Mind for Health Resources Ltd.

Initial Interview Form

Date:

Identification

Name of client: B-Date: Age:

Marital Status:

Name of spouse/other: # of children

Names & Ages of Children

Occupation

Client's phone (home):

Work #

Employer:

Home Address:

Caller's name (Initiated 1st contact w/ Dr. Allen):

Relationship to client:

Emergency contact & phone number

Best way to reach you (confidentiality) – Phone – work – home? where and how can I leave messages?

Any restrictions during these calls?

Referral source (“How did you get my name?”):

Days and times preferred:

Financial information: How will you be paying for services (circle: credit cash check)

Medical Insurance (see form)

- Named employee or policy holder
- Insured’s ID number
- Group Number
- Other important information about insurance
- Other insurance you will be using

Treatment: Have you ever received psychological or psychiatric or counseling services before? □ No □ Yes

When? From whom? For what? With what results?

Have you ever taken medications for psychiatric or emotional problems? □ No □ Yes

If yes, please describe:

When? From whom?

Which medications For what With what results?

Current medication Dosage How long have you been taking this medication?

Date of last physical exam, general health:

History: Starting with your childhood and proceeding up to the present, list *all* diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had. (Use back of form if needed)

Age Illness/diagnosis Treatment received Treated by Result

Current Medical / Psychological and other health care providers

Name Specialty Address Phone # Date of last visit

Education (including military service)

Chief concern: Please describe the main difficulty that has brought you to see me:

Symptom Description: Describe the following aspects of your symptoms:

What does it feel like?

If physical, where is it located? (See body diagram)

How often do you have symptoms?

What is the daily, weekly, monthly, seasonal pattern?

How does the severity change over time?

What brings on the symptoms or makes them worse?

What makes the symptoms better?

What effect do the symptoms have on your sleep?

What effect do the symptoms have on other activities?

History of Problem:

When did your problem(s) begin (How many years have you had the symptoms(s)?

What was happening just prior to the time that may have contributed to the current problem(s)?

Who is involved or affected by this problem? How are they involved?

What have you tried so far to handle the problem?

Have there been any previous episodes of this problem? If so, what brought the problem on and how did you resolve it?

Family History of this or other emotional problems:

Lifestyle:

Do you smoke or chew tobacco, use illicit drugs (confidentiality), and how much per day?

How much coffee, cola, tea, or other sources of caffeine do you consume each day?

Do any of these substances exacerbate or diminish your current symptoms or problems

How do you feel about your work or school?

How do you feel about your relationships with peers, spouse, children, family of origin?

What kinds of physical exercise (or activity level) do you get?

What hobbies do you have?

How do you usually spend your leisure time?

Describe your eating habits.

What do you typically eat for:

Breakfast?

Lunch?

Dinner?

Snacks? (What, when, how many snacks each day)

Do you have any problems getting enough sleep? (Describe sleep habits)

Have you ever had a seizure or any neurological problems?

Objectives for Treatment:

1. If you could change anything about you or your situation, what would you change?

2. What would be different in your life if you didn't have this problem?

3. Why do you think this is happening? How do you explain it?

4. What can I do for you? How can I be of assistance? What do you expect from treatment?

5. How long will it take? How will we both know when we are done or successful?