# **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:		11 T 12 11 (T )	
	(First) (Midd	lle Initial) (Last)	
Birth Date:/ Age:			
Gender: Marital	Status:	_ Number of Marriages	No of Children
Address:			
(Street and	d Number) (Apt. #) (C	ity) (State) (Zip)	
Primary Number:	May we leav	ve a message? Yes	No
E-mail:		_ May we leave a message? _	YesNo
Where should we send an appointment rem	inder? E-ma	il or Text message	
Reason for testing:			
imary Insurance Card upload	Drive	ers License upload	
bscriber Name (If self)		Date of Birth	
bscriber Address			
ubscriber Date of Birth	_Client's relationshi	p to Subscriber	
	Is there see	condary insurance	_
OCC	CUPATIONAL IN	FORMATION:	
Are you currently employed? Yes _	No If yes, who is	s your current employer?	
Current Position?	Please list any wor	k-related stressors:	
Highest grade completed: Are	you a veteran or curre	ently active in the U.S. Militar	rv? Ves 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:

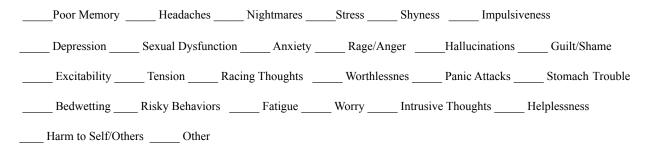
#### Mental Health Treatment History: Please list any previous psychological/psychiatric services & related information.

Type of Service	Dates of Service	Provider	<b>Reason for Service</b>

### 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:



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/WeeklyMonthlyRarelyNever
9. Have you had suicidal thoughts recently? Frequently SometimesRarely Never
Have you had them in the past? Frequently SometimesRarely 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	