Sophia Robinson, Psy.D.

Clinical Psychologist
PSY 14286

YOUNG 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 messages on one of your phones? ❒ Y ❒ N
If yes, which phone(s) ❒ Home ❒ Cell ❒ Work

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

With whom are you residing?

- ❒ Both Biological Parents
- ❒ Biological Mother Only
- ❒ Biological Father Only
- ❒ Adoptive Parents (Age at Adoption _____)
- ❒ Maternal Grandparents
- ❒ Paternal Grandparents
- ❒ Biological Mother and Step Father
- ❒ Biological Father and Step Mother
- ❒ Other _____

Mother's Information:
Name: _____ DOB: _____
Address (if different than patient's) _____
Phone: H: _____ Cell: _____ Work: _____
Email: _____
Father's Information:
Name: _____ DOB: _____
Address (if different than patient's): _____
Phone: H: _____ Cell: _____ Work: _____
Email: _____

Note: Parent's will not be contacted by Dr. Robinson without patient consent which will be obtained on a separate form if patient and therapist feel it would be helpful for Dr. Robinson to contact one or both of them.

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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(s):
#1 ❒ Mild ❒ Moderate ❒ Severe ❒ Very Severe
#2 ❒Mild ❒ Moderate ❒ Severe ❒ Very Severe
#3 ❒ Mild ❒ Moderate ❒ Severe ❒ Very Severe

School History**:**
Currently in College? ❒Y ❒N If yes, what is current year in college? _____
Highest High School Grade or College Grade Completed_____
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 _____
Typical Grades Received: _____

Employment History:
Patients 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 History:
Current Marital Status: _____ If not married, are you currently in a relationship? _____
Length of Current Relationship (Marital or other) _____
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. _____

Children/Stepchildren (names/ages & brief statement on your relationship with the child/adult):
1. _____
_____
2. _____
Siblings (name/age, brief statement about the relationship, and if deceased: age/cause of death):
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:

Current Primary Care Doctor: (Name/ city/phone)

_____

Specialists (Name and Specialty):

_____

Describe Any Serious Medical Conditions

_____
_____

Surgeries (Age, Type of Surgery, Outcome):

_____
_____
_____

Accidents / Falls/ Head Injuries:

_____

Allergies/Asthma:

_____

Chronic Ear Infections/tubes:

_____

Ear/ Hearing Problems:

_____

Eye/Vision Problems:

_____

Accident Prone/ Clumsy/ Coordination Problems:

_____

Appetite/ Eating Problems:

_____

Current Medications (Name, Dosage, Issue for which each medication is prescribed and Dr's name):

1._____
2. _____
3. _____

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

_____

_____

_____

USE OTHER SIDE OF THE PAGE FOR MORE INFORMATION ABOUT THERAPY

Psychiatric Hospitalizations (specify month/year or your age at the time, number of days in hospital, 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. _____

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

C	**P**	
❒	❒	Alcohol (describe use) _____
❒	❒	Nicotine _____
❒	❒	Marijuana _____
❒	❒	Cocaine / Methamphetamine _____
❒	❒	Opiates _____
❒	❒	Hallucinogens _____
❒	❒	Prescription sleeping pills or tranquilizers _____
❒	❒	Steroids _____
❒	❒	Other _____

Sleep Behavior:
Any problems falling asleep? _____
Any problems staying asleep? _____
Any problems waking up? _____
On average, how many hours do you sleep at night? _____
Any history of sleep apnea, snoring, sleep walking, recurrent dreams, sleep bruxism (grinding teeth)?
_____
_____
_____

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 If yes, describe: _____
Caffeine consumption per day (chocolate, coffee, tea, soda…): _____
Sugar consumption per day: _____
Describe your current bowel function: _____
Describe your current exercise routine: _____
Do you consider yourself to be over or under weight? _____
What is your ideal weight? _____

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 that.

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

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____
Patient Signature Date: