Adult Psychological History and Evaluation

Name:_____ DOB:_____ Age:_____ Sex: __M __F

Date of Evaluation:_____ Race:_____ Religion:_____ Primary MD:_____

Marital Status (check one) ___Single ___Married ___Separated ___Divorced ___Widowed

Allergies:_____

Medications: (list all routine medications) _____

A. Presenting Problems (explain)

1. _____ Health problems: _____

_____

2. _____ Family problems: _____

_____

3. _____ Social/Interpersonal problems: _____

_____

4. _____ Coping with daily role & activities: _____

_____

5. _____ Depression/Mood Disorder: _____

---

6. _____ Anxiety & Worry: _____

_____

7. _____ Suicide threat/attempt (give date of most recent occurrence): _____

_____

8. _____ Eating problems: _____

---

9. _____ Thought disorder: _____

_____

10. _____ Chronic Anger/Aggression: _____

B. Medical History

1. Prenatal History: Full term __Yes __No Birth Weight_____
2. Note any prenatal or delivery problems: _____

_____

3. Were developmental milestones reached on time? __Yes __No If no, explain _____

_____

4. Any surgery or medical hospitalizations? __Yes __No If yes, explain. _____

_____

5. Note family medical problems. _____

_____

6. Are there any physical/medical barriers that may effect treatment? __Yes __No If yes, with whom. _____

_____

C. Psychiatric History

1. Previous outpatient treatment for mental health issues? __Yes __No If yes, with whom.

   _____

2. Previous inpatient treatment for mental health issues? __Yes __No If yes, explain. _____

_____

3. List any previous medications taken for mental health problems noting if effective or any side effects. _____

_____

_____

D. Family History

1. Childhood and adolescence: Who raised patient and in what setting? _____

_____

2. Mother's name _____ Occupation_____ Age_____
   Father's name _____ Occupation_____ Age_____

3. Describe current relationship with both.

_____

_____

_____

4. Have any family members been treated for emotions problems? __Yes __No If yes, problem and treatment. _____

_____

_____

_____

5. Note any family history of alcohol/drug abuse: _____

_____

_____

_____

E. Personal History

1. List current household members

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

2. Name, age and occupation of significant other: _____

   _____

3. List any children under 18 who do not live with patient and reason for different residence:

   _____

   _____

   _____

4. Check any history of abuse: ___Emotional ___Physical ___Sexual ___Verbal ___Past ___Current ___Reported

   By whom? (*Please asterisk next to any problem relationships and describe below)

   _____

   _____

   _____

5. Note history of other significant life events (such as death, separation, abandonment, etc)

   _____

   _____

   _____

6. Note if history of alcohol and/or drug abuse? __Yes __No Check all that apply.

	Age at first use	Amount/Frequency	Last Use	Current Use
_____ Tobacco	_____	_____	_____	_____
_____ Alcohol	_____	_____	_____	_____
_____ Marijuana	_____	_____	_____	_____
_____ Cocaine	_____	_____	_____	_____
_____ Heroin	_____	_____	_____	_____
_____ Crack	_____	_____	_____	_____

7. Highest grade or year in school completed_____ GED:_____

8. Describe attitude toward school and any school problems.

_____

_____

_____

9. Currently employed? __Yes __No If yes, where and for how long? _____

_____

10. Able to perform all self-care? Yes No If no, explain: _____

_____

11. Church or community activities? Yes No If yes, explain: _____

_____

12. Interests or hobbies? Yes No If yes, please explain:_____

_____

13. Most significant stressors at this time:

_____

_____

_____

14. What does the patient hope to gain from treatment?

_____

_____

_____

FOR CLINICIAN ONLY

Alert/Oriented: __ x4 __Person __Place __Situation	**Attention/Concentration: __Good __Fair __Poor**
Affect: __Liable __Flat __Blunted __Sad __Silly __Euthymic __WNL	**Insight: __Good __Fair __Poor**
Mood: __Anger __Depressed __Anxious __Elevated __Euphoric __WNL	**Judgment: __Good __Fair __Poor**
Psychomotor Activity: __Hyperactive __Agitated __Calm __Psychomotor slowing __Other_____	**IQ: __Above avg __Below avg __Deficit**
Hallucinations: __Auditory __Visual __Tactile __None	**Speech: __Push __Rapid __Abnormal prosody __WNL __Diminished prosody __Increased latency**
Other Sensory/Perceptual Disturbances: __Racing thoughts __Flight of ideas __Intrusive thoughts __Grandiosity __Paranoia __Suspicious __Delusional content __ideas of reference	**Thought Content: __Suicidal ideation __Homicidal Ideation __Plan**
Thought Flow: __Logical __Sequential __Goal directed __Vague __Tangential __Circumstantial __Loose associations	**Memory: __WNL __STM __LTM __Slightly Impoverished __Grossly impaired __Immediate recall_____ _____# recalled after 5 minutes**
Other Thought Activity: __Recurrent intrusive thoughts __Obsessions/Compulsions __Phobias/Excessive Fears	**Self attitude: __Poor __Low __Inflated __WNL**

G. DSM V Diagnosis

Axis I:_____ Axis IV:_____

Axis II:_____ Axis V: GAF: Current:_____ Prior Year:_____

Axis II:_____

H. The following is a case management assessment. Check all that apply.

_Housing/basic living _Medication management

_Mobility/transportation _Educational/vocational

_Legal issues _Financial entitlements

_Safety _Health/somatic care and treatments

_Independent/community living _Social needs/leisure

_Rehabilitation _Treatment

I. Treatment recommendations

_ No treatment

_Medication Evaluation with a psychiatrist

_Individual therapy Frequency:_____

_Family therapy Frequency:_____

_Group therapy Frequency:_____

_Other

_____ _____

Clinician's Signature Date