The**ITM**Group

INTENSIVE TREATMENT MODALITIES
Ted Shaw, Ph.D. Alvin Butler, LMHC Harry Spears, LMHC
225 SW 7th Terrace
Gainesville, Fl. 32601
Tel: 352-379-2829 Fax: 352-379-2843

Jennifer Sager, Ph.D.

PRELIMINARY EVALUATION INFORMATION

Identifying Information **Date_____**

Client Name:_____
Address:_____City:_____State:____Zip:_____
Phone (H):_____ (W):_____Ext:_____
Date of Birth: _____/_____/_____ Sex: _____

Referred By:_____

Place of Employment / Occupation: Yours:_____
Partner/Spouse:_____

Highest grade level of education completed:_____
Degree achieved:_____

Presenting Problem

Please describe the problems that have led you to seek treatment or evaluation.
_____
_____

What do you believe to be the most important factor (s) causing the problem (s)?
_____
_____

When did you first notice these problem (s)?:_____

Have there been any family changes (new baby, death, breakup, etc.) which may be related to these problems?
_____Please explain:_____
_____

Prior Therapy Experience
Have you ever been seen for counseling or therapy? Yes_____ No_____

As an outpatient (clinic, private, etc.)
Name:_____Phone (____)_____
Address:_____City_____State_____Zip_____
For how long?_____Dates:_____
Name of doctor / therapist_____
Reason for treatment_____ ___

Name:_____Phone (____)_____
Address:_____City_____State_____Zip_____
For how long?_____Dates:_____
Name of doctor / therapist_____
Reason for treatment_____ ___

As an inpatient (in a hospital, residential treatment center, etc.)
Name_____Phone (____)_____
Address_____ City_____State_____Zip_____
For how
long?_____Dates:_____
Name of doctor / therapist_____
Reason for Admission_____ _____

Name_____Phone (____)_____
Address_____ City_____State_____Zip_____
For how
long?_____Dates:_____
Name of doctor / therapist_____
Reason for Admission_____ _____

Have you taken standard psychological assessments, (e.g. intelligence testing or personality evaluation)? Yes _____ No _____

Name of Psychologist_____Phone
(____)_____
Address_____Dates_____

Medical History

Family Doctor_____Phone (____)_____

Have you ever been in the hospital for medical problems? Yes_____ No _____

Dates	Names of hospital, city & state	Reason for hospitalization
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any serious or chronic physical or medical conditions (diabetes, etc.)? Yes_____ No_____
If yes, please explain?_____

Are you presently taking any prescribed / non-prescribed medication? Yes_____ No_____, If yes Please explain?_____

Medication	Prescribed by	How long
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any allergies? Yes _____ No _____
If yes, describe what they are and list any medication (s) you take:_____
_____

Have you been injured in any accidents or falls? Yes _____ No _____, If yes, Please describe:

Incident	Age	Injury
_____		
_____		
_____		

Have you suffered any complications of illnesses or accidents (high fever, convulsions, coma, etc.)?
Yes_____ No _____
If yes, please describe the
circumstances:_____
_____
_____

Were you ever unconscious, in a coma, or had a concussion as a result of illness or injury?
Yes_____ No____
If yes, please explain:_____
_____

Do you now, or have you in the past, used alcohol or other drugs on a regular basis?
Yes ____ No ____ If yes, how often and how much?

Type of Drug (Include alcohol)	How Often?	How much in each episode?
_____	_____	_____
_____	_____	_____

Do you now, or have you in the past, smoked cigarette / cigars / pipes on a regular basis?
Yes ___ No____
If yes, how often and how
much?_____
_____

Have you experienced difficulty with any of the following?: (Please (check) items that are <u>currently</u> a problem)

_____ Headaches
_____ Numbness / tingling in extremities
_____ Difficulty with hearing
_____Shortness of breath
_____Trouble with swallowing
_____Weight gain or loss in past year
_____Preoccupation with weight
_____Itching of skin
_____Hyperactivity
_____Nervousness
_____Attention / Concentration problems
_____Chronic fatigue or weakness
_____Sudden behavior changes
_____Impulsive: act without thinking
_____Physical assault (s) / abuse
_____Anxiety / panic episodes
_____Problems with sexual behavior
_____Family / relationship difficulties
_____Unusual experiences
_____Suicide attempts
_____Problems with the law
_____Problem maintaining balance

_____Seizure
_____ Fainting or black-out spells
_____Difficulty with vision
_____High blood pressure
_____Diarrhea, chronic
_____Loss of appetite
_____Eating problems
_____Skin rash
_____Crying spells
_____Mood spells
_____Ringing in ears
_____Problems thinking clearly
_____Sudden personality changes
_____Depression anxiety
_____Sleeping problems
_____Financial problems
_____Occupational problems
_____Learning problems
_____Social relationship problems
_____Disturbing thoughts
_____Suicidal thoughts
_____Memory problems / difficulty

Birth Information

Were there any physical or emotional difficulties during your mother's pregnancy with you?
Yes_____ No _____
If yes, please describe:_____
_____
_____

Were you born premature?
Yes _____ No _____ If yes, please give the number of weeks early: _____

Were there any immediate complication following delivery with you?
Yes _____ No _____ If yes, please
describe:_____
_____

Pregnancy Information (Biological Females Only)

Were there any physical or emotional difficulties during pregnancy with your children?
Yes_____ No _____ If yes, please describe:_____
_____

Were any of your children premature?
Yes _____ No _____ If yes, please give the number of weeks early: _____

Were there any of the following complication?
Mother taking medication or drugs
(specify):_____
Long labor_____Forceps delivery_____Breech birth _____ Eclampsia_____ Caesarean Section_____
other_____

Were there any immediate complication following delivery of your children?
Yes _____ No _____ If yes, please
describe:_____
_____

Number of pregnancies _____ Number of miscarriages_____ Weight of largest child at birth _____

Biological Family Health Information

Has anyone in the family (including grandparent) been treated for a mental health problem?
Yes_____ No _____ If yes, please explain:_____
_____

List individuals that live in your
home:_____

Family History	**Age**	**State of Health** (If deceased, list cause)	**Occupation**
Father	_____	_____	_____
Mother	_____	_____	_____
Brother (s)	_____	_____	_____
	_____	_____	_____
Sister (s)	_____	_____	_____
	_____	_____	_____
Partner/Spouse	_____	_____	_____
Children gender: _____	_____	_____	_____
Children gender: _____	_____	_____	_____
Children gender: _____	_____	_____	_____
Children gender: _____	_____	_____	_____

Who In Your Family Had:	**Father**	**Mother**	**Sister (s)**	**Brother (s)**	**G-Parent**
1. Cancer	_____	_____	_____	_____	_____
2. Drinking Problems	_____	_____	_____	_____	_____
3. Allergies or Asthma	_____	_____	_____	_____	_____
4. Strokes	_____	_____	_____	_____	_____
5. Nervous Breakdown	_____	_____	_____	_____	_____
6. Suicide	_____	_____	_____	_____	_____
7. Convulsions / epilepsy	_____	_____	_____	_____	_____
8. Headaches	_____	_____	_____	_____	_____
9. Diabetes	_____	_____	_____	_____	_____
10. Drug Abuse	_____	_____	_____	_____	_____
11. Ulcers	_____	_____	_____	_____	_____
12. High Blood Pressure	_____	_____	_____	_____	_____
13. Depression	_____	_____	_____	_____	_____

Relationship History

Present marital/relationship status (check all that apply)
Single _____ Married/Commitment Ceremony _____ Live In Relationship _____
Divorced/Separated _____ Widowed _____

If married/live-in relationship: Spouses name:_____
Date of birth: ____/____/____
Date of current marriage/commitment ceremony: ____/____/____
When did you begin living together? _____
When did you begin dating?_____

Children by present relationship:

Name	Birth Date or Age
_____	_____
_____	_____
_____	_____

Previous marriages/civil commitment/live-in relationships:

Date of Ceremony/ Began Living Together	Date Divorced/ Relationship Ended	Reason for Divorce/ End of Relationship	Children by each Relationship & Ages
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Employment

Present job title / job description and organization: _____
_____

Do you have problems performing your job? (Yes___ No___) If yes, please explain:_____
_____

Do you have problematic relationships with people on the job? (Yes____ No ____) If yes, please explain:
_____

How many jobs have you held within the past five years?_____
Reason for changes in job:_____
_____

I understand that this information will be used in my evaluation and will be included in my records.

Signed_____ Date_____
Client

Re-Disclosure: Persons, agencies, or institutions to whom this information is disclosed are prohibited by state / federal law from re-disclosure without the specific written consent of the person to whom it pertains. A general authorization for release of medical information is NOT sufficient for this purpose.