

Alliance Counseling
495 Gold Star Hwy, Ste 108
Groton, CT 06340
(860) 861-1453



Client name:	
Age:	DOB:
Dates of evaluation:	
Client referred by:	

Home address:		Sex:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
City/State/Zip code:				

Presenting problems (including Acute Precipitants):

Psychological (living situation, employment, social supports, leisure activity, legal issues, spirituality, etc):

Marital Status: Married Never Married Committed Relationship Separated Divorced Widowed

Religion: _____ N/A

Medical History (from pregnancy to present day):

Allergies: No Yes _____

Surgeries: No Yes _____

Broken bones: No Yes _____

Chronic conditions: No Yes _____

Other: _____

Primary Care Physician (PCP): _____ Telephone: _____

Release of information to PCP: Pt agrees to Pt refused Date Rol Signed: _____

If does not have any medical provider(s), recommendation was given to access care with a Primary Care Physician: Yes No

Medications (including dosages): Allergies to medications: _____ No known medical allergies.

Current medications (psychiatric or medical) including reason for treatment:

Current Psychotropic Provider: _____ Telephone: _____

Release of Information (Rol) to MD/RN prescribing: Pt agrees to Pt refused Date Rol signed: _____

Past psychotropic medication trials include: _____

Outpatient treatment history (including MH/SA, date, length of intervention, and provider):

N/A or Denied

Inpatient MH History (Month/Year):

N/A or Denied



Client name: _____	
Age: _____	DOB: _____

Psychological and Developmental History

Developmental Milestones

Walking: On time Early Delayed

Talking: On time Early Delayed

Toileting: On time Early Delayed

Social development: Normal Delayed/Immature Advanced/Mature

Trauma: sexual: Yes No If yes, explain: _____

physical: Yes No If yes, explain: _____

emotional: Yes No If yes, explain: _____

Family History of MH/SA: Yes No

Anxiety: Yes No If yes, who: _____

ADHD: Yes No If yes, who: _____

Depression: Yes No If yes, who: _____

Bipolar: Yes No If yes, who: _____

Schizophrenia: Yes No If yes, who: _____

Alcohol abuse: Yes No If yes, who: _____

Drug abuse: Yes No If yes, who: _____

Suicide attempt/completion: Yes No If yes, who: _____

Inpatient hospitalization: Yes No If yes, who: _____

Incarceration: Yes No If yes, who: _____

Learning disabilities: Yes No If yes, who: _____

Autism: Yes No If yes, who: _____

Trauma: Yes No If yes, who: _____

Personality Disorder: Yes No If yes, who: _____

Substance Abuse

ALCOHOL: Denies current alcohol use

Current pattern of alcohol use: _____

Past history of alcohol abuse: Yes No If in recovery, since when? _____

DRUG ABUSE: Denies drug use

Current pattern of drug use: _____

Past history of drug abuse: Yes No

Other addictive behaviors (e.g., tobacco, gambling, food, etc): _____

Inpatient SA History (month/year): _____