PSYCHIATRIC EVALUATION - MEDICATION EVALUATION

OFFICE USE :
Date of Eval: _____ Time:(start)_____ (end)_____ CPT _____ _____ _____ _____
Referred by:_____ DSM DX _____ _____ _____ _____

SECTION I: TO BE COMPLETED BY PATIENT/PARENT/GUARDIAN
Directions: *Answer questions the best you can. If unsure just leave blank. Where appropriate just place an "X" in the □*

Name of person completing form: _____ Self □Y□N Legal Guardian □Y□N
(Copy of Legal Custody Papers are Required to be o file in this office) □Y □N Relationship to patient: _____

PATIENT LEGAL NAME _____
Nickname_____ **AGE**_____ **DOB**_____ **SS# (last 4 digits)** _____
Complete Address _____**Zip Code** _____
Cell Phone _____ **Email** _____
Do you give permission to call/text □Y□N; email you □Y□N (*note: neither text nor email can insure confidentiality)

Are you here for Meds Only □Y □N **Meds and Therapy** □Y □N **Therapy Only** □Y □N **Second Opinion** □Y □N

Employment of Parent if patient is minor (title/where/how long):_____
Employment of Patient if appropriate _____
Do you feel you are currently being successful in workplace? □Y □N □Not applicable
Problematic Issues _____

School (where, grade, major)_____
Do you feel you are currently being successful in school? Yes___ No___ Problematic Issues _____
Do you need any special accommodations (Ex: extended test times etc)_____

Relationship Status (how many times married/divorced/significant other) _____
Spouse/partner's name? _____
Sexual Preference _____ Gender Identification _____ Preferred Pronoun: _____

CHILDREN: NAME(S) □ NONE	Age		Primary Residence
		Biological □Y □N Adopted □Y □N at age _____	
		Biological □Y □N Adopted □Y □N at age _____	
		Biological □Y □N Adopted □Y □N at age _____	

SIBLINGS: NAME(S) □ NONE	Age		Residence
		Biological □Y □N Adopted □Y □N at age _____	
		Biological □Y □N Adopted □Y □N at age _____	
		Biological □Y □N Adopted □Y □N at age _____	

Others living in the home: _____

Primary Healthcare Provider's Name _____Phone_____
Approximate Date Last Physical: _____ Date of last lab work? _____

Do you have a release of information on file with your current therapist or healthcare provider to speak with me or share information electronically? □Y □N □N/A ROI signed today □Y □N for _____

*****PRENATAL AND DEVELOPMENTAL HISTORY (IF PATIENT IS A MINOR)*****

Planned pregnancy □Y □N Prenatal care □Y □N Problems during pregnancy or delivery □Y □N
Specify_____ Apgars ____/____ Unsure □

During pregnancy did you experience more than usual stress or any physical or emotional trauma? □Y □N Specify if Yes _____ Cigarettes □Y □N Alcohol □Y □N Drug use □Y □N Specify _____
Between birth and age 3, were you or others concerned about your child's development? □ Yes □ No □ Unsure
If "Yes", please describe: _____

Does/Is your child:
Walk without holding on? □Y Age learned ____ ; □N Use single words? □Y Age learned ____ ; □N
Use phrases to talk? □Y Age learned ____ ; □N Toilet trained? □Y Age learned ____ ; □N

Did your child ever lose skills he or she once had (for example, learned words then stopped talking)? □Yes □No; If Yes please describe:_____

Why are you here today? (Chief Complaint) _____
_____
_____

What made you decide to seek help for this problem NOW? _____
_____
What are your goals for this appointment today? _____
_____
_____

Regarding the reason you came today, please answer the items below the best you can.
Onset: When did this problem first start? _____
Location: Is there any particular place you feel this in your body □Y □N (i.e. chest, neck, stomach, head?)
_____
Duration: How long has this problem been going on? _____ Have you ever had this problem before? □Y □N
Characteristics or Aggravating Factors: Are there any certain qualities to this problem or things that make it feel worse? □Y □N Specify _____
Relieving Factors: Is there anything that makes it feel better? □Y □N Specify _____
Time: How long does this problem usually last? _____ Is it off and on □Y □N OR there all the time □Y □N
Is there any time of day it is better or worse? (Be as specific as possible) _____

Severity of Symptoms: On a scale of 1-10 with "1" being the best or least problematic and "10" being the worst or most problematic: How would you rate **this problem/discomfort today?** 1-10 _____
How would you rate it over the **past 2-3 weeks**? 1-10____How would you rate it over the **past 3 months**? 1-10 _____

PSYCHIATRIC SYMPTOMS CHECKLIST	N= NEW O=OLD C=CONTINUOUS R=RECURRING
□Anxiety □N □O □C □R	□Fidgety □N □O □C □R
□Fears □N □O □C □R	□Paranoia □N □O □C □R
□Worries □N □O □C □R	□Too much energy □N □O □C □R
□Panic Attacks □N □O □C □R	□Too little energy □N □O □C □R
□Depressed □N □O □C □R	□Sleep too much □N □O □C □R
□Moodiness □N □O □C □R	□Attention problems □N □O □C □R
□Obsessions □N □O □C □R	□Lack of Pleasure □N □O □C □R
□Compulsions □N □O □C □R	□Sexual Concerns □N □O □C □R
□Agitation □N □O □C □R	Other: _____ □N □O □C □R
□Irritability □N □O □C □R	Other: _____ □N □O □C □R
□Insomnia □N □O □C □R	

Have you been treated in the past or are currently treated for this symptom? □Y □N If past, how long ago?_____

Have you had a positive or negative experience with therapy in the past? _____
Past therapist □Y □N Name:_____ Phone _____ ROI □Y □N
Current Therapist □Y □N Name:_____Phone _____ ROI □Y □N

Overall, on a scale of 1(low or worst)-10 (high or best) - **in general** how would you rate your **"overall sense of well being"** today__, over past 2-3 weeks___, 2-3months___, past year?____
When was the last time you felt "good"? _____
What has changed since then and when? _____

If you went to sleep tonight and woke up tomorrow and a "**Miracle"** happened that fixed everything for you, what would your life look like for you? What would be different?

_____
_____

If I had a magic wand what **ONE problem or symptom** would you like me to "fix or change for you **TODAY**?

_____

If you had **any 3 wishes** what would they be?

_____
_____
_____

***Please be as specific as possible on the *Medical* and *Psychiatric* Family History Sections.**

Family *Medical* History: (i.e. heart disease, diabetes, high blood pressure, high cholesterol, cancer, asthma etc.)
*Please note age and if still living. Directions: **Put an X in the box and specify under appropriate column**

MEDICAL HISTORY: FAMILY	CHILDREN	SIBLINGS	MATERNAL FAMILY (MOTHER, GRANDMOTHER, GRANDFATHER, AUNTS UNCLES, COUSINS)	PATERNAL FAMILY (FATHER, GRANDMOTHER, GRANDFATHER, AUNTS UNCLES, COUSINS)
□ Diabetes				
□ High Blood Pressure				
□ High Cholesterol				
□ Heart Attack				
□ Stroke				
□ Cancer				
□ Other				

Family *Mental Health* History: (i.e. depression, anxiety, panic, PTSD, alcoholism, drug addiction, bipolar (manic depression), schizophrenia, obsessive compulsive, dementia,alzheimer's, other) *Please note age and if still living. *(If you need more room please use back of this page)

PSYCHIATRIC HISTORY: FAMILY	CHILDREN	SIBLINGS	MATERNAL FAMILY (MOTHER, GRANDMOTHER, GRANDFATHER, AUNTS UNCLES, COUSINS)	PATERNAL FAMILY (FATHER, GRANDMOTHER, GRANDFATHER, AUNTS UNCLES, COUSINS)
□ Depression				
□ Anxiety				
□ Panic attacks				
□ Bipolar				
□ Schizophrenia				

PSYCHIATRIC HISTORY: FAMILY	CHILDREN	SIBLINGS	MATERNAL FAMILY (MOTHER, GRANDMOTHER, GRANDFATHER, AUNTS UNCLES, COUSINS)	PATERNAL FAMILY (FATHER, GRANDMOTHER, GRANDFATHER, AUNTS UNCLES, COUSINS)
□ ADHD				
□ PTSD				
□ OCD				
□ Eating Disorders				
□ Schizophrenia				
□ Asperger's				
□ Autistic Spectrum				
□ Addiction □ Substance Abuse □ Dependence				
□ Borderline				
□ Other				
□ Hospitalized				

Personal Health: Psychiatric and General Medical Conditions and Medication History

CURRENT OR PAST PSYCHIATRIC CONDITIONS/DIAGNOSIS	1.HAVE YOU EVER: BEEN HOSPITALIZED FOR PSYCH CONDITION Y□ N□ 2.DONE IOP FOR PSYCH CONDITION(S) Y□ N□ MORE THAN ONCE? Y□ N□ #TIMES _____ WHERE_____ DATE(S) _____ _____ _____ HOW LONG _____ VOLUNTARY Y □ N □	PERSONALITY DISORDERS OR TRAITS
□ Depression □ Anxiety □ Panic attacks □Agoraphobia □ Bipolar □ Post-partum dep □ ADHD Tested for ADHD Y□ N□ by: _____ _____ Other:_____ _____ _____ _____	□ PTSD □ OCD □ Anorexia □ Bulimia □ Schizophrenia □ Psychotic disorder □ Asperger's □ Autistic Spectrum □ Special learning needs □Y □N _____ _____ Accommodations □Y □N IEP □Y □N 504Plan □Y□ N □ Addiction/Substance Abuse/Dependence □ Conduct disorder □ Oppositional defiant □ Reactive attachment	□ Borderline □ Narcissistic □ Avoidant □ Dependent □ Paranoid □ Histrionic □ Antisocial □ Schizoid □ Schizotypal □ Obsessive compulsive □ Personality change due to medical condition □ Other _____ _____

History of Seizures Y□ N□ Head Injuries Y□ N□ Loss of Consciousness Y□ N□ Migraines Y□ N□_____

Eating Disorders (i.e. anorexia, bulimia etc.) Y□ N□_____ Specify: _____

ALLERGIES/SENSITIVITIES: Are you allergic or sensitive to any medications that you know of Y□ N□
List any medication(s) you are **allergic or sensitive** to: _____ _____ _____
Reaction(s) _____ Other allergies Y□ N□ _____ Latex Y□ N□ Epi-pen Y□ N□

Vital Signs if indicated: Height_____Weight_____BMI_____Waist Circumference_____Pulse_____B/P_____

REVIEW OF SYMPTOMS		
General Health- □ No Problems □ Weight loss or gain □ Fatigue □ Weakness □ Fever or chills □ Trouble sleeping	**Eyes-** □ No Problems □ Vision Loss/Changes □ Glasses or contacts □ Pain □ Redness □ Flashing lights □ Specks □ Glaucoma □ Cataracts □ Blurry or double vision	**Endocrine-** □ No Problems □ Head or cold intolerance □ Sweating □ Frequent urination □ Thirst □ Change in appetite
Head & Neck- □ No Problems □ Headache □ Head injury □ Neck Pain □ Lumps □ Pain □ Stiffness □ Swollen glands	**Neurologic-** □ No Problems □ Dizziness □ Fainting □ Seizures □ Weakness □ Numbness □ Tingling □ Tremor	**Skin-** □ No Problems □ Rashes □ Lumps □ Itching □ Dryness □ Color changes □ Hair and nail changes
Ears- □ No Problems □ Decreased hearing □ Ringing in ears □ Earache □ Drainage	**Nose-** □ No Problems □ Stuffiness □ Discharge □ Itching □ Hay fever □ Nosebleeds □ Sinus pain	**Hematologic (Blood Issues)-** □ No Problems □ Ease of bruising □ Ease of bleeding
Throat- □ No Problems □ Bleeding □ Dentures □ Sore tongue □ Dry mouth □ Sore throat □ Hoarseness □ Thrush □ Non-healing sores **Breasts-** □ No Problems □ Lumps □ Pain □ Discharge □ Self-exams □ Breast-feeding **Musculoskeletal-** □ No Problems □ Muscle or joint pain □ Stiffness □ Back pain □ Joint Redness □ Swelling □ Trauma	**Respiratory-** □ No Problems □ Cough □ Sputum □ Coughing up blood □ Shortness of breath □ Wheezing □ Painful breathing **Cardiovascular-** □ No Problems □ Chest pain/discomfort □ Tightness □ Palpitations □ Shortness of breath with activity □ Difficulty breathing lying down □ Swelling □ Sudden awakening from sleep with shortness of breath	**Vascular-** □ No Problems □ Calf pain with walking □ Leg cramping **Gastrointestinal-** □ No Problems □ Swallowing difficulties □ Heartburn □ Nausea □ Rectal bleeding □ Constipation □ Diarrhea □Yellow eyes or skin □ Change in appetite □ Change in bowel habits **Urinary-** □ No Problems □ Frequency □ Urgency □ Burning or pain □ Blood □ Incontinence □ Change in urinary strength
Other:	Other:	Other:
Past Surgery: Specify type/age	Past Surgery: Specify type/age	Past Surgery: Specify type/age

TRAUMA HISTORY & ADVERSE CHILDHOOD EXPERIENCES (ACE) Have you ever experienced any of the traumas listed below? *Please be specific and note age and duration of trauma event and if still occurring. Some of these may be occurring now or when you were a child.	Agency reports; Name of contact, results, & ref #'s
Physical Abuse ▫ Y ▫ N Age started _____ Duration of Abuse _____ Still Occurring ▫Y ▫N **Physical Neglect** ▫ Y ▫ N Age started _____ Duration of Abuse _____ Still Occurring ▫Y ▫N **Emotional Abuse** ▫ Y ▫ N Age started _____ Duration of Abuse _____ Still Occurring ▫Y ▫N **Emotional Neglect** ▫ Y ▫ N Age started _____ Duration of Abuse _____ Still Occurring ▫Y ▫N **Sexual Abuse** ▫ Y ▫ N Age started _____ Duration of Abuse _____ Still Occurring ▫Y ▫N **Bullying** ▫ Y ▫ N Age started _____ Duration of Abuse _____ Still Occurring ▫Y ▫N **Other** ▫ Y ▫ N Age started _____ Duration of Abuse _____ Still Occurring ▫Y ▫N	
Experienced or witnessed violence in family □ Y □ N Age started _____ Duration of Abuse _____ Still Occurring □ Y □ N Specifics _____ **Family Member Incarcerated** □ Y □ N **Hospitalized** □ Y □ N Relationship _____ Age of pt at time _____ Duration of incarceration/hospitalization _____ **Current relationship** □ Y □ N Specify _____ **Alcohol or drug abuse in household** □ Y □ N Age started ___Duration of Abuse _____ Still Occurring □ Y □ N	
Other:	

PAST psychiatric medications (name/dose/how long were you on/for what condition/ who prescribed/ what was positive or negative effects of this med)? _____ _____ _____

_____ _____ _____ _____ _____

All **CURRENT** Prescribed **PSYCH** Medications (dose/how long have you been on med/for what condition/ who prescribed/what has been the benefit or adverse effects)? _____ _____

_____ _____ _____ _____ _____

All **CURRENT** Prescribed **NON-PSYCH** Medications (dose/how long have you been on med/for what condition/ who prescribed/what has been the benefit or adverse effects)? _____ _____

_____ _____ _____ _____ _____

Current use of **herbal remedies/VITAMINS**/or **dietary supplements** (dose/duration/reason for taking)

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Describe Current Family/Social History: (current living situation, any legal/work/school or other issues)

_____

On a scale of 1(low) to 10 (high) how willing are you to take action to change some things in or for yourself in order to feel better? _____ Do you have any ideas what would be helpful to change? _____

Is there anything else you feel is important for the psychiatric provider to know about you or your situation in order to best help you? (Any secrets you have been afraid to share about what is going on with you? Any fears about discussing what is going on with you?)

_____

_____

Section II:

Sleep Hygiene: easy to fall asleep □Y □N; stay asleep □Y □N; early am awakening □Y □N; How do you get to sleep(bedtime routine) _____

average number hours of nightly sleep over past two weeks ____ ; what is norm ____; feel rested upon awakening □Y □N

What is the longest time you have gone without sleeping and felt OK? _____ When _____ What did you do?

_____

Appetite: □No problem Intentional Weight Gain □Y □N; Intentional Weight Loss □Y □N
Over what period of time did weight gain or loss occur? _____

Physical Energy: □No problem □ Exhausted (hard to do what needs to be done) □High Energy (plenty of energy to get things done) Specify_____

Mental Energy: □No problem □ Exhausted (hard to do what needs to be done) □High Energy (plenty of energy to get things done) Specify_____

Pleasure: (what do you do for fun? when is the last time you did something for fun? Do you have best friend/ friends?)_____
_____

Sex: Sexually active □Y □N; Desire □Y □N; Pleasurable □Y □N; Pain with intercourse □Y □N;
Ability to orgasm □Y □N; Masturbate □Y □N; Any concerns? _____
Possibly pregnant □Y □N; Last Period _____Menopause □Y □N; PMS □Y □ N; Andropause (males)□Y□N

Cognitive Functioning: Difficulties with concentration □ Y □ N; Focus □ Y □ N; Memory, □ Y □ N;
Decision making □ Y □ N; Reading □ Y □ N;

RISK ASSESSMENT: Violence toward self/others/objects/places

SUICIDE	HOMICIDE/VIOLENCE	SELF HARMING BEHAVIORS
▫ Ideation ▫ Plan ▫ Previous Attempt ▫ Weapons ▫ Access ▫ Passive thoughts of death/dying Specify	▫ Ideation ▫ Plan ▫ Previous Attempt ▫ Weapons ▫ Access Specify ▫ Assault of another ▫ Destruction of property Specify	▫ Cutting ▫ Burning ▫ Branding ▫ Other Specify
If you should ever think about suicide **what would stop you** from acting on it?	If you should ever think about harming someone else **what would stop you** from acting on it?	
Comment/quotes:	Comment/quotes:	Comment/quotes:

Have you ever destroyed property of self or someone else? □ Y □ N Specify_____
_____

Do you have a safety plan: □ Y □ N Specify _____

Resources Available: □Family □Friends □Community □Church □Spiritual □Other _____

Spiritual Beliefs/Religious Affiliation: _____

Therapist's Notes:

SUBSTANCE USE / ABUSE / DEPENDENCE HISTORY - *Current and past use of *non-prescription* or *prescription drugs/substances* (legal or illegal) **FOR ALL USED, LIST AGE STARTED AND STOPPED & IF PAST OR CURRENT USE. *Mark "X" in the □C □P by each substance. **Write in any substances used not listed.**

SUBSTANCES - PRESCRIPTION OR NON-PRESCRIPTION	
□ NICOTINE (cigarettes, gum, patches) age started ____ amount used/day _____ □C □P □ TOBACCO (other than cigarettes) age started ____ amount used/day _____ □C □P □ ALCOHOL age started ____ amount used/day _____ □C □P □ CAFFEINE (coffee,tea,mountain dew,red bull,energy drinks) age started ____ amount used/day _____ □C □P □ POT (marijuana) age started ____ amount used/day _____ □C □P □ COCAINE age started ____ frequency _____ □C □P □ METH age started ____ amount used/day _____ □C □P □ ECSTASY /□ MDMA age started ___ frequency _____ □C □P LSD age started ____ amount used/day _____ □C □P □ MUSHROOMS age started ____ frequency _____ □C □P □ STIMULANTS (speed)/adderall/ritalin/vyvanse/provigil age started ____ amount used/day _____ □C □P □ PAIN PILLS (oxycontin, opana, lortabs, percocets, vicodin) age started ____ amount used/day _____ □C □P □ BENZO'S (xanax-zanni bars/footballs)/ Klonopin (k-pins/valium/ativan/ age started ____ amount used/day _____ □C □P □ SLEEPING PILLS (ambien, restoril) age started ____ amount used/day _____ □C □P □ OTHER SYNTHETICS (spice, kratom, molly, other) age started ____ amount used/day _____ □C □P □ HEROIN □ MORPHINE/□DEMEROL □ DILAUDID age started ____ amount used/day _____ □C □P □ METHADONE □ SUBOXONE □ SUBUTEX age started ____ amount used/day _____ □C □P	□ COUGH SYRUP age__amt___freq__ □C □P □ TRIPLE C age___amt____freq_____ □C □P □ ROBITUSSIN age___amt___freq ___ □C □P □ DXM age___amt_____freq_____ □C □P □ NYQUIL age___amt_____freq_____ □C □P Other Meds: _____ _____ Related to any past or current use have you experienced any of the following: 1. Ever charged for any drug-related offenses □Y □N Specify_____ 2. Served time in jail/prison □Y □N Specify _____ 3. Overdosed □Y □N Specify _____ _____ 4. Any negative consequences or losses □Y □N Specify _____ 5. Have you ever been concerned about your own alcohol or substance use? □Y □N Specify_____ 6. Have any friends/family ever told you they were worried about your alcohol or substance use? □Y □N Specify _____ 7. Have you ever tried to stop using alcohol or substances? □Y □N Specify _____ 8. Hospitalization/Rehab/Detox □Y □N (Details) _____ _____ _____ _____ Therapist's notes:

******STOP HERE****** **The following section will be completed by the evaluator**

What question(s) should I have asked that I did not? _____

_____

SCREENING TESTS /SCORES: MDQ□__ Depression:PHQ9□__ Zung□__ SAD(gero)□__ Edinburgh Post-Natal□___ Yale-Brown OCD□___ Anxiety□___ Panic□___YMRS□___ ADHD□___ Test taking anxiety□___ PTSD□___ Other□ _____

Labs- □reviewed□ ordered □CBC □CMP □HbA1C □Thyroid w/TPO □Lipid Panel □Vit D □B12 □Folate □Ferritin □CRP □Homocysteine □Creatinine □Beta Hcg □PSA □Free & Total Testosterone □DHEA-S □Progesterone □Estradiol(E2) □Lithium □Depakote □Tegretol ____ □EKG □EEG □CT SCAN □MRI _____ □Sleep Study □UA □UDS □7 □12 Panel OTHER _____Directions for fasting or drug levels given □ Y □ N

MENTAL STATUS EXAM	***MENTAL STATUS EXAM***	***RISK ASSESSMENT SUMMARY***
Appearance- □ Casual dress, normal grooming & hygiene □ Other **Attitude/Response to Rapport-** □ Calm & cooperative □ Easily engaged □Hostile □ Uncooperative □Other **Behavior-** □ No unusual movements or psychomotor changes □ Other **Speech-** □ Normal rate/tone/volume/ □ Pressured □Loud □Soft □ Monotone □Slurred □Poverty □ Tangential □Other **Orientation-** □Oriented X3 □ Other **Memory/Concentration-** □ Short Term Intact □ Long Term Intact □ Distractible/Inattentive □ Other **Insight/Judgment-** □ Good □ Fair □ Poor **Impulse Control-** □ Good □ Fair □ Poor	**Affective Expression-** □ Full range displayed - appropriately □ Mood congruent □Labile □Depressed □Tearful □ Constricted □Blunted □Flat □Superficial □Other **Mood-** □ Euthymic □Anxious □Irritable □Angry □ Depressed □Elevated □Anhedonic □Other **Thought Process/Form-** □Goal-directed/Logical □Disorganized □Other **Thought Content-** **Suicidal ideation** □None □Passive □Active If Active: □ Plan □ Intent □ Means **Homicidal ideation** □None □Passive □Active If Active: □ Plan □ Intent □ Means **Specify if Duty to Warn**: □Y □N _____ □ Delusions □Paranoia □Phobias □Perseveration □ Obsessions/compulsions □Grandiosity □ Flight of ideas □Other **Perception-** □ No hallucinations or delusions during interview □Dissociation □Depersonalization □Other **Intelligence-** □ Appears WNL for age/education □Other: **Notes:** _____ _____ _____	□ **Preoccupations** **Suicidal Ideation** □None Currently □ Ideation history □ Previous attempt/s □ Current ideation □ Impulsiveness □ Viable plan □ Available means □ Settling of affairs **Hostile Intent** □None Currently □ Previous intimidation □ History of violence □ Current intent □ Impulsiveness □ Viable plan □ Available means **Other risk factors** such as alcohol or substance use: _____ _____ _____ **Intervention**: _____ _____ _____ _____

CURRENT DIAGNOSTIC IMPRESSION/PROVISIONAL DIAGNOSIS/ INCLUDE DIFFERENTIAL DIAGNOSIS:

Plan for treatment: (Therapy and Medications): □Individual □Family □Couples □Group _____
_____
_____
_____

Currently prescribed any **controlled substance**(s) □Y □N By other provider □Y □N **KASPER** □Y □N _____
Specify: _____
Medication(s) Started/Recommended:

Medication Plan Discussed □Y □N □N/A Usefulness of Medication and Possible Side Effects Reviewed □Y □N □N/A
Handout Given □Y □N WebMd.com □Y □N Other _____ Consent for off label (Age) □Y

PLAN for next appt: □Life event timeline □Child self pic □Letter writing □Past/Present/Future □Journal □Music
□Photography □Collage □Art □Energy Release □None at this time Other _____
_____

Other Referrals Given: □Psych Testing □PCP/Specialist □Other_____
Were goals of this initial appointment met? □Y □N Follow-up Appt: _____
Therapist's Notes: Miscellaneous: _____
_____
_____
_____
_____

Evaluation Completed By _____ **Date** _____

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