**Jenison Psychological Services, P.C.**

1836 Baldwin Street

Jenison, MI 49428

**Name: DOB: Date:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| PRESENTING PROBLEMS: (CHECK ALL THAT APPLY) | NONE | MILD | MODERATE | SEVERE | HAD THIS PROBLEM IN THE PAST (INDICATE SEVERITY) |
| Tension or Anxiety |  |  |  |  |  |
| Anger/Irritation |  |  |  |  |  |
| Depression |  |  |  |  |  |
| Tired or Fatigued |  |  |  |  |  |
| Feelings of Guilt |  |  |  |  |  |
| Marital Problems |  |  |  |  |  |
| Arguing with Significant Other |  |  |  |  |  |
| Sexual Concerns |  |  |  |  |  |
| Problems with Children |  |  |  |  |  |
| Physical Complaints |  |  |  |  |  |
| Sleep Disturbance |  |  |  |  |  |
| Obsessions or Compulsions |  |  |  |  |  |
| Concentration/Attention Problems |  |  |  |  |  |
| Memory Problems |  |  |  |  |  |
| Eating Problems |  |  |  |  |  |
| Work-related Problems |  |  |  |  |  |
| Alcohol or Drug Use Problems |  |  |  |  |  |
| Abuse or Related Problems |  |  |  |  |  |
| Suicidal Thoughts |  |  |  |  |  |
| Suicidal Actions or Attempts |  |  |  |  |  |
| Other Self Harm |  |  |  |  |  |
| Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |

**Describe what you hope to accomplish in counseling:**

**Mental Health History**

Have you received counseling in the past? Yes/No

If yes, when, with whom & for what reason?

Have you been hospitalized for a mental health issue? Yes/No

If yes, when & for what reason?

Is there a family history of mental health problems or nervous problems? Yes/No

If yes, please explain.

**Psychiatric Medication Use History:** (antidepressants or others)

**{ } I have tried medication, but they have not reduced my symptoms sufficiently**

**{ } I continue to work with Medical Staff in maintaining and making appropriate medication**

**adjustments. (List Current Psychiatric Meds in Medication Chart Below.)**

**{ } I cannot tolerate psychiatric medications due to adverse side effects**

**{ } I decline or refuse psychiatric medication**

**Physical Health Assessment**

**Primary Physician: Date of last visit:**

**List any current medications including psychiatric meds:**

|  |  |  |  |
| --- | --- | --- | --- |
| **MEDICATION** | **DOSE/FREQUENCY** | **PURPOSE** | **PRESCRIBING DOCTOR** |
|  |  |  |  |
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|  |  |  |  |

**Describe any Current or Past Medical Concerns/Problems:**

**Please describe your sleeping habits and any concerns you have in this area: (Normal, apnea, etc)**

**Please describe your eating habits and any concerns you have in this area: ? (Circle/describe all that apply): Normal, poor appetite, overeating, eating disorder, special diet needs**

**Substance Use/Abuse History**:

**Have you any concerns with substance abuse? (Circle/describe all that apply) No history of problems, past problem, current abstinence, current social use, current abuse – fill in chart below:**

None Past Present Frequency/Amount per day

Nicotine \_\_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol \_\_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marijuana \_\_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drugs \_\_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

–Specify Drug type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you received treatment for any of the above substances? Yes/No**

**If yes, Inpatient or Outpatient? When? For what substance? For how long?**

**Do you have any family members with substance abuse problems? Yes/No**

**If yes, list relationship and substance abused.**

**Family History:**

**What is/was your relationship like with your parents?**

**Sibling’s Names: Age: Describe Relationship: Circle One**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ Good/Fair/Poor**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ Good/Fair/Poor**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ Good/Fair/Poor**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ Good/Fair/Poor**

**Is there any history of verbal, physical or sexual abuse in your family? Yes/No**

**If yes, please describe.**

**Who do you currently live with?**

**Are there any difficulties in your living arrangements? Please describe.**

**Are you currently married or in a relationship? What is that relationship like?**

**Children Names Age: Describe Relationship: Circle One**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ Good/Fair/Poor**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ Good/Fair/Poor**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ Good/Fair/Poor**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ Good/Fair/Poor**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ Good/Fair/Poor**

**Are there other family concerns you feel your therapist needs to know about? Describe.**

**Do you or others have any concern for your safety?**

**Education/Occupation:**

**Highest Grade Completed: \_\_\_\_\_\_\_\_\_ Other Educational Training:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Long:\_\_\_\_\_**

**Spiritual Background**:

**List any formal religious affiliation and involvement:**

**Emergency Contact**:

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Office Use:**

**Provider Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Reviewed \_\_\_\_\_\_\_\_\_\_\_**