meadowlark
PSYCHIATRIC SERVICES
1 South Gilbert Street, Iowa City, IA 52240
319.626.3300

We appreciate the opportunity to work with you. The information you give us is important for our evaluation. Please note that some of the questions may not be applicable given your concerns. If that is the case, please write "NA" in that section.

Today's date: _____ Name of Person Completing this Form: _____

Patient's Full Name: _____ Birth Date: _____

Identified Gender: _____ Race/ethnicity/cultural identity: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Referred for evaluation by: _____

Is the patient their own legal guardian? ☐Yes ☐No

If no, please list ALL legal guardians of patient and provide a copy of guardianship papers:

Please list ALL individuals currently living in the patient's home:

Name	Gender	Age	Relationship to Patient

What is/are your main concern(s):

☐ Anxiety ☐ Attention-deficit/hyperactivity disorder ☐ Autism spectrum disorder
☐ Depression ☐ Intellectual disability ☐ Learning concerns
☐ Other cognitive/psychological concerns (Please list):

What do you/the patient hope to gain from this evaluation *(please note, we do not directly assist with the application process for any services)?*

Please note: for autism spectrum disorder, attention-deficit/hyperactivity disorder, and/or intellectual disability evaluations, we typically require that an informant who knew the patient as a young child be able to provide information regarding the patient's early developmental history (e.g., what the patient was like as a young child). Please provide the name of the person who will be providing this information:

Name: _____ Relationship to Patient: _____

Is this person able to attend the appointment? ☐ Yes ☐ No

If no, are they available to talk on the phone? ☐ Yes ☐ No

If someone is not available to provide this information, please explain why or note whether there may be another informant (e.g., partner, sibling, long-time friend) available who may be able to provide additional information (we will determine whether we can still conduct this evaluation on a case-by-case basis):

There is a possibility that the provider will determine that the patient does not meet criteria currently for specific diagnoses or that the provider does not have enough information to make a diagnosis at the end of the appointment. Would you/the patient be willing to accept this? ☐ Yes ☐ No

Highest Level of the patient's education: _____

Did the patient receive special education services (IEP, 504 Plan, other): ☐ Yes ☐ No

If Yes, please list:

Is the patient currently employed? ☐ Yes ☐ No

If Yes, what is patient's current occupation? _____

Has the patient previously had a psychological or neuropsychological evaluation? ☐ Yes ☐ No

If yes, please list provider and reason for evaluation(s) (*Also, please provide copies of these evaluations either by uploading as attachment or mailing a hard copy)*:

Does the patient have any current or previous psychiatric diagnoses? ☐Yes ☐No

If yes, please list:

Is the patient followed by a psychiatric provider for medication management? ☐ Yes ☐ No

If yes, please list provider: _____

Is the patient currently taking any medications? ☐ Yes ☐ No

If yes, please list:

Is the patient currently participating in any psychotherapy/counseling services? ☐ Yes ☐ No

If yes, please list provider: _____

Does the patient have any medical concerns? ☐Yes ☐No

If yes, please explain:

Has the patient had (check all that apply):

☐ Major Illnesses

☐ Serious injuries/accidents/head injuries

☐ Surgeries

☐ Hospitalizations

☐ Seizures or neurological problems

☐ Sleep problems

☐ Other

Please explain any items checked above and/or provide additional information, including dates:

Does the patient have relatives (e.g., parents, brothers, sisters, grandparents, aunts, uncles, first cousins) with the following:

	Who? (Please indicate mother's or father's side of family)
Seizures	
Neurological disease	
Diabetes	
Thyroid problems	
Hearing problems	
Anxiety	
Attention-deficit/hyperactivity disorder	
Autism spectrum disorder	
Bipolar disorder	
Depression	
Intellectual disability	
Learning problems	
Obsessive compulsive disorder	
Psychosis/Schizophrenia	
Speech/language problems	
Tics	
Alcohol abuse	
Drug abuse	
Problems with the law	
Suicide/attempted suicide	
Other: _____	
Other: _____	

Is there anything that was not asked on this form that you feel would be important for us to know?

Please return completed form to:

meadowlark
PSYCHIATRIC SERVICES

GeneralMailbox@MeadowlarkPsych.Com

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