Fawn Gonzales, LCSW
Independent Practitioner

The Sharing Place

14 Cottage Street • Medford, OR 97504 • (541) 779-2390 • fax (541) 779.3260

Initial Evaluation Questionnaire

Client Name: _____ Today's Date: _____

Questionnaire Completed By: _____ Relationship to Client: _____

Describe the problem(s) that prompted you to seek treatment:

_____

_____

_____

_____

Check any of the symptoms that the client has been having:

___Depressed mood
___Muscle tension
___Difficulty with school
___Low self-esteem
___Trouble concentrating
___Problems with sleeping
___Feeling fearful
___Tearful/crying spells
___Lack of energy
___Worries
___Stuttering
___Feeling stressed
___Feeling hopeless
___Irritability
___Self harm
___Problems getting along with others
___Fire setting
___Obsessions or compulsions
___Sudden feelings of panic
___Deep sadness
___**Thoughts of killing self***
___**Seeing things that others do not***
___**Other***: _____

___Feeling guilty
___Change in eating habits
___Eating problems
___Trouble performing job responsibilities
___Perfectionism
___Identity problems
___Problems getting along with family
___Anger outbursts
___Difficulty enjoying usual activities
___Bedwetting
___Physical complaints of pain
___School truancy
___Weight/appetite changes
___Memory problems
___Acting violently
___Toileting problems
___Feeling of extreme happiness
___Isolation/withdrawal
___Harm to animals
___Sexual dissatisfaction
___**Thoughts of killing others***
___**Legal Issues***
___**Other*:** _____

***Describe in detail:**

_____

_____

Significant Stressful Events: Please describe any history of trauma, loss, divorce, moves, major accidents, deaths, abuse (physical, sexual or emotional), etc., starting with the most recent

_____

_____

_____

_____

_____

Please describe your goals for therapy:

_____

_____

_____

PRIOR COUNSELING HISTORY:

Please describe any prior counseling below starting with the most recent

Therapist name(s): _____

What worked/didn't work?:

_____

_____

_____

Current and/or prior psychiatric medication history (include doctor's name):

_____

_____

Name of current medications and dosage(s):

_____ _____

_____ _____

_____ _____

SUBSTANCE USE HISTORY:

Check Here If Not Applicable _____

Alcohol use	___Current	___Suspected	___Past	___No
Recreational drugs	___Current	___Suspected	___Past	___No
Abused Prescription drugs	___Current	___Suspected	___Past	___No

List type of drug(s) used:

_____

_____

MEDICAL HISTORY:

Was the client seen by a doctor within the last year? ___Yes ___No

Purpose of visit:

_____

_____

Client's Primary Care Provider: _____Phone: _____

Please list any prescription or over-the-counter medications currently being taken:

_____ _____

_____ _____

_____ _____

Please list any major medical problems and/or conditions such as serious illness, operations, injuries, trauma to the head, diabetes, etc.:

_____

_____

List allergies:

_____

FAMILY MENTAL HEALTH & SUBSTANCE ABUSE HISTORY:
Please describe and include all extended family usage:

_____
_____
_____
_____
_____
_____

Other Issues:
Please describe any other issues or facts I may need to know for client treatment:

_____
_____
_____
_____