



# Central Iowa Psychological Services

Compassionate, Whole Person Care, Where You Matter

## Psychological History Initial Information/Evaluation for Adults

Adapted with permission from: PSYCHOTHERAPY ASSESSMENT CHECKLIST (1/01)

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### PERSONAL DATA

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex M F

Home Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

No. Years Education \_\_\_\_\_ Degree \_\_\_\_\_ Occupation \_\_\_\_\_

Marital Status \_\_\_\_\_ Currently living with \_\_\_\_\_

Spouse/Partner's Occupation \_\_\_\_\_ No. of Children \_\_\_\_\_ Ages \_\_\_\_\_

**Emergency Contact Information:** Name: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Contact Address: \_\_\_\_\_

Spirituality/Religious Affiliation: \_\_\_\_\_ Military Service?  Yes  No;  Past  Current

### MAIN CONCERNS:

Please list the major concerns that you would like help with in therapy, and rate the severity of each one according to the scale below:

1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Not a Problem    Mild Problem    Moderate Problem    Severe Problem    Couldn't be worse    **RATING**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Briefly describe what motivated you to seek therapy at this time (rather than some time earlier or later): \_\_\_\_\_

**MEDICAL HISTORY:** Do you have any serious medical conditions? (If yes, please describe)..... No    Yes

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

Name of Primary Care Physician (PCP) \_\_\_\_\_ Physician Phone # \_\_\_\_\_

Please list all medications you are currently taking \_\_\_\_\_

Please list all medications you have previously taken \_\_\_\_\_

List any known allergies: \_\_\_\_\_ Any serious hospitalizations, illness, accidents? If yes, describe \_\_\_\_\_

In Past Year, how many: Visits to doctor \_\_\_ Sick days \_\_\_ Cigarettes-day \_\_\_ Alcoholic drinks/day \_\_\_ Psychotherapy sessions, ever \_\_\_

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

- 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

## Psychological History Initial Information/Evaluation

**MEDICAL HISTORY** (continued)

Prior outpatient psychotherapy? \_\_\_ Yes \_\_\_ No

Prior/Current Psychiatry? \_\_\_ Yes \_\_\_ No

Prior substance use counseling? \_\_\_ Yes \_\_\_ No

If Yes, please provide further information below:

Prior provider name(s)    City                    State                    Phone                    Diagnosis                    Beneficial?

**CURRENT STRESSFUL EVENTS:** Legal \_\_\_ Financial \_\_\_ Family problems \_\_\_ Family Illness \_\_\_

Other \_\_\_\_\_ Are you in an abusive relationship? No \_\_\_ Somewhat \_\_\_ Yes \_\_\_

Recent losses (jobs, relationships, or difficult changes) \_\_\_\_\_

Changes in friendships? \_\_\_ Yes \_\_\_ No

Academic/School Stress? \_\_\_ Yes \_\_\_ No

**FAMILY OF ORIGIN HISTORY:**

**Present during childhood:**

	Present entire childhood	Present part of childhood	Not present at all
mother	[ ]	[ ]	[ ]
father	[ ]	[ ]	[ ]
stepmother	[ ]	[ ]	[ ]
stepfather	[ ]	[ ]	[ ]
brother(s)	[ ]	[ ]	[ ]
sister(s)	[ ]	[ ]	[ ]
other (specify)	[ ]	[ ]	[ ]

**Parents' current marital status:**

[ ] married to each other  
 [ ] separated for \_\_\_\_\_ years  
 [ ] divorced for \_\_\_\_\_ years  
 [ ] mother remarried \_\_\_\_\_ times  
 [ ] father remarried \_\_\_\_\_ times  
 [ ] mother involved with someone  
 [ ] father involved with someone  
 [ ] mother deceased for \_\_\_\_\_ years  
     age of patient at mother's death \_\_\_\_\_  
 [ ] father deceased for \_\_\_\_\_ years  
     age of patient at father'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

**Describe Parents:**

**Father**

**Mother**

Full Name \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Education \_\_\_\_\_  
 General Health \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Special or unusual circumstances in childhood: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**IMMEDIATE FAMILY HISTORY:**

**Marital status:**

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

**Intimate relationship:**

[ ] never been in a serious relationship  
 [ ] not currently in relationship  
 [ ] currently in a serious relationship

**Relationship satisfaction:**

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

**List all persons currently living in your household:**

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

**List children not living in same household as you:**

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

Frequency of visitation of above: \_\_\_\_\_

Describe any past or current significant issues in intimate relationships: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Describe any past or current significant issues in other immediate family relationships: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Psychological History Initial Information/Evaluation

### Self-Report of 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 ..... \_\_\_\_\_
- Physical recreation or exercise of some kind ..... \_\_\_\_\_
- Hobbies (crafts, games, music, dancing, reading, etc.) \_\_\_\_\_
- Social activity with friends, family ..... \_\_\_\_\_
- Church, charity, spiritual or inspirational activities .... \_\_\_\_\_
- Quiet, non-productive, or relaxing time ..... \_\_\_\_\_
- Average number of hours of sleep per night ..... \_\_\_\_\_

**LIFELONG FUNCTIONING:** Please check the best and worst times of your life:

<u>Age</u>	<u>Best Times</u>	<u>Average times</u>	<u>Worst Times</u>
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) ..... No Yes

**BEST TIME IN LIFE:**

(Please briefly describe) \_\_\_\_\_

\_\_\_\_\_ Was there someone to share it with? Yes No

Do you have a close friend who is supportive and someone you can confide in during 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?** VeryMuch Much Somewhat A little No

**How much enjoyment or pleasure are you currently getting out of living?** VeryMuch Much Moderate A little None

**SELF-ASSESSMENT OF FUNCTIONING:**

Please rate (from 1-10) how well you feel you are currently functioning in each of the three areas listed below, according the following scale:

10 ----- 9 ----- 8 ----- 7 ----- 6 ----- 5 ----- 4 ----- 3 ----- 2 ----- 1

Excellent Functioning    Mild difficulty    Moderate difficulty    Severe Difficulty    Barely able to function

**1. General Mood (Depression, Anxiety, etc.)** \_\_\_\_\_ **2. Social Relationships?** \_\_\_\_\_ **3. Daily work or school?** \_\_\_\_\_

Personal and Family Medical 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, mom, dad, 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?
<b>Cardiovascular/circulatory</b>			<b>Urinary</b>			<b>Psychological</b>		
Heart disease			Bladder or kidney infections			Attention deficit hyperactivity disorder		
High blood cholesterol			Kidney disease/stones			Anxiety (frequent)		
High blood pressure			Urinary stress incontinence			Obsessive-compulsive disorder		
Rheumatic fever			Nighttime wetting			Panic disorder		
Swelling of feet			Daytime wetting			Bipolar disorder		
<b>Endocrine</b>			Painful urination			Depression		
Diabetes			Frequent urination			Anorexia		
If yes, at what age?			<b>Respiratory</b>			Bulimia		
Gallstones / gallbladder disease			Asthma or emphysema			Binge eating		
Thyroid disease/goiter			Lung disease/pneumonia			Reading disorder		
<b>Gastrointestinal/digestive</b>			Chronic obstructive pulmonary disease			Math disorder		
Acid reflux (heartburn)			Tuberculosis			Written language disorder		
Diverticulosis			Shortness of breath			Schizophrenia		
Ulcers (stomach or intestinal)			Sleep apnea/on c-pap			Suicidal thoughts, plans, or behavior		
Pancreatitis			<b>Musculoskeletal</b>			<b>Neurological</b>		
Liver disease/hepatitis			Arthritis			Epilepsy or seizures		
Frequent diarrhea			Joint pain			Stroke		
Frequent constipation			Back pain			Dizziness		
Blood in stools			Hip pain			Headaches		
Irritable colon/bowel			Knee pain			Migraines		
<b>Hematological</b>			Ankle & foot pain			Numbness or tingling		
Anemia			Broken bones			Pins and needles feelings		
Blood clots			<b>Sleep-related</b>			Muscle weakness		
Bleeding disorders			Snoring			Weakness of grip		
			Observed apnea			Shakiness		
			Restless sleep			Convulsions		
			Trouble falling asleep			Loss of consciousness		
			Trouble waking up			<b>Other medical issues (list below)</b>		
			Morning headache					
			Daytime drowsiness					

**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 AND AMERICAN EXPRESS.
- OUR FULL SERVICE FEE IS CHARGED FOR TIME RESERVED WHEN APPOINTMENTS ARE FAILED OR CANCELLED WITHOUT SUFFICIENT NOTICE (ONE DAY.)

IF YOU BELIEVE YOUR MEDICAL INSURANCE MAY COVER THE COSTS OF ALL OR PART OF YOUR VISITS HERE, PLEASE GIVE US A COPY OF YOUR INSURANCE CARD AND COMPLETE THE FOLLOWING INFORMATION:

POLICY HOLDER	INSURANCE COMPANY OR PLAN	GROUP OR POLICY NUMBER
EMPLOYER OF POLICY HOLDER	RELATIONSHIP TO CLIENT	POLICY HOLDERS DATE OF BIRTH
POLICY HOLDERS SSN	POLICY HOLDERS ADDRESS (if different)	

While we will file your insurance claim for you, WE SUGGEST YOU CALL YOUR INSURANCE COMPANY to get information concerning your co-pay and deductible. We suggest you do this before your 1st or 2nd visit and ask them about your coverage for "out patient mental health services". This will help you to determine the appropriate payment for your counseling sessions. In lieu of this information we suggest a payment of at least 50% of the initial fee for the session. We will reimburse any excess amount once your insurance company pays us. All co-payments must be paid at the time of each session unless you make other arrangements with your therapist. Mastercard, Visa, Discover and American Express are accepted. If your plan requires a physicians 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 legal representative of \_\_\_\_\_  
YOUR NAME (FOR ADULTS) FOR A CHILD LESS THAN 18 (OR SOME OTHERS)

authorize CENTRAL IOWA PSYCHOLOGICAL SERVICES (CIPS) 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 Iowa Code Chapter 228, or as subsequently amended, to provide utilization review or quality assurance service for the administration of claims for benefits. I further authorize CIPS to directly receive all payment of benefits due.

This authorization allows (CIPS) and/or it's representatives to release information to my Insurance Company, to administrator 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 written revocation to (CIPS) and/or it's 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 the information is true, accurate, complete and I agree to be personally responsible for all reasonable charges not paid by my Insurance company.

DATE \_\_\_\_\_ PATIENT SIGNATURE (if legal adult or legal representative of minor) \_\_\_\_\_