohol

Use tobacco

Sexually active

No sexual desire

Indiscriminately affectionate

Other sexual issues

________________________</td><td>Depressed
I
Irritable

Angry

Not interested in things

Weight change gain loss

Appetite change

Agitation

Fatigue

Feel worthless

Feel guilty

Poor concentration

Indecisive

Crying spells

Thoughts of death

Thoughts of suicide

Suicide plan

Suicide attempt/s</td></tr>
<tr><td>TICS

Pick at skin

Pull hair

Cutting self</td><td>History of: Physical abuse

Sexual abuse

Mental abuse

Neglect</td><td>Don't want to eat
Binge
Vomit
Use laxatives for weight loss

Feel fat
Feel ugly</td></tr>
<tr><td>Anxious

Heart palpitations
Sweating
Trembling
Shortness of breath
Choking
Chest pain
Nausea
Diarrhea
Dizziness
Faintness
Chills
Hot flashes

Feel unreal
Feel detached from self
Fear losing control
Fear dying
Numbness
Tingling

Don't like to be home alone
Don't like to leave home</td><td>See things that aren't there

Feel no emotion

Don't trust others

Hear voices
____

Sleep disturbances*

Falling asleep

Early waking

Interrupted sleep

Nightmares

Sleep Apnea

Restless Leg Syndrome

Narcolepsy</td><td>Relating to others

Can't sustain conversation

Odd thoughts

Need outlines

Use rituals

Comfort in repetitive activities

Avoid things/objects/people
Describe</td></tr>
</table>

Thank you for taking the time to complete this form.
Is there any other information you'd like me to know?