Giblin Consulting, Inc.
Markham S. Giblin, Ph.D.
President & Licensed Psychologist
Telephone: (541) 738-6516/Fax: (541) 738-6517
Corvallis Office: 1300 NW Harrison Blvd, Suite #140, Corvallis, OR 97330
Eugene Office: 492 E. 13th Ave, Suite #201, Eugene, OR 97401

# INITIAL PSYCHOLOGICAL EVALUATION REPORT

## IDENTIFYING INFORMATION:

Full Name: _____ Preferred Name to be Called: _____

Date of Birth: _____ Age: _____ Sex: _____ Occupation: _____

Race/Ethnicity: _____ Religion (optional): _____

Referred by: _____ Primary Care Physician: _____

Person(s) Interviewed for Evaluation: _____

Date(s) of Evaluation: _____

## PRESENTING PROBLEM(S):

Description of the problem or problems that led to contact at this time, including when the problem was first noticed, how long it has been going on, whether it is getting better or worse, and if any similar difficulties have been experienced in the past:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

*Patient Name:* _____

*Date(s) of Evaluation:* _____

## CURRENT SITUATION:

Employment status: _____

Marital/relationship status: _____

Family/household status: _____

Names and relationships of all those living in the home at least part-time:

| Name | Age | Sex | Full or Part-Time in Household | Relationship To Patient |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Names and relationships of any children/step-children living outside the home:

| Name | Age | Sex | Residence Location | Relationship To Patient |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

## DEVELOPMENTAL/FAMILY HISTORY:

Born in (location): _____

Raised in same area? ☐ Yes ☐ No/details (including major moves and reactions to them): _____

Any significant complications during birth or early childhood development? ☐ No ☐ Yes/details: _____

Raised in an intact family environment (both parents living & married to each other)? ☐ Yes ☐ No/details: _____

Sibling status: ☐ Only child ☐ Oldest of _____ children ☐ Youngest of _____ children ☐ Other/details: _____

Parents & siblings still living? ☐ Yes ☐ No/details: _____

Past/present relationship with mother (& step-mother if applicable): _____

Past/present relationship with father (& step-father if applicable): _____

*Patient Name:* _____

*Date(s) of Evaluation:* _____

Past/present relationships with siblings (& step-siblings if applicable): _____

_____

_____

_____

Any history of physical, sexual, or emotional abuse? ☐ No ☐ Yes/details: _____

_____

_____

_____

Any history of major trauma? ☐ No ☐ Yes/details: _____

_____

_____

Marital history (including dates/durations of current/prior marriages): _____

_____

_____

## ACADEMIC/EMPLOYMENT HISTORY:

Graduated from high school? ☐ Yes ☐ No/details: _____

Any colleges/trade schools attended after high school? ☐ No ☐ Yes/details (including school(s) attended, degree(s) earned):

_____

_____

Any learning difficulties &/or special education services received while in school? ☐ No ☐ Yes/details: _____

_____

General attitude toward school: _____

Employment history over the past five years, including length of time jobs held and reason(s) for leaving: _____

_____

_____

## MEDICAL HISTORY:

Any current or recurrent medical conditions? ☐ No ☐ Yes/details: _____

_____

_____

Any history of major medical problems/surgeries/hospitalizations? ☐ No ☐ Yes/details: _____

_____

_____

_____

Any history of head traumas? ☐ No ☐ Yes/details: _____

_____

Any history of seizures? ☐ No ☐ Yes/details: _____

*Patient Name:* _____

*Date(s) of Evaluation:* _____

Currently taking any prescription or over-the-counter medications or herbal supplements? ☐ No ☐ Yes/details:

| Name of medication/supplement | Dosage | # times per day | Prescribing Doctor | Date Started | Taken regularly? |
|---|---|---|---|---|---|

Any known allergies, reactions, or intolerances to medications? ☐ No ☐ Yes/details: _____

Any medical issues/problems affecting or being affected by behavioral health/psychological factors? ☐ No ☐ Yes/details: ____

## FAMILY MENTAL HEALTH/SUBSTANCE ABUSE HISTORY:

Any family members/blood relatives ever experienced any emotional/psychological problems, learning problems in school, substance abuse problems, or attention or behavioral difficulties? ☐ No ☐ Yes/details: _____

Any family members/blood relatives ever given a mental health or substance abuse diagnosis, received any inpatient or outpatient mental health or substance abuse treatment, or prescribed any medication for a mental health or substance abuse condition?
☐ No ☐ Yes/details: _____

## PERSONAL MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT HISTORY:

Any prior inpatient or outpatient mental health treatment? ☐ No ☐ Yes/details (including when, where, with whom, & results):

Any history of inpatient, outpatient, or 12-step treatment for substance abuse difficulties? ☐ No ☐ Yes/details: _____

Ever taken any prescription medications or herbal supplements for a mental health condition in the past? ☐ No ☐ Yes/details:

*Patient Name:* _____

*Date(s) of Evaluation:* _____

## SYMPTOMS:

Severity rating of symptoms experienced over the past month (leave blank if not experienced over the past month):

*0 Absent* *1 Minimal* *2* *3 Mild* *4* *5 Moderate* *6* *7 Serious* *8* *9 Severe* *10 Extreme/Disabling*

_____ Depressed/sad mood
_____ Anxious/fearful mood
_____ Angry/irritable mood
_____ Mood swings
_____ Uncontrolled crying
_____ Feeling hopeless
_____ Feeling worthless
_____ Difficulty falling asleep
_____ Disrupted/broken sleep
_____ Sleeping too much
_____ Loss of appetite
_____ Weight loss
_____ Overeating
_____ Weight gain
_____ Binging on food
_____ Purging food (vomiting, laxatives)
_____ Excessive exercise
_____ Difficulty concentrating
_____ Loss of interest in activities
_____ Feeling guilty
_____ Feeling ashamed/shame
_____ Withdrawing from others
_____ Lack of motivation
_____ Feeling tired/fatigued
_____ Loss of sexual interest/performance
_____ Low self-esteem
_____ Being negative/critical
_____ Less energy than usual
_____ More energy than usual
_____ Mind racing
_____ Excessive talking
_____ Restless/can't sit still
_____ Feeling invincible
_____ Feeling lonely
_____ Feeling ignored/abandoned
_____ Feeling too much pain
_____ Feeling suicidal
_____ Specific suicidal thoughts/plans
_____ Suicidal actions/attempts
_____ Homicidal feelings/impulses
_____ Anger/temper difficulties
_____ Relationship conflicts
_____ Marital stress/difficulties
_____ Communication difficulties
_____ Parenting problems
_____ Other family problems
_____ Other relationship problems
_____ Difficulties making friends
_____ Problems at work/school
_____ Medical/health problems
_____ Financial stress/problems
_____ Legal problems
_____ Difficulty trusting anyone
_____ Feeling used by people
_____ Feeling others are out to get me
_____ Watched/talked about by others
_____ Seeing/hearing strange things
_____ Problems controlling thoughts
_____ Unwanted/intrusive thoughts
_____ Feeling compelled to do things
_____ Excessively dwelling on problems
_____ Worrying too much
_____ Excessive or irrational fears
_____ Panicky feelings/panic attacks
_____ Shaky/trembling
_____ Difficulties breathing
_____ Hot or cold spells
_____ Lightheaded/dizzy
_____ Sweating
_____ Heart racing
_____ Upset stomach
_____ Nightmares
_____ Confusion
_____ Memory problems
_____ Re-living traumatic events
_____ Sexual problems
_____ Problems coping with divorce
_____ Blended-family problems
_____ Alcohol usage
_____ Marijuana usage
_____ Other substance usage
_____ Other/details _____

_____

_____

_____

_____

_____

*Patient Name:* _____

*Date(s) of Evaluation:* _____

## SUBSTANCE USE:

### *ALCOHOL*

Frequency of use: ☐ Never ☐Less than 1x/month ☐ 1-4 times/month ☐ 2-3 times/week ☐ 4-5 times/week ☐ Daily

Usual consumption: ☐ None ☐ 1-2 drinks/occasion ☐ 3-4 drinks/occasion ☐ 5 or more drinks/occasion

Intoxication frequency: ☐ Never ☐ Less than 1x/month ☐ 1-4 times/month ☐ 2-3 times/week ☐ 4-5 times/week ☐ Daily

Alcohol-related problems (check all that apply): ☐ Personal concern/worry about drinking ☐ Hangovers ☐ Sleep disturbance

☐ Inability to stop after 1-2 drinks ☐ Changes in tolerance ☐ Interpersonal problems ☐ Job/school problems

☐ Medical complications ☐ Binges ☐ Passing out ☐ Blackouts ☐ Physical withdrawal ☐ Seizures ☐ Arrests

☐ Other/details _____

Self-perception of use (check all that apply): ☐ None ☐ Occasional/social use, not a problem ☐ Problem use, no dependence

☐ Psychological dependence ☐ Physiological dependence ☐ Other/details: _____

If perceived as problem, onset of problem: ☐ Within last month ☐ 2-6 mos. ago ☐ 6-12 mos. ago ☐ More than a year ago

If perceived as problem, motivation to stop: ☐ Not interested in stopping ☐ Thinking about but not committed ☐ Motivated

History of treatment attempts (check all that apply): ☐ None ☐ Stopped on own ☐ Attended AA or other 12-step program

☐ Attended diversion or other outpatient program ☐ Attended inpatient program ☐ Other/details: _____

_____

### *OTHER SUBSTANCES*

Tobacco use? ☐ No ☐ Yes/details (if cigarettes, include number per day & for how long): _____

Caffeine intake per day: ☐ None ☐ 1-2 cups of coffee/soda per day ☐ 3-4 cups per day ☐ 5 or more cups per day

Any other substances used in past 6 months? ☐ No ☐ Yes/details (leave blank if particular substance not used in past 6 mos.):

| | *Frequency* | | | *Duration* | |
|---|---|---|---|---|---|
| | *Daily* | *Weekly* | *Monthly(or less)* | *Less than 1 Year* | *More than 1 Year* |
| Marijuana | ____ | ____ | ____ | ____ | ____ |
| Sedative | ____ | ____ | ____ | ____ | ____ |
| Stimulants | ____ | ____ | ____ | ____ | ____ |
| Cocaine | ____ | ____ | ____ | ____ | ____ |
| Opiates | ____ | ____ | ____ | ____ | ____ |
| Inhalants | ____ | ____ | ____ | ____ | ____ |
| Hallucinogens | ____ | ____ | ____ | ____ | ____ |
| Prescription Drugs | ____ | ____ | ____ | ____ | ____ |

Substance-related problems (check all that apply): ☐ Personal concern/worry about usage ☐ Inability to control usage

☐ Changes in tolerance ☐Sleep disturbance ☐ Interpersonal problems ☐ Job/school problems

☐ Medical complications ☐ Preoccupation with obtaining drugs ☐ Loss of consciousness ☐ Physical withdrawal

☐ Seizures ☐ Suicidal thoughts ☐ Assaults ☐ Arrests/legal problems ☐ Other/details: _____

Self-perception of use (check all that apply): ☐ None ☐ Occasional/social use, not a problem ☐ Problem use, no dependence

☐ Psychological dependence ☐ Physiological dependence ☐ Other/details: _____

If perceived as problem, onset of problem: ☐ Within last month ☐ 2-6 mos. ago ☐ 6-12 mos. ago ☐ More than a year ago

If perceived as problem, motivation to stop: ☐ Not interested in stopping ☐ Thinking about but not committed ☐ Motivated

History of treatment attempts (check all that apply): ☐ None ☐ Stopped on own ☐ Attended 12-step program

☐ Attended diversion or other outpatient program ☐ Attended inpatient program ☐ Other/details: _____

_____