INSIGHT BEHAVIORAL WELLNESS OF NORTHERN MICHIGAN LLC

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SELF-REPORTED PATIENT INFORMATION

*****If you need more space, please feel free to use additional paper.*****

Name _____ DOB: _____ Age _____

Why are you seeking therapy at this time?:_____

_____

_____

What is happening that makes this a problem for you?_____

_____

_____

What is/are your goals for treatment?: _____

_____

ACADEMIC/EMPLOYMENT

Employment/School:_____

_____

Language Preference: _____ Reading Level: _____

Academic History (Include background, future possibilities):_____

_____

_____

Vocation History (include jobs, vocation preference, interests, and goals, financial issues):

_____

_____

_____

RELATIONSHIP STATUS: □ Married □ Single □ Divorced □ Widowed □ Other
Support: □Spouse □Partner □Nuclear Family □Extended Family □Significant Other
□Close Friend □Group of Friends □Church/Mosque/Temple □12-step □Other_____

Available support for assistance in treatment if necessary?_____

_____

Family Situation/Living Environment/Status (Who is in the living environment? How would you describe it? Abuse occurring?):

_____

_____

_____

If you are currently in a primary relationship, which of the following problems, if any, do you have with your partner (read the list and check those that apply. If "other" please describe):

Conflict about money □	Conflict about children □	Conflict about lifestyle □
Conflict about sex □	Conflict about friends □	Conflict about substance use □
Conflict about employment □	Conflict about time together□	Conflict about friends □
Conflict about step-children □	Conflict about spouse's family □	Conflict about religious beliefs □
None of these apply: □	Other:□	Other:□

Additional details: _____

_____

Family of origin:

Names of Parents, Caretakers, Siblings	Age	Current Relationship: (1=regular contact, 2=irregular contact, 3=no contact, 4=deceased)	Quality of relationship: (1=Excellent, 2=Good, 3=Fair, 4=Poor)

Children:

Name	Age	Current Relationship: (1=regular contact, 2=irregular contact, 3=no contact, 4=deceased)	Quality of relationship: (1=Excellent, 2=Good, 3=Fair, 4=Poor)

MEDICAL HISTORY

Current physical problems/conditions/disabilities: ____no ___yes

_____

_____

_____

_____

Family Health History

Condition:	Relationship (mother, father, etc.)

Past physical problems: _____

_____

_____

Current medications/conditions:_____

_____

_____

Hospitalizations in past 3 years? ____no ____yes. Why? _____

_____

_____

Name of general practitioner: _____

Any other relevant medical history? _____

_____

PSYCHIATRIC HISTORY

Any prior outpatient mental health treatment? ___no ___ yes

Clinician/Facility: _____ Approximate date of service_____

Diagnosis: _____ Successful completion: ____no ___yes

Clinician/Facility: _____ Approximate date of service_____

Diagnosis: _____ Successful completion: ____no ___yes

Clinician/Facility: _____ Approximate date of service_____

Diagnosis: _____ Successful completion: ____no ___yes

Any prior psychiatric hospitalizations? ___no ___ yes

Hospital: _____ Length of stay _____

Diagnosis: _____ Reason for admission: _____

_____

Hospital: _____ Length of stay _____

Diagnosis: _____ Reason for admission: _____

Are you taking medication for an emotional or mental health issue? _____no ____yes: Please

list: _____

_____

Name of medical professional prescribing medication: _____

Family history of mental health issues? ____no ____yes:

Relationship (father, mother, etc.):	Diagnosis:

SUBSTANCE USE/ABUSE HISTORY

Substance	Quantity	Frequency	Length of time	Current use

Prior substance abuse treatment? ____no ____yes. Where? When? _____

Any other information you want your clinician to know? _____