



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.

**OUTPATIENT INITIAL ASSESSMENT
ADULT PATIENT INFORMATION (PART I)**

INSTRUCTIONS: To assist us in understanding and helping you, please fill out this form as completely as possible. This information is confidential and only released with your permission.

IDENTIFICATION:

Patient's Legal Name _____ Date of Birth: _____

Ethnic background: American Indian/Alaska Native Asian Black/African American
 Caucasian/White Hispanic/Latino Other _____

Form completed by (if other than patient): _____ Relationship to patient: _____

PRESENTING PROBLEM:

What is your reason for seeking treatment? _____

Who referred you to this Pine Rest location: _____

What are your expectations for treatment? _____

SIGNS/SYMPTOMS: (check those that are problematic to you)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Alcohol/Drug Use | <input type="checkbox"/> Fear | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Self-harm |
| <input type="checkbox"/> Angry outbursts | <input type="checkbox"/> Feel like hurting others | <input type="checkbox"/> Money management | <input type="checkbox"/> Sexual problem |
| <input type="checkbox"/> Anxious feelings | <input type="checkbox"/> Gambling | <input type="checkbox"/> Mood shifts | <input type="checkbox"/> Sleep problem |
| <input type="checkbox"/> Appetite change | <input type="checkbox"/> Grief/Loss issues | <input type="checkbox"/> Not enjoying things | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Concentration difficulties | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Unable to experience forgiveness |
| <input type="checkbox"/> Crying spells | <input type="checkbox"/> Health worries | <input type="checkbox"/> Recurring behaviors | <input type="checkbox"/> Unable to pray |
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Hopeless/helpless | <input type="checkbox"/> Recurring thoughts | <input type="checkbox"/> Withdrawing |
| <input type="checkbox"/> Disorganized thoughts | <input type="checkbox"/> Impulsive behaviors | <input type="checkbox"/> Recurring pain | <input type="checkbox"/> Worrying excessively |
| <input type="checkbox"/> Energy level changes | <input type="checkbox"/> Irritable | <input type="checkbox"/> Relationship issues | |
| <input type="checkbox"/> Excessive guilt | <input type="checkbox"/> Life changes | <input type="checkbox"/> Other(specify): _____ | |

How do the symptoms you checked affect your daily functioning? _____

Medical History:

Have you had any past surgical procedures? No Yes If yes, list: _____

Have you been exposed to any contagious diseases such as Tuberculosis? No Yes If yes, what were you exposed to and when did that exposure take place? _____

Are your immunizations up to date? No Yes

Any functional impairments? No Yes If yes, what type of impairment and have you had any rehab services for this? _____

Any current pain? No Yes If yes, type and duration: _____

Pain severity? (rate 1 to 10 with 1 being the least amount): _____

Has pain been an issue in the past? No Yes If yes, type and duration: _____

Have you experienced weight loss greater than 10 pounds in one month? No Yes When? _____

Have you gained more than 15 pounds in one month? No Yes When? _____

Are you following any special diet and desire more information about your special diet? No Yes

Female patients: Do you have any reproductive health medical issues/concerns you wish to discuss? No Yes

Trauma History:

Have you had a history of trauma or abuse? No Yes
If yes, what type of abuse or trauma occurred? Physical Sexual Emotional Neglect

Substance Use History:

Do you use alcohol or drugs? No Yes If yes, what is your current substance of preference? _____

Do you see your use as a problem? No Yes

If yes, how motivated are you to make changes? Unsure Somewhat Very

Is your current living situation and/or family helpful in supporting any changes? (please explain)

Have you received inpatient or outpatient treatment or educational programs for alcohol or drug use?

Where & With Whom	Type of Treatment	Dates	Was it Helpful
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever tried to cut down on your alcohol or drug use or quit using? No Yes If yes, please explain: _____

Has alcohol/drug use interfered with family or interpersonal life? No Yes If yes, please explain: _____

Have you experienced any of the following in relation to your alcohol or drug use?

- Anxiety
- Depression
- Hallucinations
- Inability to abstain
- Other adverse reactions (Please explain) _____
- Increased tolerance
- Loss of control
- Memory loss
- Overdoses
- Preoccupied with substance
- Stomach problems
- Tremors
- Withdrawal symptoms

Personal Psychiatric Counseling/Treatment History: (Please provide past and present information)

	No	Yes	When	Purpose	Result
Counseling/Therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Drug/Alcohol Treatment	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Hospitalizations	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Self-help Groups	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

SOCIAL/CULTURAL/SPIRITUAL INFORMATION:

In your experience, how important are spiritual matters? _____

What is your present religious affiliation? _____

Do you have spiritual concerns that you would like to address in the therapy process? No Not sure Yes, Describe _____

Do you have concerns that you would like to address related to cultural or ethnic issues? No Yes

If yes, explain: _____

Supportive Relationships:

Name	Age	Relationship	Quality of Relationship		
_____	_____	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
_____	_____	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
_____	_____	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor

Family/Significant Other’s Psychiatric Counseling/Treatment Information:

	No	Yes	Relationship	Reason	Response
Counseling/Therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Drug/Alcohol Treatment	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Hospitalizations	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Self-help Groups	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

Social Relationships:

How do you usually get along with people?

___ Avoidant ___ Shy ___ Leader ___ Outgoing ___ Assertive ___ Follower ___ Irritable

Has there been a recent change in your attitude/relationships with others? No Yes

If yes, circle the above word(s) that describe that change

Optional: What is your sexual orientation? ___ Heterosexual ___ Bisexual ___ Homosexual

Legal History: (if applicable)

Are you currently involved with the legal system? No Yes If yes, explain _____

Have you been involved with the legal system in the past? No Yes If yes, explain _____

Do you currently have a probation or parole officer? No Yes If yes, name _____

Educational History: (check all that apply)

___ Currently in school No Yes

___ High School Grad/GED No Yes

___ Vocational Graduated No Yes Major _____

___ Graduate School Graduated No Yes Major _____

___ College Graduated No Yes Major _____

Did you experience any of the following problems in school? ___ Learning ___ Emotional ___ Discipline ___ Social

Do you currently experience any of the following learning barriers?

___ Learning disability ___ Vision impairment ___ Hearing impairment ___ Language

I learn best through: (check all that apply) ___ Discussion ___ Written materials ___ Videos ___ Tapes

What is your primary language? ___ English ___ Spanish ___ Sign ___ Other

Employment History: (complete those that apply)

List job history beginning with most recent job

Employer	Dates	Job Title	Reason for Leaving
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Status: Full-time Part-time Disabled Laid off Retired Student
 Homemaker Other _____
 Attendance problems Performance problems Work load Medical leave Employer concerns
 Potential for lay off Dislike job Relationship problems with coworkers
 Other _____

Financial Status:

(circle one) Stable Unstable Comments _____

Military History:

Military experience No Yes If yes, specify branch and dates of service.

Branch	Date Enlisted	Date Discharged
_____	_____	_____

Leisure/Recreational:

Hobbies/Interests	Recent change in frequency?		
_____	<input type="checkbox"/> No change	<input type="checkbox"/> Decreased frequency	<input type="checkbox"/> Increased frequency
_____	<input type="checkbox"/> No change	<input type="checkbox"/> Decreased frequency	<input type="checkbox"/> Increased frequency
_____	<input type="checkbox"/> No change	<input type="checkbox"/> Decreased frequency	<input type="checkbox"/> Increased frequency

Signature: _____ Date: _____

Thank you!

Reviewed by Clinician: _____ Date: _____

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 (Tranlycypromine) _____
- 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, Fazacla (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) _____

Patient Name: _____ Medical Record #: _____

Pine Rest's Mission: We are called to express the healing ministry of Jesus Christ by providing behavioral health services with professional excellence, Christian integrity and compassion.

Thank you for selecting Pine Rest for your behavioral health needs. We look forward to serving you.

Confidentiality: Pine Rest is careful to follow all confidentiality laws and policies.

- No patient information is released without your written permission except for a situation in which you or another person is in immediate danger.
- Please note that when you sign our Consent for Treatment Form it allows Pine Rest to share pertinent information regarding your treatment with your insurance company.
- Please be aware that employees of Pine Rest have access to confidential information on a “need to know” basis. These employees are bound by confidentiality laws and will not release this information without proper authorization.
- E-mail is not a secure (confidential) form of communication, and should not be used to communicate with your Pine Rest Clinician.

Phone Calls and Messages: Your care is important to us. Every possible effort to return your call or respond to a message will be made in a timely manner. If your situation is an emergency, notify the support staff of this. If you have a life threatening mental health emergency situation after normal business hours, Michigan clients please call 616-455-9200 or 800-678-5500; Iowa clients please call 515-331-0303 for Des Moines or 641-628-9599 for Pella.

Medication Refill Requests: If you are receiving a prescription from one of our providers, please be aware that you must allow a minimum of 3 business days for your refill request to be processed.

Smoking Policy: All Pine Rest locations are *non-smoking*. There are NO designated smoking areas.

Attendance and Missed Appointment fees:

- Please arrive ten minutes prior to the start of your appointment and check in at the reception desk.
- If you arrive late, (generally 15 minutes for therapy, 10 minutes for groups or 5 minutes for a psychiatric medication check) you may be asked to reschedule your appointment or may not be allowed into a group session.
- We have reserved this time for you and require proper notification if you are unable to make your appointment. If you need to cancel an appointment, you must call at least **24 hours prior to the appointment** so that we can fill this appointment slot. **Late cancellations or no-shows for appointments will be charged a fee of \$50.** This fee will be your responsibility as insurance companies do not pay for appointments you do not keep.
- If you have 3 or more broken appointments, your case will be reviewed to determine your ability to continue in treatment at Pine Rest.

Account Balances:

- Most insurance companies do not cover 100% of charges.
- You are expected to pay your co-pay and/or deductible at the time of each service.
- If you find it difficult to make your payment, you must notify us of your circumstances to determine eligibility for our Patient Assistance Fund.
- If at any time your balance exceeds \$300, you will be required to set up a payment plan.

Letters/Forms/other Correspondence: If you request a letter, form or other type of correspondence (SSI paperwork, medical leave, attorney letter, etc.) to be completed on your behalf, you will need to provide information as requested by the clinician or letter recipient. In addition, a release of information is required. Charges for the clinical time to address such correspondence must be paid before the material is released.

Patient/Parent Signature

Date

Clinician Signature

Date