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Welcome to West Psychological Services PLLC. In order to most efficiently provide services, we ask that you complete this form.

**ADULT INITIAL EVALUATION: Patient Form** Date:

Patient: DOB: Referred by:

Name of Person completing this form if not patient:

Briefly describe the events that led to this appointment:

Have there been any previous mental health contacts? If yes, list these contacts and approximate dates of treatment (include hospitalization dates)

Please check any of the following symptoms or complaints that apply to your situation. Add comments if necessary:

* Sad Mood
* Low Energy/Fatigue
* Hopelessness
* Worthlessness
* Crying Spells
* Guilt
* Decreased Motivation
* Loss of Interest in Usual Activities
* Irritability
* Hyperactivity
* Impulsiveness
* Elevated Mood
* Racing thoughts
* Concentration/Memory Difficulties
* Increased Sexual Interest
* Decreased Sexual Interest
* Decreased Appetite
* Difficulty Falling Asleep
* Early Morning Awakening

**Patient Name: Page 2**

* Difficulty Staying Asleep
* Excessive Sleeping
* Suicidal Thoughts

□Thoughts of Harming Others

* Anxious/Worried
* Panic Attacks
* Fear of Leaving the House
* Fear of Driving
* Fear of Specific Situations or Things
* Fear of Embarrassing Oneself in Public
* Intruding, Uncomfortable, Upsetting Thought
* Repetitive Thoughts or Behaviors
* Excessively Orderly and Perfectionistic
* Periods of “Lost” Time
* Excessive Anger / Aggressiveness
* Difficulty Trusting Others
* Binging/Purging
* Rebellious/Defiant
* Victim of Abuse or Trauma:
	+ Emotional
	+ Sexual
	+ Physical
* Offender of Abuse
	+ Emotional
	+ Sexual
	+ Physical Do any of the people in your current living situation have a mental health, alcohol or drug problem? If yes, please list and describe.

Please list your current medications (including dosage):