TRAUMA FOCUSED - INITIAL ADULT CLINICAL EVALUATION

Date: ____/____/____
Name: _____ Age ____ DOB: ____/____/____ Sex: M F
Primary Language: _____ Referred by whom: _____

Confidentiality and exceptions explained? Yes No

PRESENTING PROBLEM

When did symptoms first appear?

Why are you seeking trauma-focused treatment (nature and details of trauma)?

MARITAL STATUS

Married Separated Divorced Single Widowed Lives with significant other

If married, this is ____ marriage. Quality of Relationship:

If have children, sex and ages:

SUPPORT AND CAREGIVING

Who do you rely on for emotional and practical support?

Close friends, support groups, church, and other organizations

What qualities do you have that enable you to form and maintain relationships, and get support?

OCCUPATION OR SCHOOL INVOLVEMENT

Current occupational or school involvement:

Quality of occupational or school involvement and support:

Are you good at what you do?

Do you have any particular skills or hobbies?

TREATMENT HISTORY

Any prior therapy? Y N When?

Where?

Any prior pharmacotherapy? Y N When?

Where?

Previous psychological testing? Y N When?

Where?

Current involvement with: DSS DMH DMR DYS Court Probation Self-help Other:

Hospitalizations: Y N When?

Where?

Suicide attempts? Y N

Details: _____

CHILDHOOD HISTORY

Achieved developmental milestones on time? Y N If not, what were unusual problems?

Peer Group Experience (Primary, junior high & high school; college)

___ Supportive ___ Maladaptive ___ Isolated ___ Frequent interpersonal disruptions

School experience: ___ Good ___ Bad Highest grade completed _____

Any current educational problems?

RELEVANT FAMILY HISTORY (genogram optional)

Current living in intact family? Y N

Relationship with partner and children?

Behavioral problems with children?

Number, age and sex of siblings? (Identify patient in birth order)

Note any family history of physical/emotional problems

Current relationship with family of origin

EARLY CAREGIVING

Who took care of you when you were growing up?

With whom did you feel safe when you were growing up?

Who made the rules and enforced the discipline at home?

How was discipline enforced?

How did your parents solve their disagreements?

Did anybody in you family have problems with drugs or alcohol?

If yes, what was the effect of that on your life?

Did you ever need to step in to limit violence at home?

Were you ever separated from either of your parents for a significant period of time?

While growing up, did you lose anybody close to you to a serious illness or death?

Have you suffered any major losses in the recent past?

As an adult, have you been involved in physical conflict that included hitting, kicking, punching, biting, knives or guns?

As a child or as an adult, have you ever been involved in sexual relations against your wishes?

WORK HISTORY (length of time, frequency, reasons for change) and Military Service

Financial status: ___ comfortable ___ some stress ___ severe stress

SUBSTANCE USE / ABUSE

Type	Year 1st Used	Current Use quant/freq	Route of administration	Hx of detox or treatment
Tobacco				
Alcohol				
Marijuana / Hashish				
Inhalants				
Stimulants				
Sedative hypnotics				
Hallucinogens				
Other				

Drug of choice (current or previous): _____ Preferred route of admin: Inhale Oral IV IM

Gambling Y N Describe _____

Compulsive sexual activity Y N Nature _____

Legal problems? Y N Current legal status: Self Guardian DSS ward Guardian ad litem

PROBLEMATIC BEHAVIORS

Emotional constriction or inability to express or tolerate intimacy	Y N
Hypersexualized behaviors	Y N
Affective volatility or difficulty self-soothing when triggered	Y N
Hyperactivity / decreased attention span	Y N
Sudden behavioral changes	Y N
Eating problems	Y N
Problems with hostility, aggression or self-harm	Y N
PTSD Symptoms (review and explore instrument(s) administered)	Y N
Complex PTSD Symptoms (review/explore measures administered)	Y N
Dissociative Symptoms (review/exposure measures administered)	Y N
Depressive Symptoms (review/exposure measures administered)	Y N

MENTAL STATUS EXAM (circle applicable terms)

Appearance: Neat Unkempt Older / Younger than stated age Good / poor hygiene

Dress: Appropriate Inappropriate Comment _____

Eye Contact: WNL Fixed Avoidant Erratic

Posture: Relaxed Tense Rigid

Psychomotor: WNL Agitated Slowed Erratic

Behavior: WNL Immature Guarded Withdrawn Threatening Provocative
Friendly Open Dependent Avoidant Distracted

Speech: WNL Pressured Slow Loud Soft Slurred Stuttering Hesitant
Goal directed Aphasic Agnostic Apraxic

Emotional State

Mood: Stable Depressed Agitated Labile Manic Hypomanic

Affect: Appropriate Inappropriate Flat Constricted Angry Sad Blunted

Suicidality: Ideation Intent (able to contract for safety: Y N)

Form of thought

Ideation: WNL Paucity Too much Flighty Rapid Slow

Nature: Relevant Irrelevant Illogical Tangential Evasive Rambling Circumstantial

Associations: WNL Blocking Pausing Neologisms Clang associations

Content of Thought

Preoccupations: None Illness Environmental problems Suicide Homicide Obsessions
Compulsions Antisocial Urges Hypochondriacal Other _____

Thought Disturbance

Dissociative: None Depersonalization Derealization Psychic numbing Flashbacks

Delusions: None Ego syntonic / dystonic Paranoid Focal Diffuse

Hallucinations: None Auditory Command Visual Tactile Olfactory Somatic

Ideation: None Ideas of reference Ideas of influence Grandiosity

Cognitive Functions

Oriented to: Time Person Place

Memory: WNL Impairment: immediate remote recent

Memory gaps: Past - cannot remember before age ____ Gaps between age ____ and ____

Present - blackouts or sense of lost time Y N

Intelligence: Superior Average Borderline Retarded

Insight: Good Fair Poor

Judgment: Good Fair Poor

Concentration: Good Fair Poor

Ability to abstract: Good Fair Poor

Impulsivity: Average High Increased under stress Danger of acting out

Energy level: Low Average High

Appetite: Average Poor Excessive Recent weight gain / loss of ____ lbs

Sleep: Avg # hours ____ Delayed onset of ____ minutes Early morning awakening

Number of nightmares per month ____

Sex Drive: Increased Decreased Unchanged

CURRENT MEDICATIONS (include dosage, frequency, and any side effects)

PAST MEDICATIONS:

Any Known Allergies (Medications, Foods, Plants, Fabrics, Physical Environments, etc.)

DIAGNOSES:

CLINICAL SUMMARY (optional)

TREATMENT RECOMMENDATIONS

Individual Therapy ____ sessions
Group Therapy ____ sessions
Family Therapy ____ sessions

Consultation ___ sessions
Psychopharmacology Y N
Couples Therapy ____ sessions

Comments:

Intake Evaluator: Name: _____ Degree: _____
Signature _____

Case assigned to: Name: _____ Degree: _____

Supervisor: Name: _____ Degree: _____
Signature _____