



**Thank you for choosing Pine Rest Christian Mental Health Services. We look forward to providing services to you.**

**In order to make the most of your first appointment, please come at least 30 minutes prior to your scheduled time. It is important that you bring the following items with you:**

**1) Completed paperwork**

In order for us to provide the highest quality service, it is important for us to obtain a detailed personal and family history. Also, information about medical conditions and current medications can be very important, so please include this information on the forms to the best of your ability. [If you have a typed list of your current medications, you may bring that in rather than fill out the current medication form.](#)

**2) Your Insurance Card(s)**

We will be scanning your card(s) into our system. Please contact your insurance company to verify your outpatient behavioral health benefits and secure any preauthorization requirements. If a required authorization is not obtained, you will be responsible for payment of services.

**3) A picture I.D.**

We will be scanning your driver's license or picture I.D. into our system for verification of your identity and to protect you from medical identity theft.

**4) Copayment and/or Deductible (amount not covered by insurance)**

**Insurance co-payments and deductibles are payable at the time of service. Most insurance companies do not cover 100% of charges.**

**5) Proof of Guardianship**

**In case of a minor or an adult under guardianship, a parent or legal guardian must be present at the first appointment.** If you are not a biological parent, you must bring in proof of guardianship.

**Please do not bring other children with you to this appointment. Children cannot be left unattended.**

As a reminder, in order to avoid being charged, please give at least 24-hour notification for broken or canceled appointments. If you have any questions, please call our information office at (616) 831-2601 or 1 (866) 457-6363. Thank you.

**OUTPATIENT INITIAL ASSESSMENT  
ADULT PATIENT INFORMATION (PART I)**

**INSTRUCTIONS:** To assist us in understanding and helping you, please fill out this form as completely as possible. This information is confidential and only released with your permission.

**IDENTIFICATION:**

Patient's Legal Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Ethnic background:  American Indian/Alaska Native  Asian  Black/African American  
 Caucasian/White  Hispanic/Latino  Other \_\_\_\_\_

Form completed by (if other than patient): \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**PRESENTING PROBLEM:**

What is your reason for seeking treatment? \_\_\_\_\_

Who referred you to this Pine Rest location: \_\_\_\_\_

What are your expectations for treatment? \_\_\_\_\_

**SIGNS/SYMPTOMS:** (check those that are problematic to you)

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Alcohol/Drug Use           | <input type="checkbox"/> Fear                     | <input type="checkbox"/> Loneliness            | <input type="checkbox"/> Self-harm                        |
| <input type="checkbox"/> Angry outbursts            | <input type="checkbox"/> Feel like hurting others | <input type="checkbox"/> Money management      | <input type="checkbox"/> Sexual problem                   |
| <input type="checkbox"/> Anxious feelings           | <input type="checkbox"/> Gambling                 | <input type="checkbox"/> Mood shifts           | <input type="checkbox"/> Sleep problem                    |
| <input type="checkbox"/> Appetite change            | <input type="checkbox"/> Grief/Loss issues        | <input type="checkbox"/> Not enjoying things   | <input type="checkbox"/> Suicidal thoughts                |
| <input type="checkbox"/> Concentration difficulties | <input type="checkbox"/> Hallucinations           | <input type="checkbox"/> Panic attacks         | <input type="checkbox"/> Unable to experience forgiveness |
| <input type="checkbox"/> Crying spells              | <input type="checkbox"/> Health worries           | <input type="checkbox"/> Recurring behaviors   | <input type="checkbox"/> Unable to pray                   |
| <input type="checkbox"/> Depressed mood             | <input type="checkbox"/> Hopeless/helpless        | <input type="checkbox"/> Recurring thoughts    | <input type="checkbox"/> Withdrawing                      |
| <input type="checkbox"/> Disorganized thoughts      | <input type="checkbox"/> Impulsive behaviors      | <input type="checkbox"/> Recurring pain        | <input type="checkbox"/> Worrying excessively             |
| <input type="checkbox"/> Energy level changes       | <input type="checkbox"/> Irritable                | <input type="checkbox"/> Relationship issues   |   |
| <input type="checkbox"/> Excessive guilt            | <input type="checkbox"/> Life changes             | <input type="checkbox"/> Other(specify): _____ |   |

How do the symptoms you checked affect your daily functioning? \_\_\_\_\_

**Medical History:**

Have you had any past surgical procedures?  No  Yes If yes, list: \_\_\_\_\_

Have you been exposed to any contagious diseases such as Tuberculosis?  No  Yes If yes, what were you exposed to and when did that exposure take place? \_\_\_\_\_

Are your immunizations up to date?  No  Yes

Any functional impairments?  No  Yes If yes, what type of impairment and have you had any rehab services for this? \_\_\_\_\_

Any current pain?  No  Yes If yes, type and duration: \_\_\_\_\_

Pain severity? (rate 1 to 10 with 1 being the least amount): \_\_\_\_\_

Has pain been an issue in the past?  No  Yes If yes, type and duration: \_\_\_\_\_

Have you experienced weight loss greater than 10 pounds in one month?  No  Yes When? \_\_\_\_\_

Have you gained more than 15 pounds in one month?  No  Yes When? \_\_\_\_\_

Are you following any special diet and desire more information about your special diet?  No  Yes

Female patients: Do you have any reproductive health medical issues/concerns you wish to discuss?  No  Yes

**Trauma History:**

Have you had a history of trauma or abuse?  No  Yes  
If yes, what type of abuse or trauma occurred? \_\_\_ Physical \_\_\_ Sexual \_\_\_ Emotional \_\_\_ Neglect

**Substance Use History:**

Do you use alcohol or drugs?  No  Yes If yes, what is your current substance of preference? \_\_\_\_\_

Do you see your use as a problem?  No  Yes

If yes, how motivated are you to make changes? \_\_\_ Unsure \_\_\_ Somewhat \_\_\_ Very

Is your current living situation and/or family helpful in supporting any changes? (please explain)

\_\_\_\_\_

Have you received inpatient or outpatient treatment or educational programs for alcohol or drug use?

Where & With Whom	Type of Treatment	Dates	Was it Helpful
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever tried to cut down on your alcohol or drug use or quit using?  No  Yes If yes, please explain: \_\_\_\_\_

Has alcohol/drug use interfered with family or interpersonal life?  No  Yes If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Have you experienced any of the following in relation to your alcohol or drug use?

- Anxiety
- Depression
- Hallucinations
- Inability to abstain
- Other adverse reactions (Please explain) \_\_\_\_\_
- Increased tolerance
- Loss of control
- Memory loss
- Overdoses
- Preoccupied with substance
- Stomach problems
- Tremors
- Withdrawal symptoms

**Personal Psychiatric Counseling/Treatment History:** (Please provide past and present information)

	No	Yes	When	Purpose	Result
Counseling/Therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Drug/Alcohol Treatment	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Hospitalizations	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Self-help Groups	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

**SOCIAL/CULTURAL/SPIRITUAL INFORMATION:**

In your experience, how important are spiritual matters? \_\_\_\_\_

What is your present religious affiliation? \_\_\_\_\_

Do you have spiritual concerns that you would like to address in the therapy process?  No  Not sure  Yes, Describe \_\_\_\_\_

Do you have concerns that you would like to address related to cultural or ethnic issues?  No  Yes

If yes, explain: \_\_\_\_\_



**Supportive Relationships:**

Name	Age	Relationship	Quality of Relationship		
_____	_____	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
_____	_____	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
_____	_____	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor

**Family/Significant Other's Psychiatric Counseling/Treatment Information:**

	No	Yes	Relationship	Reason	Response
Counseling/Therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Drug/Alcohol Treatment	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Hospitalizations	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Self-help Groups	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

**Social Relationships:**

How do you usually get along with people?

\_\_\_ Avoidant \_\_\_ Shy \_\_\_ Leader \_\_\_ Outgoing \_\_\_ Assertive \_\_\_ Follower \_\_\_ Irritable

Has there been a recent change in your attitude/relationships with others?  No  Yes

If yes, circle the above word(s) that describe that change

Optional: What is your sexual orientation? \_\_\_ Heterosexual \_\_\_ Bisexual \_\_\_ Homosexual

**Legal History:** (if applicable)

Are you currently involved with the legal system?  No  Yes If yes, explain \_\_\_\_\_

Have you been involved with the legal system in the past?  No  Yes If yes, explain \_\_\_\_\_

Do you currently have a probation or parole officer?  No  Yes If yes, name \_\_\_\_\_

**Educational History:** (check all that apply)

\_\_\_ Currently in school  No  Yes

\_\_\_ High School Grad/GED  No  Yes

\_\_\_ Vocational Graduated  No  Yes Major \_\_\_\_\_

\_\_\_ Graduate School Graduated  No  Yes Major \_\_\_\_\_

\_\_\_ College Graduated  No  Yes Major \_\_\_\_\_

Did you experience any of the following problems in school? \_\_\_ Learning \_\_\_ Emotional \_\_\_ Discipline \_\_\_ Social

Do you currently experience any of the following learning barriers?

\_\_\_ Learning disability \_\_\_ Vision impairment \_\_\_ Hearing impairment \_\_\_ Language

I learn best through: (check all that apply) \_\_\_ Discussion \_\_\_ Written materials \_\_\_ Videos \_\_\_ Tapes

What is your primary language? \_\_\_ English \_\_\_ Spanish \_\_\_ Sign \_\_\_ Other

**Employment History:** (complete those that apply)

List job history beginning with most recent job

Employer	Dates	Job Title	Reason for Leaving
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Status:  Full-time  Part-time  Disabled  Laid off  Retired  Student  
 Homemaker  Other \_\_\_\_\_  
 Attendance problems  Performance problems  Work load  Medical leave  Employer concerns  
 Potential for lay off  Dislike job  Relationship problems with coworkers  
 Other \_\_\_\_\_

**Financial Status:**

(circle one) Stable Unstable Comments \_\_\_\_\_

**Military History:**

Military experience  No  Yes If yes, specify branch and dates of service.

Branch	Date Enlisted	Date Discharged
_____	_____	_____

**Leisure/Recreational:**

Hobbies/Interests	Recent change in frequency?		
_____	<input type="checkbox"/> No change	<input type="checkbox"/> Decreased frequency	<input type="checkbox"/> Increased frequency
_____	<input type="checkbox"/> No change	<input type="checkbox"/> Decreased frequency	<input type="checkbox"/> Increased frequency
_____	<input type="checkbox"/> No change	<input type="checkbox"/> Decreased frequency	<input type="checkbox"/> Increased frequency

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you!

Reviewed by Clinician: \_\_\_\_\_ Date: \_\_\_\_\_

### Pre-Treatment Medication Checklist

Please indicate all the medications you have ever been prescribed, include comments on effectiveness and reasons for discontinuing the medication.

ANTIDEPRESSANTS

- Anafranil (Clomipramine) \_\_\_\_\_
- Celexa (Citalopram) \_\_\_\_\_
- Cymbalta (Duloxetine) \_\_\_\_\_
- Desyrel (Trazodone) \_\_\_\_\_
- Effexor, (Venlafaxine) \_\_\_\_\_
- Elavil (Amitriptyline) \_\_\_\_\_
- ENSAM Transdermal Patch (Selegiline) \_\_\_\_\_
- Lexapro (Escitalopram) \_\_\_\_\_
- Luvox, (Fluvoxamine) \_\_\_\_\_
- Nardil (Phenelzine) \_\_\_\_\_
- Norpramin (Desipramine) \_\_\_\_\_
- Pamelor (Nortriptyline) \_\_\_\_\_
- Parnate (Tranlycypromine) \_\_\_\_\_
- Paxil, (Paroxetine) \_\_\_\_\_
- Pristiq (Desvenlafaxine) \_\_\_\_\_
- Prozac; Sarafem (Fluoxetine) \_\_\_\_\_
- Remeron, (Mirtazapine) \_\_\_\_\_
- Serzone (Nefazodone) \_\_\_\_\_
- Sinequan (Doxepin) \_\_\_\_\_
- Surmontil (Trimipramine) \_\_\_\_\_
- Tofranil (Imipramine) \_\_\_\_\_
- Vivactil (Protriptyline) \_\_\_\_\_
- Wellbutrin, (Bupropion)/Zyban \_\_\_\_\_
- Zoloft (Sertraline) \_\_\_\_\_

ANTI-ANXIETY and INSOMNIA MEDICATIONS

- Ambien, (Zolpidem) \_\_\_\_\_
- Ativan (Lorazepam) \_\_\_\_\_
- Benadryl (Diphenhydramine) \_\_\_\_\_
- BuSpar (Buspirone) \_\_\_\_\_
- Dalmane (Flurazepam) \_\_\_\_\_
- Halcion (Triazolam) \_\_\_\_\_
- Klonopin (Clonazepam) \_\_\_\_\_
- Librium (Chlordiazepoxide) \_\_\_\_\_
- Lunesta (Eszopiclone) \_\_\_\_\_
- Noctec (Chloral hydrate) \_\_\_\_\_
- ProSom (Estazolam) \_\_\_\_\_
- Restoril (Temazepam) \_\_\_\_\_
- Rozerem (Ramelteon) \_\_\_\_\_
- Serax (Oxazepam) \_\_\_\_\_
- Sonata (Zaleplon) \_\_\_\_\_
- Tranxene (Clorazepate) \_\_\_\_\_
- Unisom (Doxylamine) \_\_\_\_\_
- Valium (Diazepam) \_\_\_\_\_
- Vistaril, Atarax (Hydroxyzine) \_\_\_\_\_
- Xanax (Alprazolam) \_\_\_\_\_

OTHER MEDICATIONS NOT LISTED ABOVE

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

STIMULANT MEDICATIONS

- Adderall \_\_\_\_\_
- Concerta, Daytrana TD Patch, Metadate, Ritalin (Methylphenidate) \_\_\_\_\_
- Dexedrine (Dextroamphetamine) \_\_\_\_\_
- Focalin (Dexmethylphenidate) \_\_\_\_\_
- Provigil \_\_\_\_\_
- Strattera (Atomoxetine) \_\_\_\_\_
- Tenex (Guanfacine) \_\_\_\_\_
- Vyvanse (Lisdexamfetamine) \_\_\_\_\_

MEDICATIONS FOR SIDE EFFECTS

- Artane (Trihexyphenidyl) \_\_\_\_\_
- Benadryl (Diphenhydramine) \_\_\_\_\_
- Cogentin (Benztropine) \_\_\_\_\_
- Inderal (Propranolol) \_\_\_\_\_
- Parlodel (Bromocriptine) \_\_\_\_\_

MOOD STABILIZERS

- Carbatrol, Equetro, Tegretol (Carbamazepine) \_\_\_\_\_
- Depakote, (Divalproic Acid) \_\_\_\_\_
- Eskalith, Lithobid (Lithium) \_\_\_\_\_
- Lamictal (Lamotrigine) \_\_\_\_\_
- Topamax (Topiramate) \_\_\_\_\_
- Trileptal (Oxcarbazepine) \_\_\_\_\_

ANTIPSYCHOTICS

- Abilify, (Aripiprazole) \_\_\_\_\_
- Clozaril, Fazacla (Clozapine) \_\_\_\_\_
- Geodon, (Ziprasidone) \_\_\_\_\_
- Haldol (Haloperidol) \_\_\_\_\_
- Invega (Paliperidone) \_\_\_\_\_
- Loxitane (Loxapine) \_\_\_\_\_
- Mellaril (Thioridazine) \_\_\_\_\_
- Moban (Molindone) \_\_\_\_\_
- Navane (Thiothixene) \_\_\_\_\_
- Prolixin (Fluphenazine) \_\_\_\_\_
- Risperdal, (Risperidone) \_\_\_\_\_
- Serentil (Mesoridazine) \_\_\_\_\_
- Seroquel, (Quetiapine) \_\_\_\_\_
- Stelazine (Trifluoperazine) \_\_\_\_\_
- Thorazine (Chlorpromazine) \_\_\_\_\_
- Trilafon (Perphenazine) \_\_\_\_\_
- Zyprexa, (Olanzapine) \_\_\_\_\_

MEMORY

- Aricept (Donepezil) \_\_\_\_\_
- Exelon (Rivastigmine) \_\_\_\_\_
- Namenda (Memantine) \_\_\_\_\_
- Reminyl (Galantamine) \_\_\_\_\_

