Adrienne Benson Psychotherapy Services

Psychological History Initial Information/Evaluation for Adults

PERSONAL DATA:

Name _____ Date _____

Address _____ Age _____ DOB _____/_____/_____ Sex M F

_____ 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

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 therapy at this time (rather than some time earlier or later): _____

_____

MEDICAL HISTORY: Do you have any serious medical conditions? _____Yes _____ No (If yes, describe): _____

_____

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, 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 MENTALTH 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

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? _____ Yes _____ Somewhat _____No

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:

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, phone, electronics, etc. ..... ____
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:

Ages	Best Times	Average Times	Worst Times
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) _____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 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? Very Much I Much I Somewhat I A little I No

How much enjoyment or pleasure are you currently getting out of living? Very Much I Much I Somewhat I A little I 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:

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

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

General Mood/Mental Health (depression, anxiety, etc.) ____ Social Relationships ____ Daily work/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			Writing disorder		
Acid reflux (heartburn)			Shortness of breath			Schizophrenia		
Diverticulosis			Sleep apnea/on c-pap			Suicidal thoughts, plans, or behavior		
Ulcers (stomach/intestine)			**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					