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?