Presque Isle Mind-Body Wellness Center

In order to most efficiently use your face to face time with your provider we ask that you complete this form. This information will enable your provider to understand and help you. If there are any questions you do not wish to answer, please draw a line through them and initial the item(s).

ADULT INITIAL EVALUATION:

Date: _____ Patient: _____DOB: _____

Referred by: _____

Name of Person completing this form if not patient:

_____

Relationship to Patient:

_____

Briefly describe the events that led to this appointment:

_____

_____

_____

_____

What do you wish to accomplish through your involvement in treatment?

_____

_____

Has there been any previous mental health treatment? List the reason for treatment, what treatment was provided, who provided it and dates.

_____

_____

Did you feel it was helpful? Why?

_____

_____

**Check off any symptoms/problems that give you concern**:

□ Sadness □ Fatigue □ Hopelessness □ Guilt □ Loss of Interest □ Irritability □ Too much energy □ Too little energy □ Impulsivity □ grief issues □ Racing thoughts □ Obsessive/Compulsive concerns □ Memory problems □ Excessive Sex Interest/activity □ Decreased Sex Interest/activity □ Sleep problems □Thoughts of harming myself □ Thoughts of harming others □ Anxious □ Panic attacks □ Specific fears □ Anger control □ Trusting others □ Eating habits □ Social Phobia □ Cutting yourself □ Sexual performance □ Relationship issues

Other Symptoms not listed:

_____

Do any of the people in your current living situation have a mental health, alcohol or drug problem?

□ Yes □ No

Highest Education Level Completed:
_____ Occupation:
_____ During your school years were you identified as having a learning disability? YES / NO Did you have an Individualized Education Plan (IEP) YES / NO If yes, explain:_____

Who lives with you in your home?
Name_____
Relation to Yourself_____ Age_____
Education_____
Occupation_____
_

Please check any of the following issues that apply: □ Blood Pressure □ Diabetes □ Childhood Sexual physical abuse □ Domestic violence in child- Problems □ Sexual/Physical abuse as an adult hood home □ Thyroid □ Heart □ Mental Illness in family members □ Alcohol/drug abuse □ Lungs □ Kidney □ Seizures □ Domestic Violence □Stomach □ Cancer □ Divorce □ Headaches □ Neurological □ Other - including disabilities and disorders – List below:

_____
How have you adjusted socially to your disability and/or disorder?

_____

_____
Have you been a victim of abuse, neglect, sexual assault or other trauma? Yes ___ No ____

Have you witnessed trauma? Explain the trauma and tell when it was experienced.

_____

_____

_____
Legal Involvement: Past:

_____
Present:_____

Check if any of the following existed in your childhood home:

□ Poor relationship with parents □ Parent(s) with substance abuse problems □ Legal problems

□ Involvement of Child Protective Services □ neglect/abuse □Incest □ Poor relationship with siblings

Are you currently pregnant? Yes___ No ___ N/A ___ If yes, are you receiving prenatal care? _____

Who is your Primary Care Doctor?

_____

Have you had a recent physical? _____

If yes, when_____

List any ongoing medical conditions

_____

_____

List all current medications and identify if the medications helped reduce your symptoms:

_____

Allergies (include allergies to medication):_____

Are you interested in information for social support regarding your current situation? Yes_____ No____

Do you have any concerns regarding use of drugs/alcohol?

_____

_____

_____

Do you use tobacco products? Yes ___ No ___If yes, how often do you use the tobacco product? _____ Are you able to read and write English? Yes _____ No _____

Employment history

_____

_____

Present Occupation:_____

□ Full time □ Part time □ Retired □ Disabled

List your personal strengths _____

_____

_____

_____

Do you use supplemental health approaches such as acupuncture, supplements or holistic medicine?

Yes ___ No____ If yes, list the supplemental health approaches you use.

_____

_____

Optional Questions: Do you have any cultural or spiritual beliefs that your provider should be aware of?

_____

_____

_____

What is your Sexual Orientation? _____

Gender Expression? _____

**~Thank you~**