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:**

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:

_____

_____

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

_____

_____

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

_____

Over the *last two 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	○	○	○	○
2. Feeling down, depressed, or hopeless	○	○	○	○
3. Trouble falling or staying asleep, or sleeping too much	○	○	○	○
4. Feeling tired or having little energy	○	○	○	○
5. Poor appetite or overeating	○	○	○	○
6. Feeling bad about yourself, or that you are a failure or have let yourself or your family down	○	○	○	○
7. Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being fidgety or restless—moving around a lot	○	○	○	○
9. Thoughts that you would be better off dead, or of hurting yourself in some way	○	○	○	○

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

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** ○

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.

- ☐ Fears of crowds or having to talk to people
- ☐ Feeling panic, heart pounding, feel like I'm losing it, I can't stand it
- ☐ Can't get to sleep, or stay asleep
- ☐ Sudden horrible memories or bad nightmares
- ☐ Feeling that I have to do or think something over and over
- ☐ Worrying a lot about germs, diseases, my health
- ☐ Wanting to get revenge or hurt other people
- ☐ Thoughts racing faster than I can follow them
- ☐ Very extreme happiness or ambition
- ☐ Hearing voices in my head or other strange experiences
- ☐ Feeling like people are following me, monitoring me, or plotting to hurt me somehow
- ☐ Out of control spending or gambling
- ☐ Using drugs or drinking too much
- ☐ Out of control eating
- ☐ Dieting too much, or using laxatives or vomiting to lose weight
- ☐ Concerns about sex
- ☐ Frequent headaches
- ☐ Loss of balance
- ☐ Numbness
- ☐ Sudden vomiting
- ☐ Frequent, constant, and/or extreme pain
- ☐ Other problems:

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 ◯

Other information you would like to provide: