PINE REST Christian Mental Health Services

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.

PINE REST Christian Mental Health Services

MR # _____

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:

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

_____ _____

_____ _____

_____ _____

PINE REST Christian Mental Health Services

MR # _____

Medical Information

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

__ **Allergies**
(e.g., allergic reactions, seasonal allergies, etc)

__ **Blood disease**
(e.g., anemia, bleeding disorders, etc)

__ **Bone disease**
(e.g., osteoporosis, arthritis, broken bones, etc)

__ **Digestive system disease**
(e.g., ulcers, heartburn, Celiac Disease, IBS, etc)

__ **Endocrine disease**
(e.g., diabetes, hypothyroid, low testosterone, etc)

__ **Genetic disease**
(e.g., Sickle Cell, Fetal Alcohol, other syndromes, etc)

__ **Head and brain illness or injury**
(e.g., fainting, concussion, seizures, dementia, etc)

__ **Heart/cardiovascular disease**
(e.g., heart arrhythmia, heart attack, high blood pressure)

__ **Immune disease**
(e.g., serious infections, MRSA, Rheumatoid Arthritis, etc)

__ **Lungs and breathing disease**
(e.g., asthma, COPD, emphysema, etc)

__ **Mouth and teeth disease**
(e.g., gum disease, cold sores, canker sores, etc)

__ **Muscle and movement disease**
(e.g., tremors, tics, Restless Legs, Parkinson's, etc)

__ **Poisoning & chemical exposure**
(e.g., overdose, lead exposure, work fumes, etc)

__ **Serious injuries and wounds**
(e.g., burns, cuts, stabs, crushed limbs, etc)

__ **Other** _____

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

__ **Cancer**
(e.g., procedures for cancer treatment)

__ **Cardiac / Vascular**
(e.g., procedures for heart, blood clot, stroke)

__ **Ear, Nose, Throat**
(e.g., tonsillectomy, thyroidectomy, etc)

__ **Gastroenterology (digestive system)**
(e.g., stomach, gall bladder, liver, etc)

__ **Obstetrics & Gynecology**
(e.g., hysterectomy, c-section, abortion, etc)

__ **Orthopedic**
(e.g., joint replacement, bones, spinal fusion, etc)

__ **Plastic surgery**
(e.g., reduction, implant, reconstruction, etc)

__ **Neurosurgery**
(e.g., brain surgery, spinal fusion, etc)

__ **Urology**
(e.g., kidney stones, hypospadias, erectile dysfunction, etc)

__ **Vision**
(e.g., LASIK, eye muscle correction, etc)

__ **Weight loss**
(e.g., gastric bypass, band, sleeve, etc)

__ **Other**:
_____

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 _____

PINE REST Christian Mental Health Services

MR # _____

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!

PINE REST Christian Mental Health Services

Name: _____

MR#: _____
(office use only)

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 (Tranylcypromine)_____
- ☐ 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, Fazaclo (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) _____