Place sticker here

stepping stones psychiatric care

Initial Client Assessment for Adults/Adolescents/Children

Presenting Information and Current Symptoms:

What are the main reasons you are seeking psychiatric treatment?

_____

_____

When did the problem(s) first begin?

_____

_____

Please list your current symptoms that you feel are problematic or inhibit you from living your daily life.

_____

_____

Please indicate if any of the following medical and psychiatric symptoms are present (P), or not present (NP):

Convulsions/Seizures	P	NP	Allergies	P	NP	Sadness/Moodiness	P	NP
Vision Problems	P	NP	Chronic Pain	P	NP	Anxiety	P	NP
Nausea/Vomiting	P	NP	Dizziness/Fainting	P	NP	Hyperactivity	P	NP
Constipation/Urinary problems	P	NP	Thyroid Problems	P	NP	Inattentiveness	P	NP
Arthritis	P	NP	Sexually Transmitted Disease	P	NP	Obsessive/Compulsive Behavior	P	NP
Hallucinations	P	NP	Asthma	P	NP	Irritability/Anger	P	NP
Social Discomfort	P	NP	Cough/Asthma	P	NP	Homicidal/Suicidal Thoughts	P	NP
Poor Memory/Confusion	P	NP	Hearing Problems	P	NP	Sleep Problems	P	NP
Panic Attacks	P	NP	Diabetes	P	NP	Paranoia	P	NP
Addiction	P	NP	Headaches	P	NP	Mood Swings	P	NP

Does the patient have any allergies?

Food: _____

Drug: _____

Seasonal/Environmental Allergies:_____

Other Allergy (please explain): _____

Place sticker here

Personal Medical/Surgical History:

Do you have any **current** or **past** medical conditions? Please explain.

_____

_____

Please list any surgeries the patient has had in their lifetime, and indicate dates if possible.

_____

_____

Have you experienced any traumatic injuries/accidents? If yes, please explain and include dates if possible.

_____

_____

Please indicate if the patient has taken any of the following psychoactive medications or is currently being prescribed them by another practice. In the blank box next to the medications, please indicate an "H" for Helpful, and "NH" for not helpful, for each medication the patient has previously tried. If the medication has not been tried by the patient, please leave the box blank.

Mood Stabilizers	**Currently Taking (C) Or Past Medication (P)**	**Helpful (H) or Not Helpful (NH) Please circle**	**Medication Dose**	**Side Effects Experienced or circle "None"**
Geodon	C P	H NH		None
Abilify	C P	H NH		None
Depakote	C P	H NH		None
Risperdal	C P	H NH		None
Seroquel	C P	H NH		None
Lithium	C P	H NH		None
Tegretol	C P	H NH		None
Haldol	C P	H NH		None

Anti-Depressants	**Currently Taking (C) Or Past Medication (P)**	**Helpful (H) or Not Helpful (NH) Please circle**	**Medication Dose**	**Side Effects Experienced or circle "None"**
Trazodone	C P	H NH		None
Zoloft	C P	H NH		None
Prozac	C P	H NH		None
Cymbalta	C P	H NH		None
Celexa	C P	H NH		None
Lexapro	C P	H NH		None

Stimulants	**Currently Taking (C) Or Past Medication (P)**	**Helpful (H) or Not Helpful (NH) Please circle**	**Medication Dose**	**Side Effects Experienced or circle "None"**
Ritalin	C P	H NH		None
Adderall	C P	H NH		None
Concerta	C P	H NH		None
Vyvanse	C P	H NH		None
Straterra	C P	H NH		None

Other Psychiatric Medications				

Please list all non-psychiatric medications currently taken by the patient:

_____

_____

Does the patient have a family history of any medical conditions? Please explain.

_____

Family Psychiatric History:

Are the following members of your family currently or have previously been treated for any psychiatric conditions?

Mother: _____

Father: _____

Siblings: _____

Is there a family history of suicide or attempted suicide? Yes ☐ No ☐ If yes, please explain:

_____

_____

Are you experiencing conflict within your family? Yes No (Please circle) If yes, please explain:_____
_____

Patient Psychiatric History:

Are you currently participating in any psychiatric care at another facility? Yes ☐ No ☐
If yes, where and what service? _____

Do you have a previous history of psychiatric care that you are no longer participating in? Yes☐ No☐
If yes, please explain:

_____

_____

Please list any previous Psychiatrists, Psychologists, or Therapists that the patient has seen:

Name or Facility	Dates Seen (mm/yy-mm/yy)	Medications Prescribed	Hospitalized? (yes/no, location)

Place sticker here

Social History:

Please detail the Patient's circumstances for the following:

Gender Identity: ☐Female ☐Male ☐ Transgendered ☐ Other:_____

Sexual Orientation: ☐Gay ☐Lesbian ☐Queer ☐Bisexual ☐Heterosexual ☐Pansexual ☐Other:_____

Marital History: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Children: ☐ No Children ☐ Children

Living Situation: ☐ Living Dependently ☐ Living Independently ☐ Homeless

Support System (Family, friends, etc.): _____

Military History: ☐Never in Military ☐Military Experience If yes, what branch?_____ Do you have combat related trauma?_____

Are you financially secure (do you have food, shelter, water, clothes, ect)? Yes No (If no, please explain:_____ _____)

Are you employed? Please circle one: Full-time Part-time Disability Retired In school Recently lost job Other:_____

If employed, what do you do for a living? _____

Do you have any current legal charges? ☐No ☐Yes

If yes, are you:

Currently on Probation? ☐No ☐Yes

Court ordered for Psychiatric Treatment? ☐No ☐Yes

Have an upcoming hearing? ☐No ☐Yes

Registered on Megan's Law? ☐No ☐ Yes

Education (Level achieved/performance) Please circle one: Elementary Highschool Trade School Some College College Degree

If the patient is enrolled in elementary school, middle school, or highschool, please answer the following questions. If the patient is not enrolled in any of the above, please skip this section and move on to "History of Abuse and Traumatic Events".

Marital status of parents: _____If parents are separated/divorced, how old was child at time of separation? _____

With whom does the child live? _____

Custody: ☐Lives in one home with both legal parents. ☐Mother has physical custody.
☐Father has physical custody. ☐Physical custody is shared. ☐Other: _____

List all people living in household:

Name	Age	Relationship to child

Place a check next to any behavior or problem that your child currently exhibits.

____ Has difficulty with speech
____ Has difficulty with hearing
____ Has difficulty with language
____ Has difficulty with vision
____ Has difficulty with coordination
____ Prefers to be alone
____ Does not get along well with other children
____ Is aggressive
____ Is shy or timid
____ Has poor bowel control (soils self)
____ Is more interested in things (objects) than in people
____ Engages in behavior that could be dangerous to self (describe) _____

____ Has frequent tantrums
____ Has frequent nightmares
____ Has trouble sleeping (describe) _____
____ Has blank staring spells
____ Rocks back and forth
____ Bangs head
____ Holds breath
____ Eats poorly
____ Is stubborn
____ Is much too active

How do you describe the child's friendships:
☐No Friends ☐Only Acquaintances ☐Both acquaintances and close friends

School: _____ Grade: _____
Place a check next to any educational problem that your child currently exhibits:
Check Check
_____ Has difficulty with reading
_____ Has difficulty with arithmetic list) _____
_____ Has difficulty with spelling _____
_____ Has difficulty with writing
_____ Does not like school
Is your child in a special education class? Yes _____ No _____
If yes, what type of class? _____

Has your child been held back in a grade? Yes _____ No _____
If yes, what grade and why? _____

Has your child ever received special tutoring or therapy in school? Yes _____ No _____
If yes, please describe: _____

Has your child ever been suspended or expelled? Yes _____ No _____
If yes, please describe: _____

Has, or is, your child experiencing bullying? Yes_____ No_____ If yes, please explain:_____
_____

History of Abuse and Traumatic events (Please circle Y or N):

Physical Abuse: Yes No

Emotional Abuse: Yes No

Sexual Abuse: Yes No

Domestic Violence: Yes No

Witnessed Domestic Violence: Yes No

Witnessed a traumatic event: Yes No

Neglect: Yes No

Experienced a death of a loved one: Yes No

If yes to any of the above, is the abuse (please circle): In the past or Current or Both

Do you feel safe in your current living situation? Yes No If you answered no, please explain:_____
_____

If you answered "yes" to any of the above abuse questions, please answer the following questions.

* Have you had any unwanted memories of the traumatic event while you were awake? Yes No
* Have you experienced any unpleasant dreams about the traumatic event? Yes No
* Have there been times when you suddenly acted or felt as if the traumatic even were actually happening again? Yes No
* Have you gotten emotionally upset when something reminded you of the event? Yes No
* Have you had strong negative beliefs about yourself, other people, or the world? Yes No
* Have you blamed yourself for the traumatic even or what happened as a result of it? Yes No
* Have you had any strong negative feelings, such as fear, horror, anger, guilt, or shame? Yes No
* Have you been less interested in activities that you used to enjoy? Yes No
* Have you been especially alert of watchful, even when there was no specific threat or danger? Yes No
* Have you had any strong startle reactions? Yes No
* Have you had any problems with concentration? Yes No
* Have you had any problems falling asleep? Yes No

Have you experienced a recent loss? Yes No
If yes, please briefly explain the loss:_____

If there anything else that you feel I should know regarding your trauma history: Yes No
If yes, please explain: _____

History of Substance Abuse:

Has the patient **previously or is the patient currently** abusing any of the following substances? Please note, this information is protected and will not be shared without written consent from the patient.

Substance Type	**Current Use (Last 6 Months)**			**Past Use**		
	Y	N	Frequency/Amount	Y	N	Frequency/Amount
Alcohol						
Tobacco						
Marijuana						
K2/Spice						
Cocaine/Crack						
Ecstasy						
Methamphetamines						
Pain Medication/Rx Meds						
Inhalants						
Heroin						
Xanax/Valium/Klonopin						
PCP/LSD						
Steroids						
Tranquilizers						
Other:						

Do you use tobacco? Yes No (If yes, what do you use and how often:_____)
Do you have a history of overdose? Yes No (If yes, when and with what substance:_____)

Place sticker here

Do you have a history of withdrawal symptoms? Yes No (If yes, what substance and what symptoms:_____
_____)
Do you have a history of withdrawal seizures? Yes No (If yes, when:_____)
Do you have a history of sharing needles? Yes No
Have you ever been to an inpatient detox unit? Yes No (If yes, where and when:_____)

Does anyone important to you believe you a problem with substances? Yes No (If yes, please briefly explain:_____
_____)

Have you ever participated in outpatient drug and alcohol tx? Yes No (If yes, where and
when:_____)
Have you ever been to an inpatient rehab? Yes No (If yes, where and when:_____)

Developmental History:

Has the patient ever been diagnosed with a learning disability? ☐ Yes ☐ No
If yes, please explain:

_____

_____

Does the patient have problems reading and/or writing? ☐ Yes ☐ No

If yes, please explain:
_____

_____

Are the patient's motor skills inhibited in any way? If yes, please explain:

_____

Did the patient reach all developmental milestones at age appropriate at appropriate times (i.e.: crawling, talking, toilet training)?

_____

Is there anything else that you feel I should know about you before engaging in treatment? Yes No
If yes, please explain:_____
_____
_____

The patient/authorized parent or guardian authorizes that the information provided in this document is true to the best of my knowledge, but also retain the ability to modify my response at any time. The clinician understands that this information may change at any time.

_____ _____
PRINTED name of Patient or Authorized Parent/Guardian Date

_____ _____
SIGNATURE of Patient or Authorized Parent/Guardian Date

_____ _____
SIGNATURE of Clinician Date

Place sticker here