Psychological History Initial Information/Evaluation for Adults

Personal Data:

Name: _____ DOB: _____/_____/_____ Age: _____

Preferred Name: _____ Gender: _____

Marital Status: _____ Preferred Gender Pronouns: _____

Address: _____ Phone Number: (_____) _____ - _____

_____ Leave Voicemail: Yes No

_____ Email: _____

Highest level of formal education completed

(School/ Degree/ Year): _____ Currently living with: _____

Military Service: Yes No Past Current

Occupation: _____ If yes, branch of service/ MOS: _____

Religious Affiliation: _____ If past, separation date/ status? _____

Ethnicity: _____

Emergency Contact: Address: _____

Name: _____ _____

Phone Number: (_____) _____ - _____ _____

Main Concerns: Please list the major concerns you need help with, 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 you to seek treatment at this time (rather than some time earlier or late):

_____

Current Stressful Events (circle all that apply):

Legal Financial Financial Family Family Illness Other: _____

Are you currently or have you ever experienced domestic violence/abuse? Yes, currently Yes, past Never

Significant life events related to grief/loss? Yes No _____

Changes in Friendship? Yes No Academic/School Stress? Yes No

Medical History

How would you rate your overall health? Excellent Good Fair Poor

Do you have any serious medical conditions? Yes No (If yes, please list): _____

Are you up to date on all recommended vaccinations? Yes No

Name of Primary Care Physician (PCP) _____ Phone: (____) _____-_____

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

Please list all medications you are currently taking:

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

Please list all medications you previously taken:

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

List any known allergies: _____

Any serious hospitalizations, illness, accidents? If yes, describe (what/year): _____

In the past year, how many: Visits to Doctor ____ Sick days _____ Cigarettes/day _____ Alcoholic drinks/day _____

Psychotherapy sessions, ever _____ If drinking, what do you typically drink? _____

Number of family members with: Alcohol/drug problems _____ Psychiatric problems (e.g., depression, psychosis, etc.) _____

Have you ever felt you ought to cut down on your alcohol use or drug use?	Yes	No
Have people annoyed 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 a drink or used drugs first thing in the morning? (as an eye opener, to steady your nerves or to get rid of a hangover?)	Yes	No

PRIOR MENTAL HEALTH OR SUBSTANCE ABUSE TREATMENT:

Prior substance use/abuse counseling? Yes No Prior outpatient psychotherapy? Yes No

Prior inpatient mental health treatment? Yes No Prior psychiatry? Yes No

Current psychiatry? Yes No

Prior Provider Name(s)	City	State	Phone	Diagnosis	Beneficial? (Y/N)

Family of Origin History:

Describe Parents: Parent 1 Parent 2

Full Name: _____

Occupation: _____

Education: _____

General Health: _____

Present During Childhood:

	Present entire childhood	Present part of childhood	Not present at all
Parent 1			
Parent 2			
Step Parent 1			
Step Parent 2			
Brother(s)			
Sister(s)			
Other (specify) _____			

Parents' Current Marital Status:

[ ] married to each other
[ ] separated for ____ years
[ ] divorced for ____ years
[ ] parent 1 remarried ___ times
[ ] parent 2 remarried ___ times
[ ] parent 1 involved with someone
[ ] parent 2 involved with someone
[ ] parent 1 diseased for ___ years age of patient at mother's death ____
[ ] parent 2 diseased for ___ years age of patient at mother's death ____

Describe Childhood Family Experience:

[ ] outstanding home environment
[ ] normal home environment
[ ] chaotic home environment
[ ] witnessed physical/verbal/sexual abuse
[ ] experienced physical/verbal/sexual abuse

List all persons currently living in your household:

Name	Age	Sex	Relationship to you
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____

List children <u>not</u> living in same household as you:

Name	Age	Sex	Relationship to you
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____

Marital Status:

[ ] single, never married
[ ] engaged ____ months
[ ] married ____ years
[ ] divorced for _____ years
[ ] separated for _____ years
[ ] divorce in process _____ months
[ ] live-in for ____ years
[ ] ____ prior marriages (self)
[ ] ____ prior marriages (partner)

Relationship Satisfaction:

[ ] very satisfied with relationship
[ ] satisfied with relationship
[ ] somewhat satisfied with relationship
[ ] dissatisfied with relationship
[ ] very dissatisfied with relationship

Describe any past or current significant issues in intimate and/or immediate family relationships:

_____

Self Report Assessment of Functioning:

Daily Functioning: Please give a rough estimate of how many hours per week you spend doing the following in a typical week:

Working in your primary job	____
Parenting/Caretaking of others	____
Doing household chores, bills, etc.	____
TV, movies, phone, electronics, etc.	____
Physical recreation or exercise of some kind	____
Hobbies (crafts, games, dancing, reading, etc.)	____
Social activity with friends, family	____
Church, charity, inspirational activities	____
Quiet, non-productive, or relaxing time	____
Average number of hours of sleep per night	____

Lifelong Functioning:

Please check the best and worst time of your life:

Ages	Best Times	Average Times	Worst Times
0-5	_____	_____	_____
6-12	_____	_____	_____
13-19	_____	_____	_____
20-29	_____	_____	_____
30-39	_____	_____	_____
40-49	_____	_____	_____
50-59	_____	_____	_____
60-69	_____	_____	_____
70-79+	_____	_____	_____

Worst Time in Life:

Please briefly describe; You may use the back of this page for answers in the following sections, if needed:

_____

Who helped you through it? _____

Are there things that cause you to feel ashamed or that would be difficult to talk about? (No need to specify) Yes No

Best Time in Life:

Please briefly describe; You may use the back of this page for answers in the following sections, if needed:

_____

Was there someone to share it with? Yes No Do you have someone you can confide in at difficult times? Yes No

What have you done that you are **MOST PROUD OF**? _____

What are your **STRENGTHS** (How do you cope) when times are hard? _____

Do you feel you are a person of worth at least on an equal basis with others? Very Much Much Somewhat A little No

How much enjoyment or pleasure are you currently getting out of living? Very Much Much Somewhat A little No

SELF ASSESSMENT OF FUNCTIONING:

Please rate (1-10) how well you feel you are currently functioning in each of the areas listed below:

1 2 3 4 5 6 7 8 9 10

Not a problem Mild Problem Moderate Problem Severe Problem Couldn't be Worse

Mood/Mental Health _____ Social Relationship _____ Daily Work/School _____

Memory/Cognitive Abilities _____ Nutrition _____ Daily Living _____

Current Home Environment _____

Personal and Family History:

Please place an X by any of the following medical problems experienced by you or any member of your immediate family (parents, siblings, children) in the past or present. Also, please write who experienced the medical condition (e.g., you, 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 _____
Your Name — Legal Representative (if applicable)

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 Signature (if legal adult or legal representative of minor) _____

Date: _____ / _____ / _____