



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 (____) _____

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 | |

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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)í . 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		

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FAMILY OF ORIGIN HISTORY:

Describe Parents:	Father	Mother
Full Name	_____	_____
Occupation	_____	_____
Education	_____	_____
General Health	_____	_____
Age _____ or Age at time of death _____		Age _____ or Age at time of death _____
Marital status _____ To Whom _____		Marital Status _____ To Whom _____

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
stepmother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
stepfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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: _____

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: _____

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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 its 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 its 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 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 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 # _____