



# Central Iowa Psychological Services

Compassionate, Whole Person Care, Where You Matter

## Psychological History Initial Information/Evaluation for Adults

### PERSONAL DATA

Name \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex M F  
 \_\_\_\_\_  
 \_\_\_\_\_ No. Years Education \_\_\_\_\_ Degree \_\_\_\_\_  
 \_\_\_\_\_ Occupation \_\_\_\_\_  
 Home Phone (\_\_\_\_) \_\_\_\_\_ Employer \_\_\_\_\_  
 Cell Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Please select which phone #'s we could place a call to and leave a message at:  Home  Work  Cell

Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_ Spouse/Partner's Occupation \_\_\_\_\_  
 Currently living with \_\_\_\_\_ No. of Children \_\_\_\_\_ Ages \_\_\_\_\_

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

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

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

How were you referred to us? \_\_\_\_\_

### 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): \_\_\_\_\_

Please draw a circle around any of the following problems which apply to you now:

- |                |                 |                    |                   |                  |
|----------------|-----------------|--------------------|-------------------|------------------|
| Adoption       | Drug Use        | Legal Matters      | Self-Esteem       | Violence         |
| Aging          | Ex-Spouse       | Making Decisions   | Separation        | Weight Loss/Gain |
| Alcohol Use    | Fears           | Marriage           | Sexual Problems   | Work or Job      |
| Anxiety        | Finances        | Memory             | Shyness           | Worrying         |
| Being a parent | Gender Identity | Menstrual Problems | Sleep             | Your own Parents |
| Binge Eating   | Grief           | Nightmares         | Spiritual Needs   | Other: _____     |
| Bowel Problems | Guilt           | Over-Commitment    | Strange Thoughts  | _____            |
| Career Choices | Headaches       | Pain               | Step-Parenting    |                  |
| Children       | Health Problems | Panic Attacks      | Stress            |                  |
| Co-Dependency  | Home Life       | Phobia             | Stomach Trouble   |                  |
| Concentration  | Hyperactivity   | Relationships      | Substance Abuse   |                  |
| Custody        | Inferiority     | Relaxation         | Suicidal Thoughts |                  |
| Depression     | In-Laws         | School             | Temper            |                  |
| Divorce        | Insomnia        | Self-Control       | Unhappiness       |                  |

## Psychological History Initial Information/Evaluation

### MEDICAL HISTORY:

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

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

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

Have you had any major health conditions which significantly affected your life? (If yes, please describe).... No Yes

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

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

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?

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Please place an X by any of the following conditions experienced by you or any member of your immediate family (parents, siblings, children) in the past or present. Also, please write who experienced the condition (e.g., you, mom, dad, sibling) in the column marked "Person?" for any condition you put an X next to.

Psychological Condition	X	Person?
Attention deficit hyperactivity disorder		
Anxiety (frequent)		
Obsessive-compulsive disorder		
Panic disorder		
Bipolar disorder		
Depression		
Anorexia		
Bulimia		
Binge eating		
Reading disorder		
Math disorder		
Written language disorder		
Schizophrenia		
Suicidal thoughts, plans, or behavior		

## Psychological History Initial Information/Evaluation

### FAMILY OF ORIGIN HISTORY:

**Describe Parents:**

**Father**

**Mother**

Full Name \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Education \_\_\_\_\_  
 General Health \_\_\_\_\_  
 Age \_\_\_\_\_ or Age at time of death \_\_\_\_\_  
 Marital status \_\_\_\_\_ To Whom \_\_\_\_\_

\_\_\_\_\_   
 \_\_\_\_\_   
 \_\_\_\_\_   
 \_\_\_\_\_   
 Age \_\_\_\_\_ or Age at time of death \_\_\_\_\_  
 Marital Status \_\_\_\_\_ To Whom \_\_\_\_\_

### Siblings

**Present during childhood:**

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

Name	Age	Sex	Occupation	Education	Health	Marital Status	Comments

**Describe childhood family experience:**

- outstanding home environment
- normal home environment
- chaotic home environment
- experienced physical/verbal/sexual abuse

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

### Children or others in the household

**IMMEDIATE FAMILY HISTORY:**

**Marital status:** \_\_\_\_\_  
 \_\_\_\_\_ prior marriages (self)  
 \_\_\_\_\_ prior marriages (partner)

**Intimate 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

Name	Age	Sex	Occupation or Grade in School	Living With Whom	Other Special Information

**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

**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

### **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 to 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?** \_\_\_\_\_

### **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

Adapted with permission from: PSYCHOTHERAPY ASSESSMENT CHECKLIST (1/01)  
Psychotherapy Research Program at HMS, Leigh McCullough Ph.D.

**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 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 # \_\_\_\_\_