Client Name:       Date:

**Reason for Evaluation**

*Presenting Issue. When did it start? Why seeking treatment now?*

**Past Mental Health History**

Prior **Inpatient** Treatment?  If yes: When:

 Where:

 Why:

 Outcome:

Prior **Outpatient** Treatment? If yes: When:

 Where:

 Why:

 Outcome:

**Suicidal/Homicidal History**? If yes: When:

 Method:

 Triggers?

 Outcome:

**Psychotropic Medication**? If yes: Name(s):

 Dosage(s):

 Duration(s):

 Side Effects?

**Family History** of Mental Health Issues? If yes: Relationship(s):

 Diagnosis:

 Treatment:

 Outcome:

**History of Substance Use / Legal History**

**Substance Use Issues**? If yes: Types(s)?

 Age of 1st Use:

 Last Use:

 Frequency and Quantity of Use:

 IV Use?

 Tolerance Symptoms?

 Withdrawal Symptoms?

 Longest Period of Sobriety:

**Arrests/Legal Problems**? If yes: Current:

 Past:

**General Medical History**

Currently Under Medical Care? If yes: Physician:

 Physician Phone:

 Current Medical Issues?

 Current Medications?

 Allergies to Medications?

**Complete the Following for Child/Adolescent Clients:**

**Developmental, Psychosocial and Sociocultural History**

Were there pregnancy, labor or delivery complications? If yes, describe:

Did mother use alcohol or drugs during pregnancy? If yes, describe:

Was birth premature? If yes, describe:

 Age Crawled:       Birth Order:

 Age Walked:       Child was raised by**:**

 Age Spoke 1st Word:

 Age Spoke 1st Sentence:

 Age Toilet Trained:

Class Type: Grade:

 School:

 Teacher:

 Academic Issues? If yes, describe:

 Behavioral Issues at School? If yes, describe:

 Peer Relationships:

 Out of home placements?

 If yes, Where?

 When?

 Why?

 Duration?