

TheITMGroup

INTENSIVE TREATMENT MODALITIES

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PRELIMINARY EVALUATION INFORMATION

Identifying Information

Date _____

Client Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone (H): _____ (W): _____ Ext: _____
Date of Birth: ____/____/____ Sex: _____

Referred By: _____

Place of Employment / Occupation: Yours: _____
Partner/Spouse: _____

Highest grade level of education completed: _____
Degree achieved: _____

Presenting Problem

Please describe the problems that have led you to seek treatment or evaluation.

What do you believe to be the most important factor (s) causing the problem (s)?

When did you first notice these problem (s)? _____

Have there been any family changes (new baby, death, breakup, etc.) which may be related to these problems?
Please explain: _____

Prior Therapy Experience

Have you ever been seen for counseling or therapy? Yes _____ No _____

As an outpatient (clinic, private, etc.)

Name: _____ Phone (____) _____

Address: _____ City _____ State _____ Zip _____

For how long? _____ Dates: _____

Name of doctor / therapist _____

Reason for treatment _____

Name: _____ Phone (____) _____

Address: _____ City _____ State _____ Zip _____

For how long? _____ Dates: _____

Name of doctor / therapist _____

Reason for treatment _____

As an inpatient (in a hospital, residential treatment center, etc.)

Name _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

For how long? _____ Dates: _____

Name of doctor / therapist _____

Reason for Admission _____

Name _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

For how long? _____ Dates: _____

Name of doctor / therapist _____

Reason for Admission _____

Have you taken standard psychological assessments, (e.g. intelligence testing or personality evaluation)? Yes _____
No _____

Name of Psychologist _____ Phone (____) _____

Address _____ Dates _____

Medical History

Family Doctor _____ Phone (____) _____

Have you ever been in the hospital for medical problems? Yes _____ No _____

Dates	Names of hospital, city & state	Reason for hospitalization
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any serious or chronic physical or medical conditions (diabetes, etc.)? Yes _____ No _____
If yes, please explain? _____

Are you presently taking any prescribed / non-prescribed medication? Yes _____ No _____, If yes Please explain? _____

Medication	Prescribed by	How long
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any allergies? Yes _____ No _____
If yes, describe what they are and list any medication (s) you take: _____

Have you been injured in any accidents or falls? Yes _____ No _____, If yes, Please describe:

Incident	Age	Injury
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you suffered any complications of illnesses or accidents (high fever, convulsions, coma, etc.)? Yes _____ No _____
If yes, please describe the circumstances: _____

Were you ever unconscious, in a coma, or had a concussion as a result of illness or injury? Yes _____ No _____
If yes, please explain: _____

Do you now, or have you in the past, used alcohol or other drugs on a regular basis? Yes _____ No _____ If yes, how often and how much?

Type of Drug (Include alcohol)	How Often?	How much in each episode?
_____	_____	_____
_____	_____	_____

Do you now, or have you in the past, smoked cigarette / cigars / pipes on a regular basis?

Yes ___ No ___

If yes, how often and how much? _____

Have you experienced difficulty with any of the following?: (Please (check) items that are currently a problem)

- ___ Headaches
- ___ Numbness / tingling in extremities
- ___ Difficulty with hearing
- ___ Shortness of breath
- ___ Trouble with swallowing
- ___ Weight gain or loss in past year
- ___ Preoccupation with weight
- ___ Itching of skin
- ___ Hyperactivity
- ___ Nervousness
- ___ Attention / Concentration problems
- ___ Chronic fatigue or weakness
- ___ Sudden behavior changes
- ___ Impulsive: act without thinking
- ___ Physical assault (s) / abuse
- ___ Anxiety / panic episodes
- ___ Problems with sexual behavior
- ___ Family / relationship difficulties
- ___ Unusual experiences
- ___ Suicide attempts
- ___ Problems with the law
- ___ Problem maintaining balance

- ___ Seizure
- ___ Fainting or black-out spells
- ___ Difficulty with vision
- ___ High blood pressure
- ___ Diarrhea, chronic
- ___ Loss of appetite
- ___ Eating problems
- ___ Skin rash
- ___ Crying spells
- ___ Mood spells
- ___ Ringing in ears
- ___ Problems thinking clearly
- ___ Sudden personality changes
- ___ Depression anxiety
- ___ Sleeping problems
- ___ Financial problems
- ___ Occupational problems
- ___ Learning problems
- ___ Social relationship problems
- ___ Disturbing thoughts
- ___ Suicidal thoughts
- ___ Memory problems / difficulty

Birth Information

Were there any physical or emotional difficulties during your mother’s pregnancy with you?

Yes _____ No _____

If yes, please describe: _____

Were you born premature?

Yes _____ No _____ If yes, please give the number of weeks early: _____

Were there any immediate complication following delivery with you?

Yes _____ No _____ If yes, please

describe: _____

Pregnancy Information (Biological Females Only)

Were there any physical or emotional difficulties during pregnancy with your children?

Yes _____ No _____ If yes, please describe: _____

Were any of your children premature?

Yes _____ No _____ If yes, please give the number of weeks early: _____

Were there any of the following complication?

Mother taking medication or drugs

(specify): _____

Long labor _____ Forceps delivery _____ Breech birth _____ Eclampsia _____ Caesarean Section _____
other _____

Were there any immediate complication following delivery of your children?

Yes _____ No _____ If yes, please

describe: _____

Number of pregnancies _____ Number of miscarriages _____ Weight of largest child at birth _____

Biological Family Health Information

Has anyone in the family (including grandparent) been treated for a mental health problem?

Yes _____ No _____ If yes, please explain: _____

List individuals that live in your home: _____

Family History	Age	State of Health (If deceased, list cause)	Occupation
Father	_____	_____	_____
Mother	_____	_____	_____
Brother (s)	_____	_____	_____
Sister (s)	_____	_____	_____
Partner/Spouse	_____	_____	_____
Children gender: _____	_____	_____	_____
Children gender: _____	_____	_____	_____
Children gender: _____	_____	_____	_____
Children gender: _____	_____	_____	_____

Who In Your Family Had:	Father	Mother	Sister (s)	Brother (s)	G-Parent
1. Cancer	_____	_____	_____	_____	_____
2. Drinking Problems	_____	_____	_____	_____	_____
3. Allergies or Asthma	_____	_____	_____	_____	_____
4. Strokes	_____	_____	_____	_____	_____
5. Nervous Breakdown	_____	_____	_____	_____	_____
6. Suicide	_____	_____	_____	_____	_____
7. Convulsions / epilepsy	_____	_____	_____	_____	_____
8. Headaches	_____	_____	_____	_____	_____
9. Diabetes	_____	_____	_____	_____	_____
10. Drug Abuse	_____	_____	_____	_____	_____
11. Ulcers	_____	_____	_____	_____	_____
12. High Blood Pressure	_____	_____	_____	_____	_____
13. Depression	_____	_____	_____	_____	_____

Relationship History

Present marital/relationship status (check all that apply)

Single _____ Married/Commitment Ceremony _____ Live In Relationship _____
Divorced/Separated _____ Widowed _____

If married/live-in relationship: Spouses name: _____

Date of birth: ____/____/____

Date of current marriage/commitment ceremony: ____/____/____

When did you begin living together? _____

When did you begin dating? _____

Children by present relationship:

Name	Birth Date or Age
_____	_____
_____	_____
_____	_____

Previous marriages/civil commitment/live-in relationships:

Date of Ceremony/ Began Living Together	Date Divorced/ Relationship Ended	Reason for Divorce/ End of Relationship	Children by each Relationship & Ages
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Employment

Present job title / job description and organization: _____

Do you have problems performing your job? (Yes___ No___) If yes, please explain: _____

Do you have problematic relationships with people on the job? (Yes___ No ___) If yes, please explain: _____

How many jobs have you held within the past five years? _____
Reason for changes in job: _____

I understand that this information will be used in my evaluation and will be included in my records.

Signed _____ Date _____
Client

Re-Disclosure: Persons, agencies, or institutions to whom this information is disclosed are prohibited by state / federal law from re-disclosure without the specific written consent of the person to whom it pertains. A general authorization for release of medical information is NOT sufficient for this purpose.