INNOVATIVE
HEALTH CARE CONCEPTS
The Counseling Center
115 E. 16th Street | Idaho Falls, ID 83404 | t. 208.523.6727 | f. 208.523.6729

Please note: This form must be returned 48 hours prior to your initial appointment.

ADULT SELF ASSESSMENT FOR MEDICATION MANAGEMENT

The purpose of this questionnaire is to obtain a comprehensive picture of your mental health background. In treatment, records are necessary to provide a high quality of service. By completing these questions, as fully and accurately as possible, it will help to ensure the highest quality of care. All records are kept confidential - **no one outside this clinic will be permitted to see these records without your written permission.** If you do not desire to answer a particular question, please just state "Do Not Care to Answer". If a question is not applicable please state N/A. **Please type or print and use a pen.**

Full Name:			**Today's Date:**
Mailing Address:			
City:		**State:**	**Zip:**
Home Phone:	**Cell Phone:**	**Work Phone:**	
Who referred you to this clinic?			
Age:	**DOB:**	❑ **Male** ☐ **Female**	

Race:
- ❑ Caucasian
- ❑ Hispanic
- ❑ African American
- ❑ Asian American
- ❑ Native American
- ❑ Other _____

Religion:
- ❑ LDS (Mormon)
- ❑ Catholic
- ❑ Protestant _____
- ❑ Jewish
- ❑ Muslim
- ❑ Other _____
- ❑ None

Marital Status:
- ❑ Never Married
- ❑ Married number of marriages _____
- ❑ Cohabiting
- ❑ Separated
- ❑ Divorced
- ❑ Widowed

Name and relationship of person(s) with whom you live:	
Number of Children:	**Ages of Children:**
Highest level of education:	
College degree(s) [if applicable]:	
Occupation:	

Please list the modality of treatment requested:
- ❑ Medications only
- ❑ Counseling / Psychotherapy only
- ❑ Both
- ❑ Uncertain

Internal Use Only
Date sent:
Date returned:

Please state the principal reason you are requesting a consultation or treatment

(if necessary use another sheet of paper)

Please describe the current episode of your illness from the time of your first symptom to the present, including dates and significant events:

(if necessary use another sheet of paper)

Please list recent stressful life event:

(if necessary use another sheet of paper)

Clinician Comments

Specific Questions Regarding Psychiatric Problems

Depression - Have you had a period of time in which you felt unhappy, depressed or felt no interest in life consistently for at least two weeks or longer?

❑ Yes, now ☐ Yes, in the past ☐ No

Chronic Feelings of Unhappiness - Have you felt mildly unhappy or unable to enjoy life for many years, for no apparent reason?

❑ Yes, now ☐ Yes, in the past ☐ No

Suicide Attempts - Have you attempted suicide?

❑ Yes, now ☐ Yes, in the past ☐ No

If yes, when and how: _____

Self Harm- Besides attempting suicide, have you ever attempted to do physical harm to yourself in other ways, such as cutting and burning yourself?

❑ Yes, now ☐ Yes, in the past ☐ No

If yes, how: _____

High Periods of Mania - Have you had moods that lasted at least one week or longer in which you had so much energy you did not sleep for several nights, or felt you could accomplish many difficult tasks easily? Were you feeling so good that other people commented on your elevated mood?

❑ Yes, now ☐ Yes, in the past ☐ No

Psychotic Symptoms - Have you had hallucinations, "heard voices", felt you had special powers or were receiving special messages, felt very suspicious people were trying to harm you, etc.?

❑ Yes, now ☐ Yes, in the past ☐ No

Chronic Tension or Anxiety - Have you had problems with chronic anxiety, tension, nervousness or constantly over-worrying about minor concerns regardless of the situation (not related to anxiety attacks)?

❑ Yes, now ☐ Yes, in the past ☐ No

Panic Attacks - Have you had brief anxiety in which you felt like you were going to die, lose control, or were extremely frightened, anxious or uncomfortable?

❑ Yes, now ☐ Yes, in the past ☐ No

Panic Associated Fears- Have you ever been afraid of going out of the house alone, going to the grocery store, driving or using public transportation because of fear of having a panic attack?

❑ Yes, now ☐ Yes, in the past ☐ No

Obsessive Symptoms- Have you had obsessions (ideas that seem senseless but keep repeating in your mind) or compulsions to repeat tasks such as repeatedly checking things, washing, or counting?

❑ Yes, now ☐ Yes, in the past ☐ No

Social Fears and Phobias - Have you been fearful in specific social situations, felt uncomfortable doing things in front of other people or do you worry excessively about being embarrassed or humiliated in social situations?

❑ Yes, now ☐ Yes, in the past ☐ No

Post Traumatic Symptoms - Have you experienced a very traumatic event that has continued to bother you or cause emotional problems later in life such as repeated nightmares or "flashbacks" or the "event(s)"?

❑ Yes, now ☐ Yes, in the past ☐ No

Phobias - Have you had significant phobias such as heights, flying, closed spaces, insects, etc. that interfere with your life?

❑ Yes, now ☐ Yes, in the past ☐ No

If yes, please specify: _____

Dissociative Symptoms - Have you had periods in which you feel "out of touch", removed from the world around you, or lost large amounts of time you cannot account for?

❑ Yes, now ☐ Yes, in the past ☐ No

Clinician Comments

Specific Questions Regarding Psychiatric Problems (cont'd)

Anorexia - Have you ever been anorexic or purposely lost weight to obtain a weight below normal?

❑ Yes, now ☐ Yes, in the past ☐ No

Binge Eating or Bulimia - Have you had eating binges associated with inducing vomiting, using laxatives or exorcising to extreme?

❑ Yes, now ☐ Yes, in the past ☐ No

Chronic Physical Symptoms - Have you had repeated periods of time in which you felt physically sick or worried about your health when no physical cause could be found?

❑ Yes, now ☐ Yes, in the past ☐ No

Chronic Pain- Have you had problems with chronic pain such as headaches?

❑ Yes, now ☐ Yes, in the past ☐ No

If yes, please specify: _____

Sleep Problems - Have you had sleep problems such as insomnia, oversleeping, frequent nightmares or sleep-walking?

❑ Yes, now ☐ Yes, in the past ☐ No

Compulsive Behaviors - Have you had problems with compulsive behaviors such as spending, gambling, work, sexual behaviors, pornography, or other problematic compulsions?

❑ Yes, now ☐ Yes, in the past ☐ No

If yes, please specify: _____

_____

Hyperactivity / Inattention- Were you considered hyperactive as a child, had attention Deficit Hyperactivity Disorder, or been treated with Ritalin or another stimulant medication?

❑ Yes, now ☐ Yes, in the past ☐ No

Temper - Anger Problems - Have you had problems with your temper / anger?

❑ Yes, now ☐ Yes, in the past ☐ No

Substance Use / Abuse

Alcohol Use / Abuse- Do you drink alcohol?

☐ Yes, now ☐ Yes, in the past ☐ No

❑ I drink occasionally:_____X per month.

☐ I drink most days:_____X per week.

☐ I or significant others believe I have a drinking problem.

Drug Abuse - Have you abused "street" or illicit prescription drugs?

☐ Yes, now ☐ Yes, in the past ☐ No

If yes, what drugs(s) and what ages with each drug: _____

_____

Tobacco Products - Do you smoke or use other tobacco products?

☐ Yes, now ☐ Yes, in the past ☐ No

If yes, how many packs per day and how many years: _____

_____

Caffeine - Do you regularly drink coffee, tea or colas?

❑ Yes, now ☐ Yes, in the past ☐ No

If yes, how much per day: _____

If applicable, have you recognized any major negative consequences of your substance use/abuse (i.e. legal, health, relationship difficulties, job loss, etc.)?

❑ Yes, now ☐ Yes, in the past ☐ No ☐ Not Applicable

Clinician Comments

Past and Present Treatment with Counseling or Psychotherapy

Name of Therapist	Purpose of Treatment	Date Started	Length of Treatment	Was it Helpful?	Comments

Past Hospitalizations or Residential Treatment for the Treatment of Psychiatric, Behavioral or Substance Abuse Problems

Name of Institution/ Location	Reason for Hospitalization or Type of Problem	Date Started	Length of Treatment	Was it Helpful?	Comments

Past Treatment with Psychiatric Medications

(current medications listed later)

Below are listed a number of commonly used medications with significant psychiatric or emotional effects (please list in the boxes below):

Antidepressants		Mood Stabilizers	Tranquilizers	Sleeping Aids	Stimulants	Others
Prozac	Serzone	Lithium	Xanax	Ambien	Ritalin	Risperdal
Zoloft	Wellbutrin	Depakote	Klonopin	Sonata	Dexadrine	Zyprexa
Paxil	Amitriptyline	Tegretol	Ativan	Tranodone	Adderall	Seroquel
Luvox	Nortriptyline	Lamictal	Valium	Dalmane	Clondine	Geodon
Celexa	Desipramine	Neurontin	Buspar	Halcion	Concerta	Prolixin
Effexor	Anafranil	Topamax	Serax	Sominex	Provigil	Thorazine
Remeron	Cymbalta	Gabitril	Librium	Tylenol PM		Haldol
Lexapro	Nardil	Trileptal	Kava Kava	Benadryl		Antabuse
Sinequan	Parnate	Equetro		Lunesta		Abilify
Imipamine	SAM-E			Rozerem		Naltrexone
St. John's Wort						

Name of Medication	Max. Dose	Doctor	Reason for Use	Date Started	Length of Use	Response 0=none 1=poor 2=moderate 3=excellent	Side Effects

Medical History

Primary Care Physician: _____

Medical Specialists - Name and specialty: _____

_____

Weight - Current weight in pounds: _____ lbs.

Height - Your height in feet and inches: _____

Allergies - Please list all allergies, including medication allergies: _____

_____

_____

Prenatal Medical Problems - Did your mother experience significant medical problems during her pregnancy, labor or delivery with you?

☐Yes ☐No

If yes, please explain: _____

_____

Acute or Chronic Physical Illness - Please include past and present conditions and age or date of onset of conditions:

_____

_____

_____

_____

Seizures or Head Traumas with Loss of Consciousness or Amnesia - Please list date of trauma or date of onset and type of seizures, if applicable:

_____

_____

_____

Surgeries - Please include type and date: _____

_____

_____

_____

Female Menstrual History - Please include regularity, duration and if you have excessive pain or discomfort with periods: _____

_____

Do your moods, depression, irritability, and/or irrationality change significantly with your menstrual periods or due to oral contraceptives?

☐Yes ☐ No

If yes, please explain: _____

_____

Current Medical Symptoms - Please list any current physical symptoms including headaches or dizziness; ear, nose or throat problems; heart problems; lung or respiratory problems; stomach, liver or bowel problems; urinary tract or kidney problems; reproductive system problems; muscle, bone or joint problems, skin disease; blood, immune or hormonal problems; pain problems, etc:

_____

_____

_____

_____

Clinician Comments

Current Medications

Please list all medications (prescribed or over the counter), herbs, or vitamins which you have used on a regular basis during the last three months:

Medication	Dose	Date Started	Date Stopped	Prescribing Doctor	Reason for Use

Family History of Psychiatric Problems

Please include psychiatric problems, in your biological relatives, such as depression, bipolar (manic-depression), anxiety disorders (i.e. panic disorder, OCD, post traumatic stress…), schizophrenia, hyperactivity or attention deficit disorder, alcohol or drug abuse, anger or criminal problems, suicides, etc.:

Relative	Yes	No	?	Type of Problem(s)
Mother				
Mother's Parents & Sibs.				
Maternal Cousins				
Father				
Father's Parents & Sibs.				
Paternal Cousins				
Your Brothers & Sisters				
Your Children				

Clinician Comments

COMPLETE FOR ADULT PATIENTS ONLY

Social History

Place of Birth _____

Where did you **live while growing up**; did you move frequently?

What were you like as a **child**? I.e. hyperactive, moody, happy, anxious, temperamental, etc.

How many **siblings** did you have and where did you fit in the order? How'd you get along with them?

Please describe **family constellation** while growing up i.e. divorces, remarriages and step-parents, etc.

Please give a brief description of your **father's or step father's personality** and your **relationship** to him/them.

Please give a brief description of your **mother's or step mother's personality** and your **relationship** to her/them.

What was your **family structure** like when you were growing up i.e. too strict, harsh,difficult, affectionate, close, unstable, too loose, etc.

Did you experience any **traumatic events** **or abuse** (physical, sexual, verbal, neglect) while you were growing up?

☐Yes ☐No If yes, please explain:

How did you do during **grade school** academically, socially, and behaviorally? Did you require an IEP or resource class?

How did you do during your **teenage years** academically, socially, and behaviorally?

If you were in the **military service,** please describe:

Have you had any **legal charges**, past or present?

☐Yes ☐No If yes, please explain:

Are you involved in a **religious group or organization**?

- ❑ No involvement
- ❑ Active when growing up
- ☐ Would like to be more active
- ☐ Feel uncomfortable with church
- ❑ Attend occasionally
- ❑ Attend regularly
- ❑ Went on a church mission/service
- ❑ Involved in church leadership/teaching
- ❑ Converted to a new religion
- ☐ Other _____

Please list your **hobbies and interests**:

What are your **strengths**?

What are your **weaknesses**?

Clinician Comments

Social History (cont'd)

Please complete the following information regarding each **marriage** (or similar long-term relationship(s)).

Marriage	Age at start	Length	Was it good, bad, or indifferent?	If terminated, for what reason?
First				
Second				
Third				
Fourth				
Fifth				

Marriage - How would you describe your current marriage? (check all that apply)

- ❑ Good, happy with relationship
- ❑ Warm relationship
- ❑ Supportive
- ❑ Stable
- ❑ Bored
- ❑ Disagreements over children
- ❑ Sexual problems
- ❑ Conflicts over money
- ❑ Poor communication
- ❑ Disagreements over religion
- ❑ Many minor conflicts
- ❑ Many fights
- ❑ On the verge of breakup
- ❑ Abusive (verbal, physical, sexual)
- ❑ Significant problems (describe below)

Spouse's Education Level: _____
Spouse's Occupation: _____

Family, Friends, Leisure - How would you describe your social relationships and activities? (check all that apply)

- ❑ Pleased with children
- ❑ able to relax
- ❑ Spend time with hobbies/leisure activities
- ❑ Spend time with friends outside of family
- ❑ Problems - friction with children
- ❑ Problems with relatives
- ❑ Feel bored
- ❑ Feel isolated, wish you had more friends
- ❑ Significant problems (describe below)

Employment - How would you describe your employment? (check all that apply)

- ❑ Good, enjoy work
- ❑ Feel good about co-workers
- ❑ Perform well, can solve problems
- ❑ Feel successful
- ❑ Find work interesting
- ❑ Neutral, uncertain
- ❑ Feel anxious, upset at work
- ❑ Unable to keep up with work
- ❑ Trouble with co-workers
- ❑ Trouble with supervisors or boss
- ❑ Missing days frequently
- ❑ Wish you could change jobs
- ❑ On the verge of leaving
- ❑ On the verge of being fired
- ❑ Unable to work
- ☐ Significant problems (describe below)

Past Employment - type of job and duration:

Living Situation and Finances - How would you describe your living situation? (check all that apply)

- ❑ Good, happy living in Idaho
- ❑ Pleased with neighborhood
- ❑ Home adequate for you and family
- ❑ Want to move
- ❑ Minor financial problems
- ❑ Income inadequate
- ❑ Major debts, severe financial problems
- ❑ On the verge of bankruptcy
- ☐ Significant problems (describe below)

What do you **hope to accomplish in treatment**?

Clinician Comments