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ADULT EVALUATION FORM

Name: _____ ❒ Male ❒ Female Date: _____
Date of Birth _____ Birthplace _____ Age: _____
Address: _____ City, State, Zip _____
Phone: Home _____ Cell _____ Work _____

May Dr. Robinson leave personal voice messages on one of your phones? ❒Y ❒N
If yes, which phone(s): ❒ Home ❒ Cell ❒ Work

Do you consent to receiving text messages from Dr. Robinson? ❒Y ❒N

Do you consent to receiving emails from Dr. Robinson? ❒Y ❒N
Email: _____

Health Plan Information:

Primary Plan: _____ Policy/Subscriber #: _____
Subscriber's Name: _____ D.O.B: _____
Soc. Sec. #: _____
Plan Ph#: _____ Claim Address: _____

Secondary Plan: _____ Policy/ Subscriber #: _____
Subscriber's Name: _____ D.O.B: _____
Soc. Sec. #: _____
Plan Ph #: _____ Claim Address: _____

Emergency Contact Information:
Name: _____ Relationship: _____ Phone: _____
Referral Source: _____

Presenting Problems (be as specific as you can: describe problems, when did it start,…):
1. _____
_____
2. _____
_____
3. _____
_____

Estimate the severity of above problem:

#1 ❒ Mild ❒ Moderate ❒ Severe ❒ Very Severe

#2 ❒ Mild ❒ Moderate ❒ Severe ❒ Very Severe

#3 ❒ Mild ❒ Moderate ❒ Severe ❒ Very Severe

SCHOOL HISTORY:

Currently in School? ❒Y ❒N

Highest Grade / Degree: _____ Last/Current School Attended: _____

Average Grade Received _____

Learning Strengths _____

Specific Learning Disabilities _____

Any behavioral problems in school? _____
What have teachers said about you? _____
Did you like school? ❒Y ❒N Comment: _____
_____
Favorite Subject (s) _____
Least Favorite Subjects _____

EMPLOYMENT HISTORY:

Patient's Occupation _____
Current Employer: (former. if no longer working) _____
Favorite Job(s) _____
Least Favorite Job(s): _____
Any work-related problems? _____
What would employers say about you? _____

RELATIONSHIP AND FAMILY HISTORY:

Current Marital Status: ❒ Single ❒ Married ❒Separated ❒Divorced ❒Widowed ❒Living together

Name of Spouse/Long term partner: _____
Length of Current Relationship: _____ Spouse/Partner Occupation: _____
Describe any stressors in current relationship:

_____
_____
_____
_____
_____
_____

List Past Marriages **(**start and end date, years together, names & statement about the nature of the relationship/s):

1. _____
   _____
2. _____
   _____
3. _____
   _____

Children/Step Children (names/ages & brief statement on your relationship with the child/adult):

1. _____
   _____
2. _____
   _____
3. _____
   _____
4. _____
   _____
5. _____
   _____

Siblings (name/age, if deceased: age and cause of death & brief statement about the relationship):

1._____
_____
2._____
_____
3._____
_____
4._____
_____

Biological Mother's History**:**
❒Living Age ____ ❒ Deceased Age ___ Cause of Death _____
If living, describe current relationship with her _____
_____
Medical Problems: _____
Psychiatric Treatment: _____
Mother's drug / alcohol history: _____
Have any of your mother's blood relatives had any significant medical or psychiatric problems including drug or alcohol abuse/addiction, depression, anxiety, psychiatric hospitalization, suicide attempts? _____
_____
_____
_____
_____
_____

Biological Father's History**:**
❒Living Age _____ ❒ Deceased Age _____ Cause of Death _____
If living, describe current relationship with him: _____
_____
Medical Problems: _____
Psychiatric Treatment: _____
Father's drug / alcohol history: _____
Have any of your father's blood relatives had any significant medical or psychiatric problems including drug or alcohol abuse/addiction, depression, anxiety, psychiatric hospitalization, suicide attempts?
_____
_____
_____
_____
_____
_____

Describe your childhood (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems):
_____
_____
_____
_____
_____
_____
_____

If Parents Divorced, Your Age at the Time _____ How did their divorce affect you?
_____
_____
_____
_____

MEDICAL HISTORY:

Primary Care Doctor **(**name /phone/city): _____

Other Medical Specialists (name/ phone / condition they are treating):

1. _____
   _____
2. _____
   _____
3. _____
   _____

Past and Present Medical Care (major medical problems, surgeries, injuries, illness):

_____
_____
_____
_____
_____

Current Medications (Name, Dosage, Issue for which each medication is prescribed):

1._____
2. _____
3. _____
4. _____
5. _____

Past / Present Psychotherapy / Neurofeedback History (start-end date, approx. # of sessions, helpfulness, name, city, ph# of therapist, reason treatment ended)

_____
_____
_____
_____
_____
_____

Psychiatric Hospitalizations (specify: month, year, number of days of each hospitalization, name of hospital, reason for hospital)

1. _____
2. _____
3. _____

Suicidal and Violent Behavior (describe: ages, reasons, circumstances…)**:**

_____

_____

_____

Alcohol and Drug History:

Do you ever experience withdrawal symptoms from alcohol or drugs? ❒ Y ❒ N

Describe: _____

Has anyone ever told you they think you have a problem with alcohol or drugs? ❒ Y ❒ N

Please Explain: _____

Have you ever felt guilty about your alcohol or drug use? ❒ Y ❒ N

_____

Have you ever felt annoyed when someone spoke to you about your alcohol or drug use? ❒ Y ❒ N

_____

Have you ever used alcohol or drugs first thing in the morning? ❒ Y ❒ N

_____

Have you ever tried to cut down on your drug/alcohol use and been unable to do so? ❒ Y ❒ N

_____

Have you been through any programs to treat substance abuse or addiction? ❒ Y ❒ N

Please list programs:

1. _____
2. _____
3. _____
4. _____

C= Current Use P= Past Use Please describe use on line provided.

C P

❒ ❒ Alcohol _____

❒ ❒ Nicotine _____

❒ ❒ Marijuana _____

❒ ❒ Cocaine / Methamphetamine _____

❒ ❒ Opiates _____

❒ ❒ Hallucinogens _____

❒ ❒ Prescription sleeping pills or tranquilizers _____

❒ ❒ Steroids _____

❒ ❒ Other _____

Sleep Behavior: (describe any yes answers)

Any problems falling asleep? ❒Yes ❒ No _____

Any problems staying asleep? ❒ Yes ❒No_____

Any problems waking up? ❒Yes ❒ No _____

On average, how many hours do you sleep at night? _____

History of sleep apnea ❒ Yes ❒ No _____

Do you snore ❒Yes ❒No _____

Do you or have you had sleep walking ❒Yes ❒No _____
Do you have frequent nightmares ❒Yes ❒No _____
Do you grind teeth during sleep ❒Yes ❒No _____

Diet and Exercise History**:**
Would you consider your diet mostly healthy or unhealthy? _____
Any food allergies or sensitivities? _____
Are you on a restricted diet? ❒Yes ❒ No Describe: _____
Caffeine consumption per day (chocolate, coffee, tea, soda…): _____
Sugar consumption per day: _____
Describe your current bowel function: ❒Normal ❒Constipated ❒ Loose ❒Diarrhea
Describe your current exercise routine: _____
Do you consider yourself to be over or under weight ❒Underweight ❒Overweight ❒Neither
What is your ideal weight? _____
How long have you struggled with your weight issues? _____
What weight loss measures have you tried? _____
_____

Cultural and Ethnic Background: _____

Describe Yourself _____

Describe Your Strengths _____

Describe Your Weaknesses _____

Describe Your Friendships _____

Interested in Christian Counseling? ❒Yes ❒No ❒Maybe, please tell me more about it.

Please use this space to let me know anything else about yourself that you would like me to know:
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____
Patient Signature Date