INNOVATIVE
HEALTH CARE CONCEPTS
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Innovative Counseling Center

Welcome to Innovative HealthCare Concepts! Please fill out the following sections for your provider:

Name: _____ Date of Birth: _____

Specific Questions Regarding Psychiatric Problems:

Depression—Have you had a period of time in which you felt unhappy, depressed, irritable, 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 ever attempted suicide?

☐ Yes, now ☐ Yes, in the past ☐ No

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

☐ Yes, now ☐ Yes, in the past ☐ No

High Periods or Mania—Have you had moods that lasted at least one week or longer in which you have so much energy you did not sleep for several nights, or felt like 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 inappropriately suspicious people were trying to harm you?

☐ Yes, now ☐ Yes, in the past ☐ No

Chronic Tension or Anxiety—Have you ever 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 anxiety attacks 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 store/school, 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 or 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 your life such as repeated nightmares or "flashbacks" of 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

Anorexia—Have you 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 exercising to the 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 young child, had Attention Deficit Hyperactivity Disorder, or have been treated with Ritalin or other stimulate medications?

☐ Yes, now ☐ Yes, in the past ☐ No

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

_____

_____

_____

_____

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

Please list any recent stressful events in your life:

Have you ever had any past Counseling?

☐ Yes, now ☐ Yes, in the past ☐ No

If yes, please specify where, name of therapist, length of treatment, and any comments:

Have you had any past hospitalizations or residential treatment for the treatment of Psychiatric, Behavioral, or Substance Use Problems?

☐ Yes, now ☐ Yes, in the past ☐ No

If yes please specify name of location, reason for hospitalization or type of problem, length of treatment, and any comments:_____

_____

_____

_____

Medical History:

Weight: _____

If your weight increased or decreased by more than 20lbs during the last 2 years, please state the amount and explain the circumstances:

Height: What is your height in feet and inches?_____

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 Illnesses: 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:_____

_____

_____

_____

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.

_____

_____

_____

_____

_____

_____

_____

Family History Of Psychiatric Problems:

Please include psychiatric problems in your biological relatives, such as depression, bipolar (manic-depression), anxiety disorders (panic disorder, OCD, PTSD), schizophrenia, hyperactivity or attention deficit disorder, alcohol or drug abuse, anger or criminal problems, suicide, etc.:

Mother: _____

Maternal Parents and Siblings: _____

Maternal Cousins: _____

Father: _____

Paternal Parents and Siblings: _____

Paternal Cousins: _____

Brothers and Sisters: _____

Social History:

Where were you born?_____

Where did you live while growing up? Did you move around a lot? _____

_____

What were you like as a child? Hyperactive, Moody, Happy, Anxious, Temperamental, etc.?

_____

How many siblings do you have and where do you fit in the order? How do you get along with them?_____

_____

Please describe the family constellation while growing up, i.e. divorces, remarriages, and step-parents? _____

_____

Please give a brief description of your relationship with your Father or Step-Father

_____

_____

Please give a brief description of your relationship with your Mother or Step-Mother

Please describe the type of structure and discipline in the home.

Did you experience any traumatic events or abuse while growing up?

☐ Yes, now ☐ Yes, in the past ☐ No

If yes, please specify and explain:

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

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
- ☐ 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? _____

_____

Please provide information regarding each marriage or similar long-term relationship (s):

1. Marriage: age, length, was it good, bad, indifferent, if terminated, for what reason?

   _____

   _____

   _____

2. How would you describe your current marriage, check all that apply:

   - ☐ Good, happy with relationship
   - ☐ Warm relationship
   - ☐ Supportive

- ☐ Bored
- ☐ Stable
- ☐ Disagreements over children
- ☐ Sexual Problems
- ☐ Conflicts over money
- ☐ Poor communication
- ☐ Disagreements over religion
- ☐ Many minor conflicts
- ☐ Many fights
- ☐ On the verge of break up
- ☐ Abusive (verbal, physical, emotional, sexual)
- ☐ Significant Problems, please describe:_____

_____

Spouse's Education Level:_____

Spouse's Occupation: _____

How would you describe your social relationships and activities, check all that applies:

- ☐ 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, please describe:_____

_____

Employment: How would you describe your employment, check that all apply:

- ☐ Good, enjoy work
- ☐ Feel good about coworkers
- ☐ Preform 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, please describe: _____

_____

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, please describe: _____

What do you hope to accomplish in treatment? _____