



# 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 \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender M F Other \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Leave Messages Y/N? \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_ Leave Messages Y/N? \_\_\_\_\_

Email \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Leave Messages Y/N? \_\_\_\_\_

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

Marital Status \_\_\_\_\_ Currently Living With \_\_\_\_\_

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

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

### Please specify your ethnicity (mark all that apply):

\_\_\_\_ Asian or Pacific Islander \_\_\_\_ Black or African-American \_\_\_\_ Caucasian or White \_\_\_\_ Hispanic or Latino/a Other: \_\_\_\_\_

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

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

### MAIN CONCERNS:

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

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 treatment at this time (rather than some time earlier or later): \_\_\_\_\_

**MEDICAL HISTORY:** Do you have any serious medical conditions? \_\_\_\_ Yes \_\_\_\_ No (If yes, list): \_\_\_\_\_

Are you up-do-date on all recommended vaccinations? \_\_\_\_ Yes \_\_\_\_ No

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

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

May we contact your primary care physician? \_\_\_\_ Yes \_\_\_\_ No (If yes, please ask to sign a Release of Information allowing this)

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, 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

<u>Prior Provider Name(s)</u>	<u>City</u>	<u>State</u>	<u>Phone</u>	<u>Diagnosis</u>	<u>Beneficial?</u>

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

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

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/parent	[ ]	[ ]	[ ]
father/parent	[ ]	[ ]	[ ]
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/Parent**

**Mother/Parent**

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 and/or immediate family relationships: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SELF-REPORT ASSESSMENT OF FUNCTIONING:**

<b><u>DAILY FUNCTIONING:</u></b> Please give a rough estimate of how many <u>hours per week</u> you spend doing the following in a <u>typical week</u> :	<b><u>LIFELONG FUNCTIONING:</u></b> Please check the best and worst times of your life:			
	<b><u>Ages</u></b>	<b><u>Best Times</u></b>	<b><u>Average Times</u></b>	<b><u>Worst Times</u></b>
Working in your primary job .....	0-5	_____	_____	_____
Parenting/Caretaking of others .....	6-12	_____	_____	_____
Doing household chores, bills, etc. ....	13-19	_____	_____	_____
TV, movies, phone, electronics, etc. ....	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 <u>per night</u> .....				

**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 | 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 using this scale:

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 Relationships \_\_\_\_\_                      Daily Work/School \_\_\_\_\_

Memory and Cognitive Abilities \_\_\_\_\_                      Nutrition \_\_\_\_\_                      Daily Living (i.e., cooking, cleaning, hygiene, etc.) \_\_\_\_\_

Current Home Environment (assistive technologies, emergency plans, other persons in the home, pets, physical environment, etc.) \_\_\_\_\_

**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		
			Painful urination			Depression		
<b>Endocrine</b>			Frequent urination			Anorexia		
Diabetes			<b>Respiratory</b>			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		
<b>Gastrointestinal/digestive</b>			Tuberculosis			Writing disorder		
Acid reflux (heartburn)			Shortness of breath			Schizophrenia		
Diverticulosis			Sleep apnea/on c-pap			Suicidal thoughts, plans, or behavior		
Ulcers (stomach/intestine)			<b>Musculoskeletal</b>			<b>Neurological</b>		
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		
<b>Hematological</b>			Broken bones			Pins and needles feelings		
Anemia			<b>Sleep-related</b>			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			<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 AMEX
- 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 "outpatient mental health services". This will help you to 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 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 treatment provider. 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) \_\_\_\_\_