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)
Psychotherapy Research Program at HMS, Leigh McCullough Ph.D.

PERSONAL DATA

Name ____ **Date** ____________________________________

Address ____ **Age** ______ **DOB** _____/____/____ **Sex M F**

____ **Home Phone** (_____) ________________________

____ **Cell Phone** (_____) __________________________

____ **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**

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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: ______________________

____

____

____

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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:		**LIFELONG FUNCTIONING: Please check the best and worst times of your life:**			
		Age	**Best Times**	**Average times**	**Worst Times**
Working in your primary job	____	0-5	__________	___________	___________
Parenting/Caretaking of others	____	6-12	__________	___________	___________
Doing household chores, bills, etc	____	13-19	__________	___________	___________
TV, Movies	____	20-29	__________	___________	___________
Physical recreation or exercise of some kind	____	30-39	__________	___________	___________
Hobbies (crafts, games, music, dancing, reading, etc.)	____	40-49	__________	___________	___________
Social activity with friends, family	____	50-59	__________	___________	___________
Church, charity, spiritual or inspirational activities ...	____	60-69	__________	___________	___________
Quiet, non-productive, or relaxing time	____	70-79+	__________	___________	___________
Average number of hours of sleep per night	____				

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?
Cardiovascular/circulatory			**Urinary**			**Psychological**		
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		
			Painful urination			Depression		
Endocrine			Frequent urination			Anorexia		
Diabetes			**Respiratory**			Bulimia		
If yes, at what age?			Asthma or emphysema			Binge eating		
Gallstones / gallbladder disease			Lung disease/pneumonia			Reading disorder		
Thyroid disease/goiter			Chronic obstructive pulmonary disease			Math disorder		
Gastrointestinal/digestive			Tuberculosis			Written language disorder		
Acid reflux (heartburn)			Shortness of breath			Schizophrenia		
Diverticulosis			Sleep apnea/on c-pap			Suicidal thoughts, plans, or behavior		
Ulcers (stomach or intestinal)			**Muscoloskeletal**			**Neurological**		
Pancreatitis			Arthritis			Epilepsy or seizures		
Liver disease/hepatitis			Joint pain			Stroke		
Frequent diarrhea			Back pain			Dizziness		
Frequent constipation			Hip pain			Headaches		
Blood in stools			Knee pain			Migraines		
Irritable colon/bowel			Ankle & foot pain			Numbness or tingling		
Hematological			Broken bones			Pins and needles feelings		
Anemia			**Sleep-related**			Muscle weakness		
Blood clots			Snoring			Weakness of grip		
Bleeding disorders			Observed apnea			Shakiness		
			Restless sleep			Convulsions		
			Trouble falling asleep			Loss of consciousness		
			Trouble waking up			**Other medical issues (list below)**		
			Morning headache					
			Daytime drowsiness					

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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

1, ______________________________ 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 it 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) ____

SOCIAL SECURITY # ____