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## **Initial Evaluation Questionnaire**

### **Section 1: Basic Personal Information**

Name:

Maiden name (if applicable):

Today's Date:

Age:                      Date of Birth:

Street address:

City/State/Zip:

Home Telephone:

Work Telephone:

Cellular phone:

Email:

Do you mind if I communicate with you by email?

May I send you an occasional newsletter from the practice?

How did you learn about or get referred to my practice?

What is your current employment or educational status (working full-time, part-time, at home with children, in college, etc.)?

What do you do for work, if you do work?

Name of employer or school (if applicable):

Marital Status:

Please note immediate family members (spouse/partner, children, siblings, parents, etc.) using the categories below:

*Name:* \_\_\_\_\_ *Relationship to you:* \_\_\_\_\_ *Age:* \_\_\_\_\_ *Where do they live?*

Emergency Contact Person (and responsible person if you are under 18 years old):

Name:

Relationship to you:

Address:

Their home phone number:

Their work phone number:

Their cell phone number or pager:

**Please let us know if any of the above information changes (address, phone, email, etc.).  
Thanks!**

## Section 2: Current Problems and Life History

**Name:**

**Date:**

### **I. 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.

### **II. 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 environmental factors that contribute to your difficulties (e.g., financial difficulties)?

### III. Medical History

Please describe your current physical health:

Please describe any significant past medical problems and treatments (e.g., surgeries):

Do you currently have a primary care physician?

If not, would you like a referral to a primary care physician?

Primary Care Physician's Name, Address, and Phone (if applicable):

Do you wish to have your primary care physician contacted or involved in your mental health treatment?

Please list any psychiatric and nonpsychiatric medications you are currently taking using the categories below:

*Psychiatric:*

<u>Medication</u>	<u>Dosage</u>	<u>Reason for taking the medication (e.g., antidepressant)</u>
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*Nonpsychiatric:*

<u>Medication</u>	<u>Dosage</u>	<u>Reason for taking the medication (e.g., blood pressure)</u>
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Who currently prescribes your psychiatric medications?

Your prescriber's office address and phone number:

Please let me know if you would like me to consult with your medication prescriber at any point in treatment.

Which psychiatric medications have you been on in the past?

#### **IV. Mental Health Treatment History**

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

<i>Therapist or counselor</i>	<i>Dates of treatment (start – end dates)</i>	<i>Approx. # of sessions</i>	<i>Type of treatment (individual, etc.)</i>	<i>Reasons for seeking treatment</i>
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Please describe your past experiences in inpatient or day hospital programs:

<i>Facility/program</i>	<i>Dates of treatment (start – end dates)</i>	<i>Type of program</i>	<i>Reasons for seeking treatment</i>
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#### **V. 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.

## **VI. Other Symptoms**

How is your concentration?

How is your memory?

How is your appetite?

Have you gained or lost weight recently?

Is your appetite affected by emotional issues?

Do you have trouble falling asleep?

Do you wake up frequently during the night?

Do you wake up earlier in the morning than you would like?

Approximately how many hours of sleep do you get per night?

Are there any sexual issues that cause you concern?

Sexual interest is often affected by emotional issues and medications. Do you struggle with issues related to sexual interest?

## **VII. 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 nonprescribed drugs?

Do you believe your 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 other addictive behaviors such as using tobacco, gambling, pornography, food, etc.?

## **II. 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 mental illness? If so, please describe.

## **III. Other Things I Should Know**

Please describe anything else that is important to know in understanding your life and your difficulties.

**Thank you for completing this Questionnaire. It will be very helpful in developing an organized and effective treatment plan.**