Aspen Psychological Services
640 3 Mile Rd, NW, Suite 101
Grand Rapids, MI 49544
616-785-8900 (office)
616-785-8949 (fax)

Therapist assigned: _____

ASPEN PSYCHOLOGICAL SERVICES
NEW PATIENT INFORMATION FORM – ADULT

Date: ___ /___ /___

Client Name _____
Last First MI

Sex: M or F Date of Birth_ _____ Social Security Number _____

Referred by _____

PRESENTING PROBLEM

1. What is your reason for seeking consultation/counseling? _____
_____
_____

2. How long has this been a problem? _____
_____

PERSONAL HISTORY

EDUCATION

High School attended _____
College Attended _____
Other_____
Highest degree completed _____
Your present occupation _____Years in present occupation _____
How do you like your present job? _____
Are you a veteran? ___ Yes ___ No Date _____
Type of discharge_____
Please list your hobbies and recreational interests._____
_____
Please list your strengths._____
_____
Do you have a religious affiliation? ___ Yes ___ No If yes, please indicate _____
How involved are you with your congregation? (attendance)
___ Never ___ Sometimes ___ Regularly

MARITAL HISTORY

Spouse's Name _____ Age _____ Date of Birth _____
Spouse's occupation _____
Any medical problems with spouse ___ Yes ___ No If yes, explain _____
_____
Date of marriage _____ Length of courtship _____
How would you describe your marriage _____
Previous marriage(s) ___ Yes ___ No Date(s) of marriage and divorce _____

Name of Children	Age	Education	Employment	Living in Home
				Y N
				Y N
				Y N
				Y N
				Y N
				Y N

FAMILY HISTORY

Father's Name _____ Age _____ Education _____
Occupation _____
Year deceased _____ Age _____ Cause of Death _____
Describe your relationship with your father _____
_____

Mother's Name _____ Age _____ Education _____
Occupation _____
Year deceased _____ Age _____ Cause of Death _____
Describe your relationship with your mother _____
_____

Please list brothers and sisters (biological, half, step)

Name of Siblings	Age	Occupation	Living/Deceased	Cause of Death	Relationship

Are there any significant health problems in family of origin (parents, grandparents, siblings)
_____

Describe your childhood/adolescent years (attitude, feelings, likes, dislikes, etc) _____
_____

MEDICAL HISTORY

Personal Physician _____ Last seen _____
Address _____
Date of last complete physical examination _____
Please list any current medical conditions_ _____
_____
Current treatment regiment(s) _____
Allergies_____
Are you experiencing any difficulty with sleeping _____
Are you experiencing any changes in appetite _____

SURGICAL HISTORY

Have you had any surgery ___ Yes ___ No Date(s) _____
For what condition _____

MENTAL HEALTH HISTORY

Have you had previous counseling ___ Yes ___ No
Is there a history of emotional, physical, sexual abuse in your family ___ Yes ___ No
If yes, please explain _____
_____

Date	Name of Counselor	Agency/Hospital	Reason for Termination	Inpatient	Outpatient

Is there any history of mental illness in your family of origin (parents, grandparents, siblings)
_____
_____

Current Medications

Medication	Condition	Prescribed by	Start Date	Effectiveness/Side Effects

Previous Medications

Medication	Start Date	Stop Date	Prescribed By	Reason for Termination

Substance Use / Abuse History

	None	Past	Present	Frequency / Amount
Alcohol				
Drugs				
Nicotine				
Caffeine				

Have you received treatment for any of the above ___ Yes ___ No
If yes, when, for what substance and for how long _____
_____
Is there a history of substance abuse in your family of origin (parents, grandparents, siblings)
_____

Legal History

Describe any legal involvement you have had _____
_____
Number of arrests _____ Number of arrests for ___ OUIL ___ DUIL ___ DWI

ADDITIONAL INFORMATION/COMMENTS

Check any of the following that applies to you at the present time.

____ Feeling depressed
____ Always tired
____ Poor appetite
____ Trouble sleeping
____ Loss of Weight
____ Weight gain
____ Lack of energy
____ Crying spells
____ Unable to have fun
____ Feelings easily hurt
____ Lacks confidence
____ Feeling moody
____ Experience mood swings
____ Feeling lonely
____ Lack of enjoyment in activities
____ Suicidal thoughts
____ Suicide attempt(s)
____ Self-harming behaviors
____ Feeling inferior
____ Unmotivated/Can't get going
____ Loss of meaning to life
____ Unable to pray
____ Unable to experience forgiveness or a sense of peace
____ Unresolved grief
____ confused about personal religious practice
____ Feeling unloved
____ Separation/Loss/Divorce
____ Nightmares
____ Overly sensitive
____ Feeling unloved
____ Feelings of rejection or abandonment
____ Feelings of guilt
____ Feeling anxious
____ Fast heartbeat
____ Frequent sweating
____ Dizziness
____ Shaky hands
____ Stomach trouble
____ Feeling tense
____ Cold feet and hands
____ Always worried
____ Worried about health

___ Constipation
____ Muscle twitching
____ Nausea or vomiting
____ Headaches
____ Fainting spells
____ Feeling panicky
____ Unable to make decisions
____ Flashbacks
____ Painful memories
____ Substance abuse
____ Excessive alcohol use
____ Smoking
____ Problems with friends
____ Problems with parents
____ Fighting and quarreling
____ Stealing
____ Lying
____ Sexual acting out behavior
____ Easily angered
____ Impatient with people
____ Physical aggression
____ Feel like hurting someone
____ Feel like smashing things
____ Easily distracted
____ Hyperactivity
____ Poor concentration
____ Impulsivity
____ Poor decision making
____ Easily excited
____ Restless/fidgety
____ Can't hold a job
____ Difficulties at work
____ Marital problems
____ Financial problems
____ Learning disability
____ Speech/language problems
____ Poor social skills
____ Social anxiety/shyness
____ Difficulty making/maintaining friendships
____ No one understands me
____ Poor physical health
____ Poor hygiene practices