

Diagnostic Intake and Evaluation
For the Office of Cindy Barrow, LCSW

Today's Date _____

Name: _____

Address: _____

City: _____ **Zip** _____

Date of Birth: _____ **Current Age:** _____

Home Phone: _____ **Cell Phone:** _____

Where can messages be left? Home phone or Cell Phone
(Circle Home or Cell)

Parent/Guardian (if patient is a minor): _____

If Patient's Parent's are divorced, who has legal right to consent for treatment?

Name of Insured: _____

Policy Number of Insured: _____

Name of Insurance Carrier: _____

Primary Care Physician's Name, address, and phone number:

REASON FOR SEEKING SERVICES
(Check all those that apply)

- | | |
|--|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Work problems |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Family Problems |
| <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Divorce/Separation |
| <input type="checkbox"/> Couples problems | <input type="checkbox"/> Academic problems |
| <input type="checkbox"/> Grief and Loss | <input type="checkbox"/> Stress Problems |
| <input type="checkbox"/> Domestic Violence/Emotional Abuse | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Attention and Focus | <input type="checkbox"/> Gambling |
| <input type="checkbox"/> Internet Addiction | <input type="checkbox"/> Pornography
Addiction |
| <input type="checkbox"/> Other/ Explain: | |

Family History of Mental illness, Substance Abuse, or Violence:

Maternal Side: _____

Paternal or Father's Side:

Social History:

Reached Developmental Milestones on time? _____

Academic Problems? _____

Graduated From High School?

Graduated from Junior College, Technical School, or 4 year Institution:

Graduate School or Higher?

Number of Natural Children or Adopted Children:

Ages of Natural Children or Adopted Children:

Number of Step- Children

_____ **Ages:** _____

How many times married? _____

Current Living Situation (married, partner, single, children at home):

Current Work Situation or Retired?

History of Abuse (physical, emotional, sexual) _____

Current Domestic Violence? _____ **Pg. 3**

If Yes, are there guns in the home? _____

Medical History:

List Current and Past Significant Medical Problems/History:

List Current Medication:

Past Psychiatric and/or Substance Abuse Treatment:

Previous Outpatient Therapist(s) and/or Psychiatrist (s):

Treatment Episodes or Dates (Time Frame):

Suicide Attempts? _____ Dates of Attempts? _____

Psychiatric and Substance Use History Continued

Do you current thoughts of harming yourself? _____

If Yes, Do you have a plan?

Do you have any thoughts of harming anyone else? _____

Do you use the following substances? (Circle those that apply)

Alcohol Nicotine Marijuana Caffeine Pain Pills

Methamphetamines Benzodiazapines (Lorazapam, Xanax)

Cocaine or Crack

Explain: _____

Describe Current or Past Legal Involvements (Misdemeanors or Felonies):

THERAPIST TO FILL OUT THIS SECTION AND NEXT:

Diagnosis:

Axis I: _____

Axis II: _____

Axis: III: _____

Functioning: _____

Memory Impairments or Cognitive Deficits:

Mental Status Notes:

STRENGTHS: _____

Goals for Treatment and Estimated Time Frame:

Signature: _____

Cynthia L Barrow, LCSW, SW7738