Processus P.A.

Today's Date: _____
Name:_____

RETURNING CLIENT – UPDATED INFORMATION FORM

Adult

Instructions: To help us offer you the highest quality service, please fill out this form as fully and openly as possible. This information is held in **strict confidence** within legal limits.

Basic Information:

Name: _____ Preferred Name:_____ Age: _____ Date of Birth: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Email:_____

Areas of Concern: Please check from the following list, the main areas of concern you would like to address in therapy.

☐ Anxious Feelings	☐ Feeling Depressed	☐ Relationship Difficulties	☐ Drug Problems
☐ Problems Adjusting	☐ Work/Career Concerns	☐ Difficulties with School	☐ Attention Difficulty
☐ Anger Issues	☐ Alcohol Problems	☐ Memory Problems	☐ Eating concerns
☐ Chronic Pain	☐ Grief & Loss	☐ Sleep Difficulties	☐ Sexual Issues
☐ Suicide Thoughts	☐ Recovery from Abuse	☐ Traumatic Incident	☐ Stress Overload
☐ Financial Distress	☐ Panic Attacks	☐ Obsessive Compulsive Problems	☐ Bipolar Disorder

☐ Problem Behaviors, specify:_____

☐ Other Issues: _____

Have you seen any other mental health provider since we last met? ☐ Yes ☐ No
If yes, please list name of provider and approximate dates of service:_____
Have you been hospitalized for mental health concerns since we last met? ☐ Yes ☐ No
If yes, please indicate when and where:_____

Family Psychiatric History: Please list any biological relative who has experienced mental health concerns, along with any known treatment (i.e. in-patient, out-patient, none), and the outcome of treatment (i.e. poor, fair, good).

_____

_____

_____

Family of origin information/historical events: Please list the member(s) in your family with whom you grew up. Include parents, adoptive parents, step-parents, siblings, adopted siblings, and step-siblings. Indicate their approximate age now, or if deceased, approximate year of death. Indicate their relationship to you (mother, father, sister, brother, stepmother, stepfather, stepbrother, etc.). Please note significant events that have occurred in your life or the life of your family (examples may include deaths/losses, accidents, abuse, job changes, moves).

_____

_____

_____

_____

_____
_____
_____
_____
_____
_____
_____
_____

Trauma:

1) Have you ever been sexually or physically abused or assaulted, or been the victim of another violent crime? ☐ Yes ☐ No

2) Have you ever witnessed someone else being sexually or physically abused? ☐ Yes ☐ No

3) Have you ever been in an accident, fire, or natural disaster where you or someone else was seriously injured or killed? ☐ Yes ☐ No

If you answered **yes** to any of the above, please check all of the following that apply:

☐ Sudden memories of the event ☐ Upsetting memories of the event ☐ Nightmares
☐ Feeling physical reactions to reminders ☐ Feeling distress about reminders ☐ Avoiding activities related to event
☐ Avoiding places related to event ☐ Avoiding thoughts and feelings ☐ Loss of interest in life's activities
☐ Detached or numb feeling ☐ Inability to recall details of the experience ☐ Sense of limited future
☐ Difficulty falling or staying asleep ☐ Irritability or outburst of anger ☐ Difficulty concentrating
☐ Being overly alert to danger ☐ Feeling jumpy or easily startled ☐ Having difficulties in relationship
☐ Losing track of time ☐ Feeling like your body doesn't belong to you
☐ Recurrent gaps in your recall of everyday events
☐ Finding items around you that you don't remember picking up
☐ Hearing voices in your head

Current Family Information:

If you are currently married or partnered, how long have you been married/partnered? (_____ years).

1) If so, what is your spouse's/partner's name? _____ his/her age _____.
2) If you are separated, divorced or widowed, how long has that been? (_____ years).
3) How many times have you been married? (_____ times)
4) If you have children, please complete the following (add a page if you need more room):

Child's Name	Age	Child lives with me. Yes	No	If "no" who does she/he live with and where?
1.				
2.				
3.				
4.				
5.				

Any miscarriages or stillbirths? Yes _____ No _____ When? _____

Besides any children and/or spouse listed above, *who else lives in your home*?

Person's Name	Age	Relationship to You

Current Life Situation: In the following areas of life, please check all that apply (it's ok to check more than one option in each category). Feel free to add comments as well.

1. ***Marital/Partner Relationship:*** ☐ Close ☐ Conflicted ☐ Supportive ☐ Distant ☐ Neutral ☐ Strained
   Comments: _____
   _____
2. ***Current Family Life:*** ☐ Distant ☐ Close ☐ Loving ☐ Estranged ☐ Strained ☐ Supportive ☐ Changeable ☐ Conflicted ☐ Neutral ☐ Exhausting
   Comments_____
   _____
3. ***Current Living Arrangements:***
   - Please describe your current living situation, (e.g. own home, rent an apartment, living with friends/family, retirement community, group home, homeless in a shelter, etc.)
     _____
     _____
   - Are you satisfied with your living situation? ☐ Yes ☐ No
     If no, please explain:_____
4. ***Circle of Friends:*** ☐ Many ☐ Few ☐ Close ☐ Supportive ☐ None ☐ Changeable ☐ Exhausting
   Comments: _____
   _____

5. Education:

- Years of schooling (0 to 16+) _____
- Diploma or highest degree received: _____
- Any history of learning difficulties: ☐ Yes ☐ No
- If so, please check all areas of difficulty you have experienced in the area of learning. ☐ Concentration ☐ Hearing ☐ Listening ☐ Reading ☐ Writing ☐ Remembering ☐ Other Comments: _____

6. Employment:

- Are you currently employed? ☐ Yes ☐ No
- If yes, where and job title:
  _____
- Describe your work setting: ☐ Positive ☐ Supportive ☐ Challenging ☐ Stressful ☐ Rewarding ☐ Healthy ☐ Unhealthy ☐ N/A ☐ Other
  Comments: _____
  _____
- If not employed, are you (check all that apply) ☐ Actively looking for work ☐ Disabled ☐ Terminated ☐ Choosing not to be employed ☐ Laid-off ☐ Need Childcare ☐ Attending school ☐ Retired ☐ Other
- Any history of difficulties with employment? ☐ Yes ☐ No, If yes, please explain:
  _____
  _____
  _____

7. ***Hobbies and leisure activities:*** Please list any hobbies and leisure activities you enjoy (e.g. walking, exercise, video games, music, reading, shopping, sewing, crafts, outdoors, travel, gardening, sports, photography, baking, cooking):
   _____
   _____

8. Military Service:

- Have you served in the military? ☐ Yes ☐ No
- If yes, when? From _____ To _____
- What branch of service?_____

- How would you describe the experience? ☐ Mostly positive ☐ Mostly negative ☐ Positive & Negative ☐ Neutral
- Please explain: _____

9. Anything else you would like to add about your current life situation:

_____

Medical Overview: (Add an extra page if you need more room).

1. Please list current and past **medical conditions** and the approximate date you were diagnosed.

_____

_____

2. Please list any **allergies**, type of reactions you have (e.g. rash, nausea, trouble breathing), the level of severity of you reactions (mild, moderate or severe) and the approximate time the allergy started.

_____

3. Please list all current **medication(s)**, dosage and approximate time you started on the medication.

_____

_____

4. If you have any seasonal **allergies** indicate the time of year you have them. _____

5. Are there any **medical conditions in your family-of-origin?** ☐ Yes☐ No
If yes, please describe:_____

Primary Care Clinic:

☐ CentraCare ☐ St. Cloud Medical Group ☐ Williams Integracare ☐ Health Partners ☐ Other _____

Primary Care Provider: _____ Psychiatric Provider:_____

Situational Stresses:

1) Are there any recent or current situational stresses in your life that are causing significant difficulty? ☐ Yes ☐ No
If so, please name: _____

2) Other Critical Stress Factors:

☐ Disabilities
☐ Drug/alcohol problems
☐ Family problems
☐ Health problems
☐ Job related problems
☐ Legal/financial problems
☐ Spiritual concerns
☐ Divorce/Separation
☐ Emotional abuse
☐ Other trauma
☐ Parent/child conflicts
☐ Physical abuse
☐ Relationship problems
☐ School problems/truancy
☐ Sexual trauma perpetrator
☐ Sexual trauma victim
☐ Shame/Self-Esteem
☐ Significant Loss
☐ Spousal problems

Review of Symptoms *(please check any that apply to you):*

Part I:

- Anxious or uncomfortable about being in a social setting
- Chest pain/discomfort
- Chills
- Compulsive behaviors
- Difficulty concentrating
- Difficulty falling or staying asleep, or restless unsatisfying sleep
- Dry mouth
- Easily fatigued
- Fearful about going out and about
- Feel like you're dying
- Feel like you're losing control
- Feeling "on edge"
- Feeling driven to check things over and over
- Feeling like things are not real
- Feeling of choking
- Feelings of nervousness
- Frequent worry about a number of things
- Headaches
- Heart palpitations
- Inability to relax
- Irritability
- Lightheadedness
- Mind going blank
- Muscle tension
- Gastrointestinal upset
- Numbness or tingling
- Pictures in your mind that play over and over
- Restlessness/fidgeting
- Rumination about the past
- Shortness of breath
- Social isolation
- Social withdrawal
- Sweating
- Thoughts going round and round
- Trembling
- Trouble swallowing

Part II:

- Decrease or loss of appetite
- Depressed mood/feeling down
- Diminished or lack of motivation
- Feeling bad about yourself
- Feelings of helplessness
- Feelings of hopelessness
- Feelings of shame
- Feelings of worthlessness
- Grief
- Hallucinations or delusions
- Hormonal patterns
- Inappropriate guilt
- Indecisiveness
- Little interest or pleasure in doing things
- Low energy
- Low self esteem
- Mood swings
- Moving or speaking slowly
- Overeating
- Poor personal hygiene
- Previous suicide attempt
- Seasonal mood changes
- Self-injurious behavior (cutting, scratching, burning etc.)
- Significant weight loss or gain
- Sleeping too much
- Suicidal thoughts
- Tearfulness
- Uncontrollable crying episode

Part III:

- Angry outbursts
- Avoidant behavior
- Difficulty making decisions
- Difficulty problem solving
- Difficulty self-soothing
- Diminished enjoyment
- Emotional numbness
- Low frustration tolerance
- Marked distress
- Negative self-judgment
- Parenting difficulties
- Procrastination
- Relationship problems
- Self-care impairment
- Self-defeating behavior
- Feeling overwhelmed
- Financial difficulties
- Impulsive behavior
- Inadequate social support
- Interpersonal difficulties
- Isolation
- Legal troubles

Part IV: ***Has there ever been a period of time when you were not your usual self and … (check all that apply)***

- o Couldn't slow your mind down
- o Did things others thought were excessive, foolish, or risky
- o Felt driven to do fun things
- o Felt extremely good or hyper
- o Felt incredibly self-confident
- o Felt more irritable and angry
- o Felt sudden changes in mood
- o Got much less sleep and didn't miss it
- o Had much more energy
- o Had trouble concentrating
- o Had trouble sitting still
- o Shouted at people or started arguments
- o Spent more money than you could afford
- o Talking more loudly or faster than usual
- o Were much more active or did more things
- o Were much more social or outgoing

Part V:

- o Eating concerns
- o Body image concerns

Impairment:

Overall, how much difficulty do the concerns identified in the previous section cause you in the following areas of life?

(Use the following scale: 0 = none, 1 = mild, 2 = moderate, 3 = severe)

_____Current Family _____School _____Work _____Social Life

_____Family of Origin _____Leisure/Hobbies _____Self-Care _____ Parenting

_____Finances _____Primary Relationship

_____Other, specify: _____

Comments:_____

_____

Risk Assessment:

1. Have you ever had thoughts of ending your life? ☐ Yes ☐ No

If **yes**, have you attempted to take your life? ☐ Yes ☐ No

If **yes,** how many times? _____

If **yes**, please list what you attempted to do and when: _____

_____

2. If you've had suicidal thoughts but haven't attempted, what has stopped you? _____

_____

3. Have you known anyone who has died by suicide? ☐ Yes ☐ No

If so, who? _____

4. Do you have suicidal thoughts now? ☐ Yes ☐ No

5. Do you have thoughts of harming yourself? ☐ Yes ☐ No

6. Have you harmed yourself? ☐ Yes ☐ No

If so, how?_____

7. Do you have thoughts of harming someone else? ☐ Yes ☐ No

8. Have you harmed someone else? ☐ Yes ☐ No

Legal/Financial Issues:

1. Are you currently involved in any legal or financial difficulties (i.e. DWI, divorce, bankruptcy, home for-closure, lawsuit, custody dispute, felony, probation, traffic, etc.) ☐ Yes ☐ No
   If yes, briefly describe your difficulties: _____
   _____

2. Have you had any other legal or financial problems in the past? ☐ Yes ☐ No
   If **yes**, please briefly describe your difficulties _____
   _____

Substance Use:

1. Do you drink alcohol? ☐ Yes ☐ No
   If **yes**, how often? _____
   If **yes,** approximately how much each time? _____
   If **no,** have you drank alcohol in the past? ☐ Yes ☐ No

2. Do you consume caffeinated beverages? ☐ Yes ☐ No
   If **yes,** what beverage, how much, and how often? _____

3. Do you use tobacco? ☐ Yes ☐ No
   If **yes,** what kind (cigarettes, chew, etc.)? _____
   If **yes,** how often? _____
   If **yes,** would you like information on how to quit? ☐ Yes ☐ No

4. Do you use street drugs? ☐ Yes ☐ No
   If **yes,** what kind? _____
   If **yes,** how often? _____
   If **no,** have you used street drugs in the past? ☐ Yes ☐ No

5. Have you ever misused prescription medications? (e.g. pain pills or anxiety pills) ☐ Yes ☐ No

6. Has alcohol or drugs caused any problems for you in the past or present? ☐ Yes ☐ No
   If **yes,** what kind of problems? _____

7. Have you ever been in chemical dependency treatment? ☐ Yes ☐ No
   If **yes,** when? _____

8. Is there a history of any of the above chemical use issues in your family of origin? ☐ Yes ☐ No
   If yes, please describe:_____

Anything else you would like to add:

_____

_____

_____

_____

_____

_____