Kalamazoo Office
5340 Holiday Terrace
Kalamazoo, MI 49009

cfps
Child & Family Psychological Services, P.C.

Portage Office
1662 E. Centre Ave.
Portage, MI 49002

ADULT CONFIDENTIAL HISTORY

Please Print Clearly Today's Date ______________________

Client's Last Name: ______________________ First Name: ______________________ MI: ____

Birthdate: _____/_____/______ Age: ________________ Race: ________________

Address ____

City, State ______________________________ Zip______________

Phone: ______________________ Other Phone: ______________________

Please indicate with an * which phone numbers we may NOT leave a message.

Email Address: ____

In case of an emergency, contact:

Name ______________________ Relationship ______________________

Phone: ______________________ Other Phone: ______________________

PRIMARY INSURANCE

Subscriber's Name: ______________________ Subscriber's Date of Birth: ________________

Address (if different than client): ______________________________

Insurance Company Name: ______________________ Employer:______________________

Subscriber's Contract/ID:______________________ Group No: ______________________

Relationship to Client: ☐ Self ☐ Spouse ☐ Child ☐ Other ________________

SECONDARY INSURANCE

Subscriber's Name: ______________________ Subscriber's Date of Birth: ________________

Address (if different than client): ______________________________

Insurance Company Name: ______________________ Employer:______________________

Subscriber's Contract/ID:______________________ Group No: ______________________

Relationship to Client: ☐ Self ☐ Spouse ☐ Child ☐ Other ________________

How did you find out about Child & Family Psychological Services?

☐ Family/Friend ☐ Web Search ☐ Google ☐ School ☐ Church/Synagogue

☐ DocASAP ☐ CFPS Website ☐ Social Media ☐ Physician ☐ Insurance Company

☐ Other (please specify) ____

Do you (client) have a: ☐ conservator ☐ guardian ☐ representative payee ☐ personal representative

☐ Yes ☐ No If Yes: Name:_______________________________ Phone: ________________

Address: ____

Is someone coordinating your services (e.g. legal, mental health, physical)?

☐ Yes ☐ No If Yes: Name:_______________________________ Phone: ________________

Address: ____

Primary reason(s) for seeking services

☐ Anger management ☐ Anxiety ☐ Coping ☐ Depression

☐ Eating disorder ☐ Fear/phobias ☐ Mental confusion ☐ Sexual concerns

☐ Sleeping problems ☐ Addictive behaviors ☐ Alcohol/drugs ☐ Hyperactivity

Other mental health concerns (specify): ____

____

How old were you when you first felt these symptoms? ________________________________

What are your goals for therapy? (What outcome(s) would you like to take place?) ________________

____

Any additional information that would assist us in understanding your concerns or problems: __________

____

How would you like to receive appointment reminders (Check ONE option only)?

☐ Text message to my cell phone number ______________________(normal text message rates may apply)

☐ Via email message to the following email address:______________________________________

☐ Via automated telephone message to my home or cell phone number ________________________

☐ None of the above, I'll remember my appointments on my own

Appointment information is considered "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private and requesting that it be handled as I have noted above.

Signature ______________________________________ Date ____________________

Behavioral/Emotional

Please check behaviors and symptoms that occur to you more often than you would like them to:

☐ Alcohol dependence
☐ Aggressive (☐ verbal ☐ physical)
☐ Anger
☐ Anxiety
☐ Avoiding people
☐ Bizarre experiences
☐ Chest pain
☐ Computer addiction
☐ Depression
☐ Disorganized thoughts
☐ Disorientation
☐ Distractibility
☐ Drug dependence
☐ Eating disorder
☐ Emotional outbursts
☐ Fatigue
☐ Gambling
☐ Hallucinations
☐ Hearing Voices
☐ Heart palpitations
☐ High blood pressure
☐ Homicidal Ideation
☐ Hopelessness
☐ Impulsivity
☐ Irritability
☐ Judgment errors
☐ Loneliness
☐ Low self-esteem
☐ Memory impairment
☐ Overly Sensitive
☐ Panic attacks
☐ Paranoid
☐ Phobias/fears
☐ Racing Thoughts
☐ Rapid Speech
☐ Recurring thoughts
☐ Sexual addiction
☐ Sexual difficulties
☐ Sick often
☐ Sleeping problems
☐ Social Difficulties
☐ Speech problems
☐ Suicidal thoughts
☐ Trembling
☐ Withdrawing
☐ Worrying
☐ Other ______________________________

Please describe how the above symptoms impair your ability to function effectively (e.g., socially, occupationally, academically, emotionally, physically) ______________________________

____

What areas of your life are being affected by the above?

Social

☐ Unable to form or maintain friendships
☐ Withdrawal from family and friends
(excessive desire to be alone)
☐ Increased conflict with others
☐ Loss of interest in social activities
☐ Phobia

Occupational

☐ Unable to maintain job
☐ Absenteeism
☐ Conflicts with co-workers
☐ Tardiness
☐ Reduced productivity
☐ Disciplinary action for poor performance

Academic

☐ Failing grades
☐ Truancy
☐ Tardiness
☐ Detention
☐ Reduced productivity at school
☐ Fighting/conflicts with students/teachers

Physical

☐ Decreased energy/fatigue
☐ Difficulty getting out of bed
☐ Insomnia
☐ Substantial weight loss or gain
☐ Decreased/increased appetite
☐ Frequent illness

Affective Distress

☐ Crying spells
☐ Irritability
☐ Concentration problems
☐ Disorganized thoughts
☐ Feeling overwhelmed with emotions

Affective Distress (Continued)

☐ Worrying that interferes with the ability to concentrate
☐ Anger/rage
☐ Emotional meltdowns/breakdowns
☐ Memory problems

Counseling/Prior Treatment History

	Yes	No	When	Where	Overall experience
Mental health counseling	☐	☐	____	____	____
Psychiatrist for medication	☐	☐	____	____	____
Suicidal/Homicidal/Violent thoughts	☐	☐	____	____	____
Suicidal/Homicidal/Violent attempts	☐	☐	____	____	____
Drug/Alcohol treatment	☐	☐	____	____	____
Hospitalizations	☐	☐	____	____	____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous, etc.)	☐	☐	____	____	____

Any immediate family in treatment currently? If yes, whom and where? ____________________

Previous mental health diagnosis(es): ____________________

Family Information

Your current relationship status:

- ☐ Single
- ☐ Divorce in process
- ☐ Unmarried, living together
- ☐ Legally married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Annulment
- ☐ Engaged
- ☐ Other ______________________________

Assessment of relationship with significant other (if applicable): ☐ Good ☐ Fair ☐ Poor ☐ N/A

Would you like your family to be involved in your treatment? ☐ Yes ☐ No

If yes, please describe the extent of involvement: ______________________________

	Name	Age	(Indicate if step or adopted)	Living? Yes/No	Living with you? Yes/No
Spouse					
Children					
Mother					
Father					

Significant others in your life (brothers, sisters, grandparents, relatives, step-relatives):

Please specify relationship.

Relationship	Name	Age	Living? Yes/No	Living with you? Yes/No

Parental Information (check those which apply):

☐ Parents legally married ☐ Mother remarried Number of times _______
☐ Parents have been separated ☐ Father remarried Number of times _______
☐ Parents divorced: Your age at the time of divorce: _________

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.) ______________________________

Development

Are there special, unusual, or traumatic circumstances that occurred in your life? ☐ Yes ☐ No

If Yes, please describe: ______________________________

Has there been a history of child abuse? ☐ Yes ☐ No

If Yes, which type(s)? ☐ Sexual ☐ Physical ☐ Verbal

Other childhood issues: ☐ Neglect ☐ Inadequate nutrition ☐ Poor health ☐ Other (please specify)

____

How old were you at the time of abuse? ______________________________

Comments regarding childhood development: ______________________________

____

Parenting style of your parents:

☐ Authoritative (strict, but fair) ☐ Authoritarian (overly strict) ☐ Permissive (few rules)

In your developmental milestones (walking, talking, onset of puberty), were you: ☐ on time ☐ early ☐ late

Social Relationships

Check how you generally get along with other people (check all that apply):

☐ Affectionate ☐ Aggressive ☐ Avoidant ☐ Fight/argue often ☐ Follower
☐ Friendly ☐ Leader ☐ Outgoing ☐ Shy/withdrawn ☐ Submissive
☐ Other (specify)____

Do you currently have supportive friendships? ☐ Yes ☐ No

Sexual orientation: _______________ Comments: ______________________________

Sexual dysfunctions? ☐ Yes ☐ No

If Yes, describe: ____

Other History of Trauma

Any history of being abused by others? ☐ Yes ☐ No

☐ Experienced or ☐ Witnessed

☐ Neglect ☐ Abuse (☐ Emotional ☐ Physical ☐ Verbal ☐ Sexual)

☐ Violence ☐ Sexual assault

Explain: ____

Any current behaviors or history as sexual perpetrator? ☐ Yes ☐ No

If Yes, describe____

Do you have a history of social problems (e.g. being bullied, bullying others)? ____________________

____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong?______________________________

____

Are you experiencing any problems due to cultural or ethnic issues? ☐ Yes ☐ No

If Yes, describe: ____

Other cultural/ethnic information: __________________________________

Spiritual/Religious

How important are spiritual matters to you? ☐ Not at all ☐ Little ☐ Moderate ☐ Much

Are you affiliated with a spiritual or religious group? ☐ Yes ☐ No

If Yes, describe: ____________________

Were you raised within a spiritual or religious group? ☐ Yes ☐ No

If Yes, describe: ____________________

Would you like your spiritual/religious beliefs incorporated into the counseling? ☐ Yes ☐ No

If Yes, describe:____________________

Current Legal Status

Are you mandated for treatment? ☐ Yes ☐ No

Are you involved in any active cases (traffic, civil, criminal)? ☐ Yes ☐ No

If Yes, please describe and indicate the court and hearing/trial dates and charges____________________

____

Are you presently on probation or parole? ☐ Yes ☐ No

If Yes, please describe____________________

Probation officer name and telephone number: ____________________

Past Legal History

Traffic violations ☐ Yes ☐ No

Criminal involvement ☐ Yes ☐ No

Other: ____________________

DWI, DUI, etc. ☐ Yes ☐ No

Civil involvement ☐ Yes ☐ No

If you responded Yes to any of the above, please fill in the following information:

Charges	Date	Where (city)	Results

Education

Fill in all that apply: Currently enrolled in school: ☐ Yes ☐ No

☐ High school grad/GED Average school grades (current or previous): ____________________

☐ Vocational Number of years: __ Graduated: ☐ Yes ☐ No Major: ____________________

☐ College Number of years: ___ Graduated: ☐ Yes ☐ No Major: ____________________

☐ Graduate Number of years: ___ Graduated: ☐ Yes ☐ No Major: ____________________

Other training: ____

Special circumstances (e.g., learning disabilities, gifted): ____________________

Literacy Level (if known): ☐ Limited (0-275) ☐ Minimal (276 – 325) ☐ High (326 and higher)

Employment

Begin with most recent job, list job history

Employer	Dates	Title	Reason for Leaving	How Often Miss Work

Work Status

☐ FT ☐ PT ☐ Temp ☐ Unemployed ☐ Stay at Home ☐ Disabled ☐ Retired ☐ Social Security ☐ Student

☐ Other (describe): ____

Current Annual Income: Personal income: $________________ Household Income: $____________

Military

Military experience? ☐ Yes ☐ No Combat experience? ☐ Yes ☐ No # of Tours: _________

Branch: ____________________________ Discharge date: ______________________________

Type of discharge: ___________________ Rank at discharge: ___________________________

Family member in the service? ☐ Yes ☐ No Who? ___________________________________

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.):

Activity	How often now?	How often in the past?

Medical/Physical Health Condition (Check any problem areas you have or have had):

For each illness listed below, choose a single answer that best describes your health history:

Condition	Currently	In Past	Never	Condition	Currently	In Past	Never
Abortion				Loss of Consciousness			
Anemia				Memory Loss			
Appetite Change				Numbness			
Arthritis				Pain (Daily, Longer than 2 weeks)			
Asthma				Palpitations			
Back Pain				Paralysis			
Blood in Stool				Rheumatic Fever			

Blurred Vision				Seizures			
Caffeine Use				Shortness of Breath			
Chest Pain				Skin Disease			
Chicken Pox				Sleep Apnea			
Chronic Cough				Sleep Difficulties			
Colitis or Irritable Bowel				Stroke or TIA			
Confusion or Disorientation				Difficulty Swallowing			
Constipation				Dental Problems			
Diabetes				Thyroid Disease			
Diarrhea				Tuberculosis			
Dizziness				Ulcers or Indigestion			
Emphysema				Urination Difficulty			
Fainting				Sexually Transmitted Disease			
Glaucoma				Weakness			
Gluten Allergy				Recent Weight Gain			
Head Injury				Recent Weight Loss			
Headaches (Frequent)				Malnutrition			
Hearing Loss				Epilepsy			
Heart Disease				Autoimmune Condition			
Miscarriage				Hepatitis			
Infertility				Energy Level			
Low Libido				Other:			
Multiple Sclerosis							

List any current health concerns: ____

____

List any recent health or physical changes: ______________________________________

____

Please list all of your current prescription and non-prescription (over-the-counter) medications:

Name of your current medicine	What do you use it for?	When did you begin taking it?	What is the strength of each tablet or capsule?	What dose do you take, and how often?	Name of prescribing physician
Example: "Plavix"	High Cholesterol	2005	75 mg	Once/day	Dr. Smith
Please see "Medication Reconciliation Form"					

Please list all psychiatric medications that you have taken in the past:

Name of your previous medicine	What did you use it for?	How long did you take it?	When did you stop taking it?	Why was it stopped?	Was the medication effective?
Example: "Lexapro"	Depression	1 month	6 months ago	Condition improved	Yes/ No

Describe your overall compliance with the above medications: ______________________________

Please list all nutritional and herbal supplements that you currently take:

____

Medication Allergies: ____

Have you ever had any bad reactions (made you feel worse) to prior medications? (if so, specify):

____

Do you see a psychiatrist? ☐ Yes ☐ No Name: ____________________ Last appointment: ____________

Hospital of choice: _______________________________________ Phone: _________________________

Address: ____

Most recent examinations

Type of examination	Date of most recent visit	Reason/Results
Physical examination		
Doctor's visit		
Dental examination		
Vision examination		
Hearing examination		
Most recent surgery		
Other surgeries		
Upcoming surgeries		

Self-Care

Sleep:

How many hours of sleep do you receive in a typical night? _______ Hours

Any problems: ☐ Falling asleep ☐ Staying asleep ☐ Other: _________________________________

How many hours do you need to feel rested? __________ Hours

Nutrition:

How many consistent meals are you eating/day? ____

Quantity consumed at meals: ☐ Low ☐ Medium ☐ High

Explain: ____

Quality of food eaten: ☐ Low ☐ Medium ☐ High

Explain: ____

Exercise:

Do you receive regular exercise? Explain type: ______________________________
How often: ______/week/month

How long do you exercise? _________min/hours

Disabilities

Do you have any physical/psychological disabilities? ☐ Yes ☐ No

If Yes, describe and note how it affects your physical and/or psychological functioning and how you adjust to your disability(ies): ______________________________

Have you made an adjustment to the disability/disorder? ☐ Yes ☐ No

Do you have any need for assistive technology in the provision of counseling services?

☐ Yes ☐ No Explain: ______________________________

List Your history of mental illness/substance abuse:

Personal History of:	Currently	In the Past	Never
Substance Abuse			
Depression			
Anxiety			
Manic Depression (Bipolar)			
Suicide/Homicide Attempt			
Nervous Breakdown			
Addictive Behaviors (eating, sexual, etc.)			
Psychiatric Hospitalizations			

List Family history of mental illness/substance abuse:

Mother = mo; Father = fa; Sibling = s; Grandmother = gm; Grandfather = gf

Family History of:	Currently	In the Past	Never
Substance Abuse			
Anxiety			

Depression			
Manic Depression (Bipolar)			
Suicide/ Homicide Attempt			
Nervous Breakdown			
Addictive Behaviors (eating, sexual, etc.)			
Psychiatric Hospitalizations			

Do any of these illnesses significantly challenge or limit your ability to function at work or at home?

If yes, please provide details:

____

____

Substance Use History

DRUG	Never Used	Method	Age 1st Use	Age Last use	Onset of heavy use	# Days used in the last 30 days	Use in the past 48 hours	Used As an Rx	Last Use	Amount used		Drug of choice
										Dly	Wkly	
Alcohol												
Antidepressants												
Barbiturates/ Sedatives/Hypnotics												
Benzodiazepine												
Caffeine												
Cannabis												
Cocaine												
Crack												
Hallucinogens/PCP												
Heroin												
Inhalants												

Methadone/ Suboxone												
Methamphetamines/ Stimulants												
Nicotine												
Other Opiates/Painkillers												
Other Sedatives												
Over-the-Counter												
Steroids												
Tranquilizers												
Other:												

Substance(s) in order of preference

1. ______________________________ 3. ______________________________

2. ______________________________ 4. ______________________________

Describe when and where you typically use substances: ____

____

Describe any changes in your use patterns: ____

____

Describe how your use has affected your family or friends (include their perceptions of your use):

____

Reason(s) for use

☐ Addicted ☐ Build confidence ☐ Escape ☐ Self-medication

☐ Socialization ☐ Taste ☐ Other (specify): ____________________________

How do you believe your substance use affects your life?____________________________________

Who or what has helped you in stopping or limiting your use?_________________________________

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?

☐ Yes ☐ No If Yes, describe____

Substance Abuse History Continued

Has your use of alcohol or drugs interfered with your obligations at work? ☐ Yes ☐ No

Has your use of alcohol or drugs interfered with your obligations at school? ☐ Yes ☐ No

Has your use of alcohol or drugs interfered with your obligations at home? ☐ Yes ☐ No

Have you used alcohol or drugs while driving a car or truck? ☐ Yes ☐ No

Have you used alcohol or drugs while operating machinery? ☐ Yes ☐ No

Have you ever been arrested as a result of drinking or using drugs? ☐ Yes ☐ No

Have you continued to use alcohol or drugs despite having problems caused by the effects of the substance? ☐ Yes ☐ No

Have you ever used more alcohol or drugs in order to achieve the desired effect? ☐ Yes ☐ No

Has there become a markedly diminished effect with the continued use of the same amount of the substance? ☐ Yes ☐ No

Have you ever needed to take a drink or use a drug in the morning in order to relieve a hangover? ☐ Yes ☐ No

Have you ever used substances in larger amounts or over a longer period of time than was initially intended? ☐ Yes ☐ No

Have you attempted to cut down or control the amount of drinking or drug use without success? ☐ Yes ☐ No

Have you spent a great amount of time in activities necessary to obtain the alcohol or drugs? ☐ Yes ☐ No

Have important social, occupational, or recreational activities been given up or reduced because of your use of alcohol or drugs? ☐ Yes ☐ No

Have you continued to use alcohol or drugs despite knowing that physical, psychological, or legal problems are likely to occur? ☐ Yes ☐ No

Do you feel suicidal at this time? ☐ Yes ☐ No

If Yes, please explain: ____

Do you feel homicidal at this time? ☐ Yes ☐ No

If yes, please explain: ____

Are you engaged in any risk-taking behaviors? ☐ Yes ☐ No

If Yes, describe: ____

____

________________________________ ____________________

Signature of person filling out form **Date**

For Staff Use

Therapist's comments: ____

____

____

Therapist's signature/credentials: ______________________________Date: __/____/______

Medical staff comments: ____

____

Physical exam: ☐ Suggested ☐ Not suggested

Medical Staff Signature & Credentials*: ________________________ Date: _________/______/__

(Certifies case assignment, level of care and need for exam)

*= The Medical Staff's signature on the assessment form signifies his review of the information contained in this screening form.

Therapist's response to medical staff's remarks: ____

____

Therapist's signature/credentials: ______________________________Date: __/____/______