Psychological History Initial Information/Evaluation for Adolescents

Personal Data:

Name: ______________________________________ DOB: ______/______/________ Age: ________

Preferred Name: ______________________________ Gender: ________________________________

Grade in School: ______________________________ Preferred Gender Pronouns: ___________________

Address: ____________________________________ Phone Number: (_______) ________ - __________

____ Leave Voicemail: Yes No

____ Email: _________________________________

Forms completed by:____________________________ Relationship to client:________________________

Ethnicity (mark all that apply):

__ Asian/Pacific Islander

__ Black/African American

__ Caucasian/White

__ Hispanic/Latino

Other: __________________________

Emergency Contact:

Name: __________________________________

Phone Number: (_______) ________ - _________

Address: ________________________________

____

____

Family Spirituality/Religious Affiliation (if any): ____

Main Concerns: Please list the major concerns that the patient would like help with in therapy, and rate the severity of each one according to the scale.

1	2	3	4	5	6	7	8	9	10
Not a problem		Mild Problem		Moderate Problem		Severe Problem	Couldn't be Worse		

1. ____
2. ____
3. ____

Briefly describe what motivated the patient to seek treatment at this time (rather than some time earlier or late):

____

Current Living Arrangements:

Are the parents divorced or separated? Yes No If yes, is there joint custody? Yes No

Does the patient live with: Biological Parent Step-Parent Adoptive Parent Foster Home Other:______________

Is there any information about the parents' relationship with the patient that might be beneficial in counseling? Yes No

If yes, please describe: ____

Parent 1

Name: ______________________ Age: ______ Phone: (_____) ________-_________ VM? Y N

Address: ____

Occupation: ______________________ Full-Time Part-Time Employer: ______________________

Education: ______________________ Is the patient currently living with this parent? Yes No

Is there anything notable about the patient's relationship with this parent? Yes No

If yes, please explain: ____

How is the patient disciplined by this parent? ____

For what reasons is the patient disciplined by this parent? ____

Parent 2

Name: ______________________ Age: ______ Phone: (_____) ________-_________ VM? Y N

Address: ____

Occupation: ______________________ Full-Time Part-Time Employer: ______________________

Education: ______________________ Is the patient currently living with this parent? Yes No

Is there anything notable about the patient's relationship with this parent? Yes No

If yes, please explain: ____

How is the patient disciplined by this parent? ____

For what reasons is the patient disciplined by this parent? ____

Sibling and Others who live with Adolescent

Name of Siblings:

Name	Age	Sex	Lives		Quality of relationship with the patient		
____________________	____	____	Home	Away	Poor	Average	Good
____________________	____	____	Home	Away	Poor	Average	Good
____________________	____	____	Home	Away	Poor	Average	Good
____________________	____	____	Home	Away	Poor	Average	Good

Name of Others living in the household:

Name	Age	Sex	Relationship to Client	Lives		Quality of relationship with the patient		
____________________	____	____	__________________	Home	Away	Poor	Average	Good
____________________	____	____	__________________	Home	Away	Poor	Average	Good
____________________	____	____	__________________	Home	Away	Poor	Average	Good
____________________	____	____	__________________	Home	Away	Poor	Average	Good

Comments: ____

Developmental History

Pregnancy/Birth

What was the length of pregnancy with the patient: ______________________________

Biological mother's age at the patient's birth: ________ Biological father's age at the patient's birth: ________

Child number _____ of _______ total children born to the biological mother.

While pregnant did the mother smoke? Yes No If yes, what amount: ______________________

Did the mother use drugs or alcohol? Yes No If yes, what amount: ______________________

While pregnant, did the mother have any medical or emotional difficulties? (e.g., surgery, hypertension, medication)

Yes No If yes, describe: ____

Length of Labor: __________ Induced: Yes No Cesarean: Yes No

Patient's birth weight: ________________ Patient's birth length: ________________

Describe any physical or emotional complications with the delivery: ____

____

Describe any complications for the mother or the patient after the birth: ____________________________________

____

Length of Hospitalization: Mother: ___________________ Patient: ___________________________

Infancy/Toddlerhood

Circle all that apply:

Breast fed	Bottle fed	Milk Allergies	Vomiting	Diarrhea
Rashes	Colic	Constipation	Not cuddly	Very cuddly
Rarely cried	Cried often	Good sleeper	Trouble sleeping	Irritable when awakened
Lethargic	Overactive	Resisted solid food	Other: ______________________	

Major Developmental Milestones

Please note the age at which the following behaviors took place:

Sat alone: ______________________	Dressed Self: ______________________
Took 1st steps: ______________________	Tied shoe laces: ______________________
Spoke words: ______________________	Rode two-wheeled bike: ______________________
Spoke Sentences: ______________________	Toilet trained: ______________________
Weaned: ______________________	Dry during day: ______________________
Fed Self: ______________________	Dry during night: ______________________

Compared with others in the family, the patient's development was: Slow Average Fast

Have there been any issue that could have affected the patient's development (e.g., physical/sexual abuse, inadequate nutrition, neglect, etc.) Yes No

If yes, please describe: ____

Behavior/Emotional Functioning

Please circle any of the following problems that are typical for the patient at this time:

Aggressive/angry	Frequent injuries	Oppositional	Slow moving
Alcohol Use	Frustrated easily	Over active	Soiling
Anxiety	Hallucinations	Overweight	Speech problems
Bedwetting	Head banging	Panic attacks	Steals
Blinking, jerking	Hopelessness	Phobias	Stomach aches
Bullies, threatens	Hurts animals	Poor appetite	Suicidal threats, attempt
Careless, reckless	Impulsive	Quarrels	Talks back
Defiant	Irritable	Sad	Teeth grinding
Depression	Learning Problems	Selfish	Thumb sucking
Destructive	Lies frequently	Separation anxiety	Unsafe behaviors
Dizziness	Loner	Sets fires	Unusual thinking
Drug use	Low self-esteem	Sexual acting out	Weight loss
Eating disorder	Moody	Short attention span	Withdrawn
Fatigue	Nightmares	Shy, timid	Worries excessively
Fearful	Often sick	Sleeping problems	

Please describe any of the above (or other) concerns: ____

____

How are problem behaviors generally handled? ____

____

Has the patient experienced trauma? (i.e., loss of loved ones, pets, etc.; physical/sexual/emotional abuse) Yes No

At what age? ________ If yes, describe the patient's trauma and/or their reaction: ______________________

____

Have there been any other significant changes or events in the patient's life? (family, moving, fire, etc.) Yes No

If yes, describe the patient's trauma and/or their reaction: ____

____

Any additional information that would assist us in understanding current concerns or problems?

____

____

What are the goals for the patient's therapy, psychological testing, or medication evaluation?

____

____

What family involvement would you like to see in the treatment?

____

____

Educational History

Current School: ______________________________________ School Phone Number: (_____) __________ - ____________

Primary Teacher: ______________________________________ School Counselor: ____________________________________

Type of School(circle one):

Public

Private

Home Schooled

Other (specify): ______________________________________

In Special Education? Yes No

If yes, please describe: _________________________________

In a gifted program? Yes No

If yes, please describe: _________________________________

Has the patient ever been held back in school? Yes No If yes, describe: _______________________________________

Which subjects does the patient enjoy in school? ____

Which subjects does the patient dislike in school? ____

What grades does the patient usually receive in school? ____

Have there been any recent changes in the patient's grades? Yes No If yes, describe: ______________________________

Has the patient received psychological testing or testing from the AEA? Yes No

If yes, please describe and comment: ____

____

Circle the descriptions which specifically relate to the patient:

Feelings about School Work:

Anxious Passive Enthusiastic Fearful Eager No Expression

Bored Rebellious Other(describe): ____

Approach to School Work:

Organized Industrious Responsible Interested Self-directed No initiative

Refuses Sloppy Disorganized Cooperative Does only what is expected

Does not complete assignments Other(describe): ____

Performance in School:

Satisfactory Underachiever Overachiever Other(describe): ____________________________________

Patient Peer Relationships:

Spontaneous Follower Leader Difficulty making friends Make friends easily

Long-time friends Shares Easily Other(describe): ____

Patient's Prior Treatment History

Has your child ever received psychological or psychiatric help or counseling of any kind before? Yes No

Where: ____ By whom: ____

Nature of therapy: __________________________________ Time period/Dates: _________________________________

Problems for which the patient was seen: ____

Additional comments/information: ____

How would you rate this previous help? Very Helpful Somewhat helpful Not very Helpful Useless Harmful

Medical History

How would you rate the patient's overall health? Excellent Good Fair Poor

Does the patient have any serious medical conditions? Yes No (If yes, please list): ______________________________

Is the patient up to date on all recommended vaccinations? Yes No

Name of Primary Care Physician (PCP) ____________________________________ Phone: (_____) _______-__________

May we contact the patient's PCP? Yes No (If yes, please ask to sign a Release of Information to allow)

Please list all medications the patient is currently taking:

	Medication	Frequency	Dosage	Purpose	Side Effects
1.					
2.					
3.					

Please list all medications the patient has previously taken:

	Medication	Frequency	Dosage	Purpose	Side Effects
1.					
2.					
3.					

List any known allergies: ____

Any serious hospitalizations, illness, accidents? If yes, describe: ____

In the past year, how many: Visits to Doctor ____ Sick days _____ Psychotherapy sessions, ever _____

List any recent health or physical changes: ____

Does the patient have any vision difficulties? Yes No If yes, please describe: ____________________________

Does the patient have any hearing difficulties? Yes No If yes, please describe: ____________________________

Are there other disabilities/difficulties for the patient that may be helpful to know about?

____

____

Chemical Use History

Does the patient use or have a problem with alcohol or drugs? Yes No

If yes, please describe: ____

____

Personal and Family History:

Please place an X by any of the following medical problems experienced by the patient or any member of the patient's immediate family (parents, siblings) in the past or present. Also, please write who experienced the medical condition (e.g., the patient, parent, sibling) in the column marked "Person?" for any condition you put an X next to.

Medical condition	**X**	**Person?**	**Medical condition**	**X**	**Person?**	**Medical condition**	**X**	**Person?**
Cardiovascular			**Hematological**			**Psychological**		
Heart Disease			Anemia			Attention Deficit Hyperactivity Disorder		
High Blood Cholesterol			Blood Clots			Anxiety (frequent)		
High Blood Pressure			Bleeding Disorders			Obsessive-compulsive disorder		
Rheumatic Fever						Panic Disorder		
Swelling of feet			**Respiratory**			Bipolar disorder		
			Lung Disease/Pneumonia			Depression		
Endocrine			Chronic obstructive pulmonary disease			Anorexia		
Diabetes (if yes, what age?)			Tuberculosis			Bulimia		
Gallstones/gallbladder disease			Shortness of Breath			Reading Disorder		
Thyroid disease/goiter			Sleep Apnea/on c-pap			Math Disorder		
						Writing Disorder		
Gastrointestinal/digestive			**Muscoloskeletal**			Schizophrenia		
Acid Reflux (heartburn)			Arthritis			Suicidal thoughts, plans, or behavior		
Diverticulosis			Joint Pain					
Ulcers (stomach/intestine)			Back Pain			**Neurological**		
Pancreatitis			Hip Pain			Epilepsy or seizures		
Liver Disease/Hepatitis			Knee Pain			Stroke		
Frequent Diarrhea			Ankle & Foot Pain			Dizziness		
Frequent Constipation			Broken Bones			Headaches		
Blood in Stools						Migraines		
Irritable colon/bowel			**Sleep-Related**			Numbness or tingling		
			Snoring			Pins and needles feelings		
Urinary			Observed Apnea			Muscle weakness		
Bladder/Kidney Infections			Restless Sleep			Weakness of grip		
Kidney Disease/stones			Trouble falling asleep			Shakiness		
Urinary stress incontinence			Trouble waking up			Convulsions		
Nighttime wetting			Morning headache			Loss of Consciousness		
Daytime wetting			Daytime drowsiness					
Painful urination			**Other Medical Issues (list below)**					
Frequent Urination								

Payment for Time and Services:

Please Note: While insurance or another person may be paying for all or part of our charges, our agreement is with you rather than the insurance company. **Your signature below indicates your understanding and willingness to abide by our office policies regarding:**

- Payment of all reasonable charges involved in the rendering of services.
- Payment is due at the time of each visit unless other arrangements have been made in advance. Please note we accept Mastercard, Visa, Discover, AMEX
- Our full service fee is charged for time reserved when appointment are failed or canceled without sufficient notice (one day)

If you believe your medical insurance may cover the costs of all or part of your visit here, please give us a copy of you insurance card and complete the following information:

___________________	___________________	___________________
Policy Holder	Insurance Company or Plan	Policy Number
___________________	___________________	___________________
Employer of Policy Holder	Relationship to Client	Group Number
___________________	___________________	___________________
Policy Holder SSN	Policy Holder Address (if different)	Policy Holder Date of Birth

While we file your insurance claim for you, WE SUGGEST YOU CALL YOUR INSURANCE COMPANY to get information concerning your copay and deductible. We suggest you do this before your 1st or 2nd visit and ask them about your coverage for "outpatient mental health services". This will help you determine the appropriate payment for your sessions. In Lieu of this information we suggest a payment of at least 50% of the initial fee for the session. We will reimburse you any excess amount once your insurance company pays us. All co-payment must be paid at the time of each session unless you make another arrangement with your treatment provider. Mastercard, Visa, Discover and American express are accepted. If your plan requires a physician's referral, please contact your family doctor before treatment begins.

Authorization for Disclosure of Mental Health Information and Agreement to Pay:

I, ______________________________ on my own behalf or as a legal representative of ______________________________
Legal Guardian's Name Patient's Name

authorize The Mindset Counseling Group (MCG) and/or it's representatives to release mental health information to my insurance company to the full extent specified under any or all Federal laws and Texas Health and Safety Code, or as subsequently amended, to provide utilization review or quality assurance service for the administration of claims for benefits. I further authorize MCG to directly receive all payment of benefits due.

This authorization allows MCG and/or its representatives to release information to my insurance company, to administer claims submitted, or to be submitted for payment, to conduct a utilization and quality control review of mental health care services provided or proposed to be provided, or to conduct an audit of claims paid.

I acknowledge that I am aware that I may inspect the information disclosed at any time, and may revoke this authorization at any time. If I furnish a written revocation to MCG and/or its representatives and thus, I agree to accept financial liability, for mental health care services provided if insurance should deny claims for benefits because of the inability to examine my mental health records or the mental health records of the person named in this authorization.

I Certify that all information is true, accurate, complete, and I agree to be personally responsible for all reasonable charges not paid by my insurance company.

Patient Name: ______________________________ Legal Representative of minor ______________________________

Date: ______ / _______ / _________