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New Patient Evaluation and Self-Assessment Form

Please fill out the following confidential intake form prior to your first appointment with Dr. Barts. By answering these questions accurately and thoughtfully, you will be helping set the therapeutic process in motion. If you are uncomfortable answering any of these questions, please feel free to leave them blank; we can discuss them in more detail at our initial evaluation.

Purpose of Consultation. Please describe your reasons for seeking treatment at this time:

Current Problems. Please describe the key problems for which you are currently seeking treatment, and when they began. Please feel free to note situations that are difficult for you, as well as problematic moods, thoughts, and behaviors.

Your Living Environment
With whom do you currently live? Do you live in a house, apartment, etc.?

Who are the most emotionally supportive people in your life?

How would you describe your friendship network? Do you have friends you feel close to? Do they live locally?

What are typical things you do for pleasure or enjoyment, and how often?

Are there any other factors that contribute to your difficulties (e.g., job, financial difficulties)?

Medical History, Allergies
Please describe your current physical health, and any significant past medical problems and treatments

Last PCP visit:
Allergies:
Do you wish to have your PCP contacted or involved in your mental health treatment?

Medications. Please list all medications you are currently taking:

Medication	*Dosage*	*Reason for taking the medication*

Who currently prescribes your psychiatric medications?

Which psychiatric medications have you been on in the past?

Presenting Symptoms: Please check any symptoms that may pertain to you:

□ Depressed or sad mood
□ Difficulty enjoying usual activities
□ Unintentional weight loss or weight gain

□ Sleeping too much or not enough

□ Feeling agitated or sluggish
□ Lacking energy/always tired

□ Feeling guilty or worthless
□ Poor focus and concentration
□ Thoughts of death or suicide
□ Inflated self-esteem
□ Decreased need for sleep or going for days without sleeping

□ Excessive talking
□ Racing thoughts
□ Feeling highly distractible
□ Try to do or accomplish way too much in a day
□ Impulsive behavior
□ Seeing or hearing things that may not be real
□ Feeling like people are watching you or out to get you
□ Often tense or unable to relax
□ Excessive worrying
□ Panic Attacks
□ Afraid/unable to leave home
□ Extreme unreasonable fears
□ Intense fear of social situations
□ Cannot prevent repetitive thoughts
□ Cannot prevent repetitive behaviors
□ Intrusive, upsetting memories of past events
□ Always on guard or never feel safe
□ Body overreacts to "stress"

Life Problems That Currently Affect You:

□ Problems within my family
□ Problems among my friends/community

□ Educational problems
□ Occupational/Job problems
□ Housing problems
□ Financial/Economic problems

□ Problems with the law, legal system
□ Destructive/violent thoughts or behaviors

□ Attempts to hurt, harm, or mutilate self

□ Anger outbursts
□ Discipline problems at work
□ Careless, high-risk behavior

Mental Health Treatment History
Please describe your past experiences in inpatient or day hospital programs:

Facility/program	*Dates of treatment (start – end dates)*	*Type of program*	*Reasons for treatment*

Please describe your past experiences in outpatient treatment using the categories below:

Therapist and Dates (start – end dates)	*Approx. # of sessions*	*Reasons for seeking treatment*

History of Suicidal Feelings
Many people think about suicide on occasion. Have you had times in life where you were thinking a lot about suicide? If so, please briefly describe when, what seemed to be triggering the thoughts, and whether you made a suicide attempt or a suicidal gesture.

Substance Use and Addictive Behaviors
How often and how much do you drink alcohol?

Do you believe your alcohol use may be a problem?

Do you believe you have ever had a problem with alcohol use? If so, when?

How often and how much do you use other non-prescribed drugs?

Do you believe that drug use may be a problem?

Do you believe you have ever had a problem with drug use? If so, when?

Do you struggle with addictive behaviors such as using tobacco, gambling, pornography, food, etc.?

Other Symptoms Below is a list behaviors and issues that are cause for concern to some adults. Please mark with an "✖" next to items that you think might apply to you presently, and a "✓" next to items that might've been present in the past. At the end of the list there is space to enter any additional issues or concerns that you might have.

- ☐ Aggression/violence
- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Domestic violence
- ☐ Anxiety/panic
- ☐ Sexual dysfunction
- ☐ Parenting issues
- ☐ Suicidal thoughts/gestures
- ☐ Marital problems
- ☐ Relationship problems
- ☐ Difficulty at work
- ☐ Financial problems
- ☐ Career-related problems
- ☐ Homicidal thoughts/gestures
- ☐ Sadness/depression
- ☐ Loss of appetite
- ☐ Sleep difficulty
- ☐ Attention/concentration
- ☐ Overeating
- ☐ Weight gain/loss
- ☐ Eating disorder
- ☐ Excessive worry
- ☐ Difficulty trusting others
- ☐ Low self-esteem
- ☐ Physical pain/discomfort
- ☐ Medical issues
- ☐ Issues with elder parents
- ☐ Lack of joy/satisfaction in life
- ☐ Social withdrawal/isolation
- ☐ Stress
- ☐ Loneliness
- ☐ Feeling disorganized
- ☐ Problems with employer/co-worker/employee
- ☐ Alcohol
- ☐ Marijuana
- ☐ Cocaine
- ☐ Prescription drugs
- ☐ Other illicit substances
- ☐ Restlessness/fidgety
- ☐ Negativity
- ☐ Difficulty forgiving
- ☐ Nightmares
- ☐ Unemployment
- ☐ Feeling tired/fatigued
- ☐ Hopelessness
- ☐ Easily distracted
- ☐ Anger
- ☐ Self-injury (cutting, burning, scratching, pulling out hair)
- ☐ Hyperactivity
- ☐ Guilt
- ☐ Obsessive thoughts/fears
- ☐ Chronic headache
- ☐ Difficulty making decisions
- ☐ Poor judgment
- ☐ Overly concerned about what other people think
- ☐ Irritability
- ☐ Trouble with authority
- ☐ Legal problems/court involvement
- ☐ Separation/divorce
- ☐ Mood swings
- ☐ Overly sensitive
- ☐ Frequent conflicts with others
- ☐ Difficulty accepting/making changes
- ☐ Risky/dangerous behavior
- ☐ Few friends
- ☐ Smoking
- ☐ Inappropriate/uncomfortable sexual thoughts/urges
- ☐ Cruelty/neglect of pets
- ☐ Issues from childhood
- ☐ Codependency (partner's substance abuse)
- ☐ Confusion
- ☐ Feeling spacey/detached from one's surroundings
- ☐ Crying spells
- ☐ Adultery/infidelity
- ☐ Feeling empty/dissatisfied
- ☐ Feeling like a failure
- ☐ Body image
- ☐ Gambling
- ☐ Phobias (germs, heights, confined places, etc.)
- ☐ Loss/grief due to death
- ☐ Impulsiveness
- ☐ Compulsive behaviors (hand-washing, checking, etc.)
- ☐ Housework/home maintenance
- ☐ Feelings of inferiority
- ☐ Trouble taking responsibility
- ☐ Menstrual problems, PMS, menopause
- ☐ Lack of motivation
- ☐ Children with special needs
- ☐ Perfectionism
- ☐ Religion/spirituality
- ☐ Bad temper
- ☐ Self-control
- ☐ Procrastination

Family History. Has anyone in your family had significant medical difficulties or illnesses (either acute, such as surgery or a heart attack, or chronic, such as diabetes or heart disease)? If so, please describe.

Psychosocial and Developmental History
Where were you born and raised?

Can you briefly describe your family growing up?

What was your school experience like? What were your relationships with peers like?

Were you sexually, physically, or emotionally abused at any point in your life?

Have you had any other significant life changing events or traumas that affected you either negatively or positively?

Does anyone in your family struggle with emotional difficulties or mental illness? If so, please describe.

Other Things I Should Know Please describe anything else that is important to know in understanding your life and your difficulties.

Goals. Please take a moment and review the issues or problems you have noted on this questionnaire. Which three concerns would you most like to have addressed in your treatment? What criteria would be helpful to gauge progress by?

1.

2.

3.