

**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) 258-7500 or (866) 852-4001. Thank you.

To help your clinician understand your concerns, please answer the questions on this form and bring it with you to your first appointment.

**Patient's Legal Name:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_

Form completed by: \_\_\_\_\_ **Today's date:** \_\_\_\_\_

**Presenting Problem/Reason for Treatment**

What is the primary reason you are coming to Pine Rest? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Current Concerns**

Please check all of the symptoms below that apply to you:

<input type="checkbox"/> Loss of interests/not enjoying things <input type="checkbox"/> Guilt <input type="checkbox"/> Decreased energy <input type="checkbox"/> Concentration difficulty <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Sleep difficulties <input type="checkbox"/> Thoughts of suicide or self-harm	<input type="checkbox"/> Easily distracted <input type="checkbox"/> Taking risks <input type="checkbox"/> Feeling overly important <input type="checkbox"/> Racing thoughts <input type="checkbox"/> Talkative <input type="checkbox"/> Little need for sleep <input type="checkbox"/> Very active/on the go all the time	<input type="checkbox"/> Anxiety worry <input type="checkbox"/> Panic attacks <input type="checkbox"/> Avoid going places <input type="checkbox"/> Avoid being with others <input type="checkbox"/> Checking things repeatedly <input type="checkbox"/> Perfectionist <input type="checkbox"/> Fears
<input type="checkbox"/> Depression <input type="checkbox"/> Feeling helpless/hopeless <input type="checkbox"/> Episodes of crying <input type="checkbox"/> Moody <input type="checkbox"/> Feeling empty inside <input type="checkbox"/> Afraid of rejection <input type="checkbox"/> Angry/easily irritable	<input type="checkbox"/> Stomach aches <input type="checkbox"/> Headaches <input type="checkbox"/> Backaches <input type="checkbox"/> Eating difficulties <input type="checkbox"/> Body image difficulties <input type="checkbox"/> Sexual difficulties <input type="checkbox"/> Sexual addictions	<input type="checkbox"/> Concerns with drinking alcohol <input type="checkbox"/> Concerns with drug use <input type="checkbox"/> Past alcohol/drug use <input type="checkbox"/> Recreational drug use <input type="checkbox"/> Thoughts of hurting others <input type="checkbox"/> Legal problems <input type="checkbox"/> Work problems
<input type="checkbox"/> Difficulty remembering <input type="checkbox"/> Confusion <input type="checkbox"/> Getting lost more often <input type="checkbox"/> Difficulty making decisions	<input type="checkbox"/> Feeling suspicious at times <input type="checkbox"/> Having strange experiences <input type="checkbox"/> Hearing voices <input type="checkbox"/> Seeing things	<input type="checkbox"/> Financial problems <input type="checkbox"/> Learning problems <input type="checkbox"/> Relationship problems <input type="checkbox"/> Gambling

Are there other concerns (not listed above) that you want to discuss? \_\_\_\_\_

\_\_\_\_\_

How have these concerns impacted your daily life? \_\_\_\_\_

\_\_\_\_\_

What do you consider to be your strengths? \_\_\_\_\_

What do you consider to be your weaknesses? \_\_\_\_\_

**Race/Ethnicity** (optional)

Please check the box that best represents your race/ethnic background:

- American Indian or Alaska native   
  Asian   
  Black or African American   
  Hispanic  
 Native Hawaiian or Other Pacific Islander   
  Two or more races   
  White

**Sexual Orientation** (Optional)

- 
- Heterosexual
- 
- Gay/Lesbian
- 
- Bisexual

**Family & Supportive Relationships**

Marital Status:

- 
- Married
- 
- Never Married
- 
- Divorced
- 
- Annulled
- 
- Domestic Partner
- 
- Legally Separated
- 
- Widowed

Name	Age	Relationship (e.g. Husband, Wife, Son, Friend)	Quality of Relationship	Living with you?
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Y <input type="checkbox"/> N

**Education/Employment Information**

Highest (or current) Grade Level Achieved: \_\_\_\_\_

Current Employer: \_\_\_\_\_ How long? \_\_\_\_\_

- Employment Status:
- 
- Full Time (30 or more hours)
- 
- Part Time (Less than 30 hours)
- 
- Unemployed
- 
- 
- Volunteer or internship
- 
- Retired

**Current/Past Military History**

 Are you currently serving or have you served in the military?       Yes    No

If yes, please explain (when/how long/branch): \_\_\_\_\_

**Trauma History**

 Have you been a victim of trauma, abuse or neglect?       Yes    No

If yes, what type of abuse or trauma occurred?

 Physical     Sexual     Emotional     Neglect     Verbal

 Have you been the perpetrator of trauma, abuse or neglect?       Yes    No

If yes, what type of abuse or trauma occurred?

 Physical     Sexual     Emotional     Neglect     Verbal

**Mental Health Treatment History**

 Have you ever received inpatient or outpatient mental health services?       Yes    No

When?

Where?

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

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

**Medical Information**

Please check all **medical issues** for which you have had treatment:

- |   |   |
|---|---|
| <input type="checkbox"/> <b>Allergies</b><br>(e.g., allergic reactions, seasonal allergies, etc)                          | <input type="checkbox"/> <b>Blood disease</b><br>(e.g., anemia, bleeding disorders, etc)                                    |
| <input type="checkbox"/> <b>Bone disease</b><br>(e.g., osteoporosis, arthritis, broken bones, etc)                        | <input type="checkbox"/> <b>Digestive system disease</b><br>(e.g., ulcers, heartburn, Celiac Disease, IBS, etc)             |
| <input type="checkbox"/> <b>Endocrine disease</b><br>(e.g., diabetes, hypothyroid, low testosterone, etc)                 | <input type="checkbox"/> <b>Genetic disease</b><br>(e.g., Sickle Cell, Fetal Alcohol, other syndromes, etc)                 |
| <input type="checkbox"/> <b>Head and brain illness or injury</b><br>(e.g., fainting, concussion, seizures, dementia, etc) | <input type="checkbox"/> <b>Heart/cardiovascular disease</b><br>(e.g., heart arrhythmia, heart attack, high blood pressure) |
| <input type="checkbox"/> <b>Immune disease</b><br>(e.g., serious infections, MRSA, Rheumatoid Arthritis, etc)             | <input type="checkbox"/> <b>Lungs and breathing disease</b><br>(e.g., asthma, COPD, emphysema, etc)                         |
| <input type="checkbox"/> <b>Mouth and teeth disease</b><br>(e.g., gum disease, cold sores, canker sores, etc)             | <input type="checkbox"/> <b>Muscle and movement disease</b><br>(e.g., tremors, tics, Restless Legs, Parkinson's, etc)       |
| <input type="checkbox"/> <b>Poisoning &amp; chemical exposure</b><br>(e.g., overdose, lead exposure, work fumes, etc)     | <input type="checkbox"/> <b>Serious injuries and wounds</b><br>(e.g., burns, cuts, stabs, crushed limbs, etc)               |
| <input type="checkbox"/> <b>Other</b> _____   |   |

Check all areas where you have had past **surgeries**:

- |   |  |
|---|--|
| <input type="checkbox"/> <b>Cancer</b><br>(e.g., procedures for cancer treatment)                             | <input type="checkbox"/> <b>Cardiac / Vascular</b><br>(e.g., procedures for heart, blood clot, stroke)           |
| <input type="checkbox"/> <b>Ear, Nose, Throat</b><br>(e.g., tonsillectomy, thyroidectomy, etc)                | <input type="checkbox"/> <b>Gastroenterology (digestive system)</b><br>(e.g., stomach, gall bladder, liver, etc) |
| <input type="checkbox"/> <b>Obstetrics &amp; Gynecology</b><br>(e.g., hysterectomy, c-section, abortion, etc) | <input type="checkbox"/> <b>Orthopedic</b><br>(e.g., joint replacement, bones, spinal fusion, etc)               |
| <input type="checkbox"/> <b>Plastic surgery</b><br>(e.g., reduction, implant, reconstruction, etc)            | <input type="checkbox"/> <b>Neurosurgery</b><br>(e.g., brain surgery, spinal fusion, etc)                        |
| <input type="checkbox"/> <b>Urology</b><br>(e.g., kidney stones, hypospadias, erectile dysfunction, etc)      | <input type="checkbox"/> <b>Vision</b><br>(e.g., LASIK, eye muscle correction, etc)                              |
| <input type="checkbox"/> <b>Weight loss</b><br>(e.g., gastric bypass, band, sleeve, etc)                      | <input type="checkbox"/> <b>Other:</b><br>_____  |

Comments: \_\_\_\_\_

Do you have any current or ongoing medical concerns? \_\_\_\_\_

Do you have problems with pain?  Yes  No  
 Severity of your pain? (low) 1 2 3 4 5 6 7 8 9 10 (high)  
 Location of your pain? \_\_\_\_\_

Have your medical concerns interfered with your ability to work, relate to others, or be involved in activities outside of your home?  Yes  No  
 If yes, please explain \_\_\_\_\_

Please list all current medications and supplements you are taking:

(attach another page if needed, or bring a list to your appointment)

Name of Medication	Dosage/Amount	Frequency

Have you had an allergic reaction to medication(s)?

Yes  No

Name of medication

Explain reaction:

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

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

### Substance Use

Do you drink alcohol?

Daily use

Occasional Use

None

Do you use tobacco?

Daily use

Occasional Use

None

Do you use drugs?

Daily use

Occasional Use

None

Has alcohol/drug use interfered with family, work, health, or interpersonal life?

Yes  No

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

Have others viewed your use as a problem?

Yes  No

Have you ever tried to cut down on your alcohol or drug use or quit using?

Yes  No

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

Have you had any prior substance abuse treatment?

Yes  No

When?

Where?

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

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

### Legal History

Involved with the legal system, Friend of the Court or Child Protective Services?

Yes  No

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

Do you currently have a probation or parole officer?

Yes  No

If yes, name \_\_\_\_\_

Have you been involved with the legal system in the past?

Yes  No

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

### Spiritual

What is your present religious affiliation, if any? \_\_\_\_\_

Do you have any spiritual concerns you want to address in treatment? \_\_\_\_\_

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

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Thank You!**

### 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, Fazaclor (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) \_\_\_\_\_