Cedars Counseling

Initial Client Psychological Evaluation Intake

Please provide the following information for our records. Information you provide here is held to the same standards of confidentiality as our therapy.

Legal Name: _____
(First) (Middle Initial) (Last)

Birth Date: _____/_____/_____ Age: _____

Gender: _____ Marital Status: _____ Number of Marriages _____ No of Children_____

Address: _____
(Street and Number) (Apt. #) (City) (State) (Zip)

Primary Number: _____ May we leave a message? _____ Yes _____ No

E-mail: _____ May we leave a message? _____ Yes _____ No

Where should we send an appointment reminder? _____ E-mail or _____ Text message

Reason for testing:_____

Insurance Information

Primary Insurance Card upload_____ Drivers License upload _____

Subscriber Name (If self ___)_____ **Date of Birth** _____

Subscriber Address _____

Subscriber Date of Birth _____ **Client's relationship to Subscriber** _____

Is there secondary insurance _____

OCCUPATIONAL INFORMATION:

Are you currently employed? _____ Yes _____ No If yes, who is your current employer? _____

Current Position? _____ Please list any work-related stressors: _____

Highest grade completed: _____ Are you a veteran or currently active in the U.S. Military? _____ Yes _____ No

MEDICAL INFORMATION:

Physician _____ Phone _____ May we contact? _____ Yes _____ No Psychiatrist

_____ Phone _____ May we contact? _____ Yes _____ No

List any major medical problems, surgeries, hospitalizations and/or allergies.

(1)	**(3)**
(2)	**(4)**

Current Medications/Dosages Allergies: _____

_____ _____

_____ _____

_____ _____

Mental Health Treatment History: Please list any previous psychological/psychiatric services & related information.

Type of Service	Dates of Service	Provider	Reason for Service

HEALTH AND SOCIAL INFORMATION:

1. How would you describe your physical health? ___ Poor ___ Unsatisfactory ___ Satisfactory ___ Good ___ Very Good

2. Current Symptom List: Please mark all that apply at present:

_____Poor Memory _____ Headaches _____ Nightmares _____Stress _____ Shyness _____ Impulsiveness

_____ Depression _____ Sexual Dysfunction _____ Anxiety _____ Rage/Anger _____Hallucinations _____ Guilt/Shame

_____ Excitability _____ Tension _____ Racing Thoughts _____ Worthlessnes _____ Panic Attacks _____ Stomach Trouble

_____ Bedwetting ____ Risky Behaviors _____ Fatigue _____ Worry _____ Intrusive Thoughts _____ Helplessness

____ Harm to Self/Others _____ Other

3. Are you having any problems with your sleep habits? _____ Yes _____ No

If yes, mark where applicable: _____ Sleeping too little _____ Sleeping too much _____ Poor quality sleep

4. How many times per week do you exercise? _____ Approximately how long each time? _____

5. Are you having any difficulty with appetite or eating habits: _____ Yes _____ No If yes, check where applicable:

_____ Eating less _____ Eating more _____ Binging _____ Restricting

6. Have you experienced significant weight change in the last two months? _____ Yes _____ No

7. Do you regularly use alcohol? _____ Yes _____ No

In a typical month, how often do you have 4 or more drinks in a 24 hour period? _____

8. How often do you engage in recreational drug use? _____ Daily/Weekly _____Monthly _____Rarely ____Never

9. Have you had suicidal thoughts recently? _____ Frequently _____ Sometimes ____Rarely ____ Never

Have you had them in the past? _____ Frequently _____ Sometimes ____Rarely ____ Never

10. Are you currently in a romantic relationship? _____ Yes _____ No

If yes, how long have you been in this relationship? _____

On a scale of 1-10, how would you rate the quality of your current relationship? _____

11. In the last year, have you experienced any significant life changes or stressors? _____

Have you ever experienced the following? Please circle all that apply.

Extreme depressed mood	Wild Mood Swings	Panic Attacks
Rapid Speech	Extreme Anxiety	Phobias
Sleep Disturbances	Hallucinations	Suicide Attempt
Unexplained losses of time	Memory lapses	Eating Disorder
Alcohol/Substance Abuse	Chronic pain	Repetitive behaviors
Body Image Problems	Repetitive Thoughts	Homicidal Thoughts

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following: (Mark any that apply and list family member, e.g. Sibling, Parent, Uncle, etc.):

Diagnosis	Family Member(s)	Diagnosis	Family Member(s)
Depression	_____	Bipolar Disorder	_____
Anxiety Disorders	_____	Panic Attacks	_____