Alliance Counseling
333 Long Hill Rd, #2
Groton, CT 06340
(860) 861-1453

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

Home address:		**Sex:**	□ Male □ 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 RoI 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 (RoI) to MD/RN prescribing: □ Pt agrees to □ Pt refused Date RoI 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

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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): _____