INITIAL EVALUATION

20180712

ADULT

Age 18 and older (after high school)

Genesis Behavioral Health

Name: _____ **DOB:** _____ **Age:** _____ **Date:** _____

Name of others with you today: □ No one, I came alone today □ Spouse/Other: *Name, relationship to you:* _____

Are you ALLERGIC to any medicines? □ **No** □**Yes List:**_____ □ **NKDA**

Do you see a **therapist** for talk therapy? □No □Yes Name: _____

How did you hear about us? **If someone referred you, who?** _____

Check all that apply: □Insurance company □Therapist □Physician □Friend □Internet □ TV Commercial □Other _____

BACKGROUND INFORMATION

Tell us about your family & living situation

Names of those living in the same household and names of Children & Step Children *not* living with you:

□ No one lives with me. I live alone.

Living with you?	Name	Age	Relationship to you
□Yes □No			
□Yes □No			
□Yes □No			
□Yes □No			
□Yes □No			
□Yes □No			

Have you ever been divorced? □No □Yes How many times?_____

Have you ever been remarried? □No □Yes How many times?_____

Educational, Work, Legal & Religious History

Occupation: _____

Education: Current or highest grade level? _____

If in school, how are grades? _____

Legal – Have you had any legal problems or ongoing problems with custody issues? □ No □ Yes

Describe:_____

Spiritual History

Are you a Christian? □ No □ Yes □ Unsure

Other Religious beliefs?_____

How important to you is faith in God:

□ Important □ Somewhat Important □ Not Important

Do you now or have you ever met with others in religious or spiritual community? □No □Yes

How important is or was this to you?

□ Important □ Somewhat Important □ Not Important

THE PROBLEM WHICH BRINGS YOU HERE:

You may write on the other side if needed

Why are you here and What are your problems/concerns?

(*Briefly explain the problem that brings you here now and what stressful circumstances have contributed to it.)*

_____

_____

_____

_____

_____

_____

_____

Patient Initials _____

COGNITION – Mental sharpness over the past month	**0 –** Good (No problems)	**1 –** Minimal problems	**2 –** Moderate problems	**3 –** Marked problems	*MG-CPFQ*
How has your *motivation/interest level/ enthusiasm* been over the past month?	□	□	□	□	
Your *wakefulness/alertness*?	□	□	□	□	
Your *energy level*?	□	□	□	□	
Your ability to *focus/sustain attention?*	□	□	□	□	
Your ability to *remember/recall information*?	□	□	□	□	Total:
Your ability to *find words*?	□	□	□	□	
Your *sharpness/mental acuity*?	□	□	□	□	

SUICIDAL THOUGHTS, ATTEMPTS, OR SELF-HARM

CURRENT THOUGHTS OF SUICIDE OR DEATH
□ I do not think of suicide or death – *if checked, skip this section*
□ No □ Yes - I feel that life is empty or wonder if it's worth living
□ No □ Yes - I have wished I were dead or wished I could go to sleep and not wake up.
□ No □ Yes - I Have been having thoughts of killing myself
□ No □ Yes - I have been thinking about how I might do this.
□ No □ Yes - I am thinking about acting on these thoughts
□ No □ Yes - I have started to work out or have worked out the details of how to kill myself.

PAST SUICIDE ATTEMPTS
□ NONE □ 1 □ 2 □ 3 or more
SELF MUTILATION
□ I have not ever hurt myself physically to distract myself from emotional pain – *if checked, may skip to next section*
□ I used to feel like cutting or hurting myself to deal with emotional pain, bt not any more
□ Recently I have felt like cutting or hurting myself
□ I think about cutting or hurting myself several times a day

Comments:

OTHER SYMPTOMS

SOCIAL ANXIETY SYMPTOMS	**POST-TRAUMATIC STRESS SYMPTOMS**
□ A persistent fear of being embarrassed or looking foolish,	□ You have experienced a very significant traumatic event.
especially around unfamiliar people, i.e. very shy	If YES, what?_____
□ You avoid situations in which you might be embarrassed so much	□ Distressing memories or nightmares
that it interferes significantly with your ability to function normally	□ Easily startled, always 'on guard'
	□ Feeling numb, unreal, or detached
OBSESSIVE-COMPULSIVE SYMPTOMS	□ You avoid situations reminding you of the trauma
□ Do you wash or clean a lot?	**EATING ISSUES**
□ Do you check things a lot?	□ Constantly dieting despite others saying you're thin
□ Is there any thought that keeps bothering you that you would like to get rid of but can't?	□ Binge eating or purging
□ Do your daily activities take a long time to finish?	**ANGER, & AGGRESSION**
□ Are you concerned about putting things in a special order or symmetry, or is very upset by mess?	Do you have (too frequently) sudden outbursts of anger? □Yes
□ Compulsive hair pulling (Trichotillomania)	With aggression? □Yes
□ Compulsive pornography	Are you having thoughts of hurting someone else? □Yes
□ Compulsive internet use	**OTHER SYMPTOMS**
□ Compulsive shopping	
□ Compulsive stealing	Are there times that you feel fine one minute and then become tearful (or laughing) the next minute over something small or for no reason at all. □Yes
□ Are you very concerned and preoccupied about the appearance of some part(s) of your body which you consider especially unattractive?	
	Do you detect hidden meanings in what people say or do? □Yes
PHOBIAS/SPECIFIC FEARS	Do you often feel persecuted? □Yes
□ Fear of going out or going certain places	Feel that people can read or control your thoughts? □Yes
□ Other specific fears? If so, what?	Hallucinations (hear voices or see things) □Yes

PATIENT INITIALS _____

DEVELOPMENTAL, ABUSE, & TRAUMA HISTORY

Was your childhood: □ Basically happy □ Painful Why? Were you a victim of past: □ Physical abuse? □ Neglect? □ Emotional abuse? □ Sexual abuse? Other? Explain briefly: _____ _____	□ No □ Yes Do you have any history of learning difficulties – dyslexia, being a slow learner, etc? Explain: _____ _____

FAMILY HISTORY

Please indicate whether any of your (blood) relatives have had any of these concerns:

	Parents	Brothers/Sisters	Children	Grandparents	Aunts/Uncles/Cousins
Diabetes	□	□	□	□	□
ADHD	□	□	□	□	□
Autistic Disorders	□	□	□	□	□
Suicide	□	□	□	□	□
Alcohol/Drug Problems	□	□	□	□	□
Mental hospital	□	□	□	□	□
Depression problems	□	□	□	□	□
Manic or Bipolar	□	□	□	□	□
Schizophrenia	□	□	□	□	□
Anxiety and/or panic	□	□	□	□	□
Obsessive-Compulsive	□	□	□	□	□

RELATIONSHIPS AND SOCIAL SUPPORTS

MARITAL ISSUES/ SIGNIFICANT OTHERS

Are you married? □ Yes □ No If NO, are you in a steady relationship? □ Yes □ No

How would you rate your relationship? □ Happy □ Fairly happy □ Just OK □ Fairly unhappy □ Very unhappy

If VERY UNHAPPY, please write briefly in the space provided below what the general nature of the problems are.

_____

_____

SOCIAL SUPPORTS

□ Yes □ No Do you experience a lot of loneliness?

□ Yes □ No Do you have a close confidant other than spouse? How often do you talk? _____

OTHER CONFLICTUAL RELATIONSHIPS

□ Yes □ No Are you having significant conflict or stress with anyone other than your spouse? If so, who? _____

About what? _____

JOB

How would you rate your work satisfaction? □ Very happy □ Fairly happy □ Just OK □ Fairly unhappy □ Very unhappy

If VERY UNHAPPY, please write briefly below what the general nature of the problems are.

_____

_____

PATIENT INITIALS _____

EXERCISE

In a typical week, how many times do you exercise at least 20-30 min (any type, or brisk walking or yoga)?
□ None □ 1 time □ 2 times □ 3 times □ 4 times □ 5 times □ 6 times □ 7 times

SLEEP ISSUES

IN THE LAST TWO WEEKS:
Do you generally feel rested when you wake up in the morning? □ Yes □ No
What time do you typically go to bed? _____ What time do you typically fall asleep? _____
What time do you typically wake up? _____
Including naps during the day, how many hours, on average, do you sleep per 24-hour day? _____
If you awaken frequently through the night, how many times do you awaken, and how long does it take you to go back to sleep? If so, you awaken approximately times? _____ Time it takes to get back to sleep: _____
Do you struggle to stay awake when you should be awake? □Yes
Is your work, home, or social life negatively affected by excessive sleepiness, or, for example driving a car? □Yes
Do you have a tendency to snore? □Yes
Have you been told that you stop breathing briefly at times while you are sleeping at night? □Yes
Have you been prescribed CPAP? □Yes If Yes, do you use it regularly? □Yes
Do you work shifts or a nontraditional schedule (could include being a caregiver for infant or elderly)? □Yes

THE EPWORTH SLEEPINESS SCALE is used to determine the level of daytime sleepiness. *A score of 10 or more is considered sleepy.* How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? Use the following scale to choose the most appropriate number for each situation.

SITUATION	CHANCE OF DOZING OR FEELING SLEEPY
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (for example: a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

0 = **none**
1 = **slight**
2 = **moderate**
3 = **high**

Total Score

PROBLEMS WITH EMOTIONAL INSTABILITY

Having problems with emotional instability means having unstable relationships, low self-esteem, and problems with impulsive behavior, beginning by early adulthood. A common feature of this emotional instability is fear of being left alone (abandoned), even if the threat of being abandoned is not real. This fear may lead to frantic attempts to hold on to others and may cause them to become overly dependent on how others feel about them. Angry mood swings and erratic behavior can lead to troubled relationships in many areas of life.

Problems with emotional instability – do you tend to:

□ Make frantic efforts to avoid real or imagined abandonment.
□ Have a pattern of difficult relationships caused by alternating between extremes of intense admiration and hatred of others.
□ Have an unstable self-image or be unsure of his or her own identity.
□ Act impulsively in ways that are self-damaging, such as extravagant spending, sex with many partners, substance abuse, binge eating, or reckless driving.
□ Have recurring suicidal thoughts, make repeated suicide attempts, or cause self-injury through mutilation, such as cutting or burning oneself.
□ Have frequent emotional overreactions or intense mood swings, including feeling depressed, irritable, or anxious. These mood swings may only last a few hours at a time. In rare cases, they may last a day or two.
□ Have long-term feelings of emptiness.
□ Have inappropriate, fierce anger or problems controlling anger – or often display temper tantrums or get into fights.
□ Have temporary episodes of feeling suspicious of others without reason (paranoia) or losing a sense of reality.

CURRENT and PAST MEDICATIONS

List ALL CURRENT MEDICATIONS, VITAMINS, HERBAL, & SUPPLEMENTS that you are now taking:

Medication, Vitamin, or Herbal	Medication, Vitamin, or Herbal	Medication, Vitamin, or Herbal

List ALL PAST MEDICATIONS that you have taken:

√ if Taking Now or Past	Medication Have you *ever* taken any of these:	dose	When & Why Stopped	When	√ if Taking Now or Past	Medication Have you *ever* taken any of these:	dose	When & Why Stopped	When
□Now □Past	**Ritalin/Methylin**				□Now □Past	**Abilify**			
□Now □Past	**Metadate**				□Now □Past	**Aristada or Maintenna**			
□Now □Past	**Mydayis**				□Now □Past	**Rexulti**			
□Now □Past	**Aptensio**				□Now □Past	**Geodon**			
□Now □Past	**Concerta**				□Now □Past	**Risperdal/Invega**			
□Now □Past	**Focalin (or XR)**				□Now □Past	**Zyprexa**			
□Now □Past	**Daytrana**				□Now □Past	**Seroquel (or XR)**			
□Now □Past	**Adderall (or XR)**				□Now □Past	**Saphris**			
□Now □Past	**Vyvanse**				□Now □Past	**Fanapt**			
□Now □Past	**Other stimulant**				□Now □Past	**Latuda**			
□Now □Past	**Strattera**				□Now □Past	**Vraylar**			
□Now □Past	**Clonidine**				□Now □Past	**Clozapine**			
□Now □Past	**Guanfacine**				□Now □Past	**Lithium**			
□Now □Past	**Prozac**				□Now □Past	**Depakote**			
□Now □Past	**Zoloft**				□Now □Past	**Tegretol** (Carbamazepine)			
□Now □Past	**Paxil**				□Now □Past	**Trileptal**			
□Now □Past	**Luvox**				□Now □Past	**Lamictal** (lamotrigine)			
□Now □Past	**Celexa**				□Now □Past	**Topamax**			
□Now □Past	**Lexapro**				□Now □Past	**Valium** (Diazepam)			
□Now □Past	**Effexor XR**				□Now □Past	**Xanax** (Alprazolam)			
□Now □Past	**Pristiq**				□Now □Past	**Ativan** (Lorazepam)			
□Now □Past	**Cymbalta**				□Now □Past	**Klonopin** (Clonazepam			
□Now □Past	**Wellbutrin**				□Now □Past	**Lyrica**			
□Now □Past	**Remeron**				□Now □Past	**Neurontin**			
□Now □Past	**Buspirone**				□Now □Past	**Hydroxyzine**			
□Now □Past	**Trintellix**				□Now □Past	**Ambien (or CR)**			
□Now □Past	**Viibryd**				□Now □Past	**Lunesta**			
□Now □Past	**Fetzima**				□Now □Past	**Temazepam**			
□Now □Past	**Nefazodone**				□Now □Past	**Sonata**			
□Now □Past	**Amitriptyline**				□Now □Past	**Trazodone**			
□Now □Past	**Imipramine**				□Now □Past	**Rozerem**			
□Now □Past	**EMSAM**				□Now □Past	**Melatonin**			
□Now □Past	**Nardil**				□Now □Past	**Benadryl** (antihistamine)			
□Now □Past	**Parnate**				□Now □Past	**Other OTC sleep aid**			
□Now □Past	**Ketamine**				□Now □Past	**Buprenorphine**			
□Now □Past	**Provigil/Nuvigil**				□Now □Past	**Antabuse** (disulfiram)			
□Now □Past	**Aricept** (donepezil)				□Now □Past	**Campral** (acamprosate)			
□Now □Past	**Namenda** (memantine)				□Now □Past	**Naltrexone** (oral or injectable)			