BROOKHAVEN
CENTER FOR
COUNSELING &
DEVELOPMENT
P.O. Box 425
Fogelsville, PA 18051
(610) 395-3005

INITIAL EVALUATION

Name_____

Date of Birth: __/__/____ Sex: M F

Date of Evaluation __/__/__

Please read before completing: All of the following information may be important in order to properly evaluate you. However, if you are uncomfortable with completing any items, please leave them blank and discuss your concern with your mental health care provider during the initial appointment.

I. Concerns or problems that you are experiencing for which you desire our help.

II. Medical History

A. ☐ I have experienced good health across my lifespan.

☐ I have experienced the following health problems:

1._____year_____
2._____year_____
3._____year_____
4._____year_____

O additional information recorded on reverse side.

B. ☐ I have been hospitalized for the following conditions:
(list hospitalization for childbirth only if there were complications)

condition:_____year_____
condition:_____year_____
condition:_____year_____

O additional information recorded on reverse side

C. ☐ I am taking the following prescription medications:

1._____dosage_____ 3._____dosage_____
2._____dosage_____ 4._____dosage_____

O additional information recorded on reverse side

D. My family physician is _____
☐I do not have a family physician.
My last medical consult was: _____/_____With Dr._____

Name: _____

E. Wellness Behaviors
1. I sleep on average _____ hours each day.
2. Caffeine consumption (describe) _____
3. Alcohol consumption (describe) _____
4. Tobacco use (describe) _____
5. Physical exercise (describe) _____
6. Eating habits (describe)_____
7. Height & weight _____'_____" _____lbs.

III. Mental Health/Drug & Alcohol History

A. ☐ I have never been seen by a psychologist, psychiatrist, social worker, or professional counselor.
☐ I have received mental health and/or alcohol /drug abuse treatment from:

Name: _____problem/condition_____from__/__ to__/__
Name: _____problem/condition_____from__/__ to__/__
Name: _____problem/condition_____from__/__ to__/__

B. ☐ I have received inpatient treatment for a mental disorder or a drug/alcohol problem.
Where?_____When?_____Diagnosis_____
Where?_____When?_____Diagnosis_____

O additional information recorded on reverse side

C. The following relatives have received treatment for a mental disorder or drug/alcohol problem:
_____Relationship:_____problem/condition_____
_____Relationship:_____problem/condition_____

O additional information recorded on reverse side

(Leave this space blank)

IV. Personal History

A. Current Age _____
Occupation and Employer _____

Marital Status: __Single __Married 1X __Married 2X __Married 3X or more
__Widowed __Divorced __Separated: How long?_____

B. Spouse's Name _____ Current Age: _____
__1st marriage __2nd marriage __3rd or more marriage
Spouse's Occupation and Employer _____

Name: _____

(IV. Personal History continued)

C. Children:

Name _____Age_____
__at home __student/grade _____
__out of home: where _____
employment _____
health status _____
Name _____Age _____
__at home __student/grade _____
__out of home: where _____
employment_____
health status _____
Name _____Age _____
__at home __student/grade _____
__out of home: where _____
employment _____
health status _____

Name _____Age _____
__at home __student/grade _____
__out of home: where _____
employment _____
__health status _____

O additional information recorded on reverse side.

D. Education
Elementary School _____
Secondary School _____ ☐ Diploma; if not, highest grade completed _____
University _____Degree _____
Graduate Studies _____Degree _____

O additional information on reverse side

E. Employment
Previous Employer _____years worked _____job description _____
Previous Employer _____years worked _____job description _____

F. Military Service
☐ No ☐ Yes Branch _____ from __/__ to __/__ Rank _____
Type of discharge _____
Rank at discharge _____

(Leave this space blank)

Name: _____

V. Family History

A. Place of Birth _____Childhood Residence _____
Additional Residence (s) _____

Father's Name _____present age _____ _____deceased
If deceased, age at death _____ When _____ Cause _____
If living, place of residence _____Occupation_____
Health status _____

Mother's Name _____present age ____ _____deceased
If deceased, age at death _____ When _____ Cause _____
If living, place of residence _____Occupation_____
Health status _____

B. Siblings:

Name _____age _____ __single __married __divorced __remarried
deceased since _____; age at death ___
Name _____age _____ __single __married __divorced __remarried
deceased since _____; age at death ___
Name _____age _____ __single __married __divorced __remarried
deceased since _____; age at death ___

O additional information recorded on reverse side

(Leave this space blank)

VI. Sexual/Reproductive History

- ☐ I have never been sexually active

- ☐ I have been sexually active in the past, but have been inactive since ___/___
- ☐ I am currently sexually active
- ☐ I have experienced: ___ miscarriage; #____ ___ stillbirth; #____ ___ abortion; #____
- ☐ I am diagnosed with a sexually transmitted disease
- ☐ I consider my sexual orientation to be: ___heterosexual, ___ homosexual, ___ bi-sexual

Name: _____

Leave this space blank)

VII. Legal History

- ☐ I have been convicted or pled guilty to a misdemeanor or felony
- ☐ I have sued another person or entity; # of times _____
- ☐ I have been or currently am being sued or am involved in legal litigation, custody, support and/or divorce proceedings.
- ☐ I have been imprisoned.

(**Leave this space blank)**

VIII. Traumatic Events History

- ☐ I have been raped or molested.
- ☐ I have been physically abused.
- ☐ I have survived life-threatening experiences.
- ☐ Other _____

(Leave this space blank)

IX. Spiritual/Religious History

- ☐ I believe in God.
- ☐ I am a member of a church, synagogue, religious order, etc.
  If so, name & location _____
- ☐ I believe that my present problem(s) will more likely be resolved if my faith in God is included in the counseling process.
- ☐ I do not understand myself to be a spiritual person and/or I do not believe in God.

(Leave this space blank)

Name: _____

X. Financial History

- ☐ I am currently experiencing financial problems.
- ☐ I struggle chronically with being in debt.
- ☐ I or my spouse/partner tend to be be a compulsive spender, gambler.
- ☐ I have difficulty saving a portion of my income.
- ☐ My spouse/partner and I cannot cooperate and/or communicate about our finances.

(Leave this space blank)

XI. Mental Status *(Leave blank)*

XII. Risk Factors *(Leave blank)*

XII. Diagnosis *(Leave blank)*

Axis I

Axis II

Axis III

Axis IV

Axis V Current _____ Past Yr. _____

XIV. Recommendations for Treatment *(Leave Blank)*