Diagnostic Intake and Evaluation

For the Office of Cindy Barrow, LCSW

Today's Date _____

Name: _____

Adress:_____

City: _____ Zip _____

Date of Birth:_____ Current Age:_____

Home Phone:_____ Cell Phone: _____

Where can messages be left? Home phone or Cell Phone (Circle Home or Cell)

Parent/Guardian (if patient is a minor):_____

If Patient's Parent's are divorced, who has legal right to consent for treatment?

Name of Insured:_____

Policy Number of Insured:_____

Name of Insurance Carrier:_____

Primary Care Physician's Name, address, and phone number:

REASON FOR SEEKING SERVICES
(Check all those that apply)

_____Anxiety
_____Depression
_____Substance Abuse
_____Couples problems
_____Grief and Loss
_____Domestic Violence/Emotional Abuse
_____Attention and Focus
_____Internet Addiction
_____Work problems
_____Family Problems
_____Divorce/Separation
_____Academic problems
_____Stress Problems
_____Eating Disorder
_____Gambling
_____Pornography Addiction

_____Other/ Explain:
_____

Family History of Mental illness, Substance Abuse, or Violence:

Maternal Side: _____

_____

_____

Paternal or Father's Side:

_____

_____

_____

Social History:

Reached Developmental Milestones on time?_____

Academic Problems? _____

_____

Graduated From High School?

Graduated from Junior College, Technical School, or 4 year Institution:

Graduate School or Higher?

Number of Natural Children or Adopted Children:

_____

Ages of Natural Children or Adopted Children:

Number of Step- Children

_____ Ages:_____

How many times married? _____

Current Living Situation (married, partner, single, children at home):

Current Work Situation or Retired?

History of Abuse (physical, emotional, sexual)_____

Current Domestic Violence? _____Pg. 3

If Yes, are there guns in the home? _____

Medical History:

List Current and Past Significant Medical Problems/History:

_____

_____

_____

List Current Medication:

_____

_____

Past Psychiatric and/or Substance Abuse Treatment:

Previous Outpatient Therapist(s) and/or Psychiatrist (s):

_____

_____

Treatment Episodes or Dates (Time Frame):

_____

_____

Suicide Attempts? _____ Dates of Attempts?_____

Psychiatric and Substance Use History Continued

Do you current thoughts of harming yourself? _____

If Yes, Do you have a plan?

Do you have any thoughts of harming anyone else?_____

Do you use the following substances? (Circle those that apply)

Alcohol Nicotine Marijuana Caffeine Pain Pills

Methamphetamines Benzodiazapines (Lorazapam, Xanax)

Cocaine or Crack

Explain: _____

Describe Current or Past Legal Involvements (Misdemeanors or Felonies):

THERAPIST TO FILL OUT THIS SECTION AND NEXT:

Please text Cindy Barrow at 720-678-3491 to let her know prior to emailing any paperwork.

Diagnosis:

Axis I: _____

Axis II: _____

Axis: IIII: _____

Functioning: _____

_____

Memory Impairments or Cognitive Deficits:

_____

Mental Status Notes:

_____

_____

STRENTHS: _____

_____

Goals for Treatment and Estimated Time Frame:

Signature:_____

Cynthia L Barrow, LCSW, SW7738

After completing form, please click the SUBMIT Button. This will open a new email using your default email application. If you do not have one installed on your device, just save the form and email it to clbarrow66(AT)gmail.com. *Please be sure to input the email correctly as you are emailing Private & Confidential information.*

SUBMIT