Adult Re-Evaluation Form

Today's Date:

Name: (First) (M.I.) (Last)	**Birth date:**	**Age:**
Relationship Status:	**Gender Identification** **Male Female Other**	
In Case of Emergency, please contact:	**Phone:**	**Relationship:**

Please give a brief description of why you are seeking treatment:_____

_____

Please check the boxes ☒ of all other problems that you've had during *this last month*.
Then, on the line that follows each problem tell us when you first noticed these problems.

☐ 10. Worrying and feeling nervous much of the time_____
☐ 11. Fears of crowds or having to talk to people_____
☐ 12. Feeling panic, heart pounding, feel like I'm losing it, I can't stand it_____
☐ 13. Can't get to sleep, or stay asleep_____
☐ 14. Sudden horrible memories or bad nightmares_____
☐ 15. Feeling that I have to do or think something over and over_____
☐ 16. Worrying a lot about germs, diseases, my health_____
☐ 17. Easily irritated and angry _____
☐ 18. Wanting to get revenge or hurt other people_____
☐ 19. Thoughts racing faster than I can follow them_____
☐ 20. Very extreme happiness or ambition_____
☐ 21. Hearing voices in my head or other strange experiences_____
☐ 22. Feeling like people are following me, monitoring me, or plotting to hurt me somehow_____
☐ 23. Out of control spending or gambling_____
☐ 24. Using drugs or drinking too much_____
☐ 25. Out of control eating_____
☐ 26. Dieting too much, or using laxatives or vomiting to lose weight_____
☐ 27. Concerns about sex_____
☐ 28. Frequent headaches, loss of balance, numbness, or sudden vomiting (circle which ones) _____
☐ 29. Frequent, constant, and/or extreme pain_____
☐ 30. Other problems:_____
_____

Treatment Update: Please list any updates to treatment you have had since your last visit, including psychological/psychiatric, substance use and hospitalizations: _____

_____

_____

Medical Update:

Primary Care Clinic: _____ Physician: _____

Describe any current medical conditions: _____

List any drug allergies: _____

List any history of head injury, including concussion or loss of consciousness: _____

List current medications: _____

_____

_____

_____

Family Update: Please list any changes to your family/household since your last visit: _____
_____

Education/Employment Update: Please list any changes in these areas since your last visit:
_____
_____

CHEMICAL USE HISTORY

Do you use tobacco products? Yes No If yes, type_____ quantity per day _____

Do you drink caffeine? Yes No If yes, type _____ quantity per day _____

Do you drink alcohol? Yes No If yes, usual number of drinks per day_____

Usual number of drinks per week_____

Additional substances.

Please check any that are true for you	**In the past month**	**Within last 12 months**	**Have used in past**	**Never**
Cannabis- Marijuana, Hash				
Amphetamines- Speed, Cocaine, Crack, Crank, Meth, Dexedrine, White Crosses, Ritalin, Cylert, etc.				
Tranquilizers- Valium, Xanax, Ativan Librium, Sleeping Pills, Seconal, Quaaludes, etc.				
Narcotics- Codeine, Percodan, Darvon, Demerol, Morphine, Heroin, Methadone, Talwin, etc.				
Other- Inhalants, PCP, LSD Mushrooms, Paint Thinner, Glue Nitrite "Poppers", etc.				

Have you ever felt you ought to cut down on your drinking or drug use? Yes No

Have you ever had people annoy you by criticizing your drinking or drug use? Yes No

Have you ever felt bad or guilty about your drinking or drug use? Yes No

Have you ever had to drink or use drugs as an "eye opener" first thing in the morning to steady your nerves, get rid of a hangover, or to get the day started? Yes No

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	**2**	**3**
2. Feeling down, depressed, or hopeless	0	1	**2**	**3**
3. Trouble falling or staying asleep, or sleeping too much	0	1	**2**	**3**
4. Feeling tired or having little energy	0	1	**2**	**3**
5. Poor appetite or overeating	0	1	**2**	**3**
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	**2**	**3**
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	**2**	**3**
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being fidgety or restless – moving around a lot	0	1	**2**	**3**
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	**1**	**2**	**3**

☐

For items 1-9, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ***Not difficult at all*** ☐
- ***Somewhat difficult*** ☐
- ***Very difficult*** ☐
- ***Extremely difficult*** ☐

For items 1-9, when did you first notice these problems? _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

	Not at all	Several days	half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	**2**	**3**
2. Not being able to stop or control worrying	0	1	**2**	**3**
3. Worrying too much about different things	0	1	**2**	**3**
4. Trouble relaxing	0	1	**2**	**3**
5. Being so restless that it's hard to sit still	0	1	**2**	**3**
6. Becoming easily annoyed or irritable	0	1	**2**	**3**
7. Feeling afraid, as if something awful might happen	0	1	**2**	**3**

☐

For items 1-7, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ***Not difficult at all*** ☐
- ***Somewhat difficult*** ☐
- ***Very difficult*** ☐
- ***Extremely difficult*** ☐