Willows Edge, Inc.

ADULT PSYCHOSOCIAL REGISTRATION FORM

GENERAL INFORMATION:

Date: ____________ Client:____________________________________M ☐ F ☐ Age: _______ Date of Birth: ______________

Address: ____ City: __________________________ Zip: _____________

Phone:_____________________________Cell ☐ Landline ☐ Email:____

Please star (*) preferred phone number for contact and messages

EMERGENCY contact information:

Name: ____ Relationship: ________________________________

Address: ____City: __________________________ Zip: ______________

Phone: ______________________________ Cell ☐ Landline ☐ Email: ____

Why are you seeking treatment at this time? ____

____

____

Please place a mark (x) to indicate the severity of your concerns?

Totally incapacitating		Extremely Severe		Severe		Moderate		Mild	No Problems
10	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**

MARRIAGE AND PARTNERSHIP INFORMATION:

Present relationship status: ☐ Single ☐ Engaged ☐ Married: how long? ______________ ☐ Separated ☐ Widowed ☐ Divorced

☐ Previously Married ☐ Never Married ☐ In a committed relationship: how long? ________________

Assessment of current marital or partner relationship: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Unsatisfactory

Are you currently or have you in the past experienced any physical, emotional, or sexual abuse in your relationships? No ☐ Yes ☐, explain: ____

____

Do you have children? No ☐ Yes ☐, how many? ___________ Ages? ____

Previous marriages or significant relationships:

1. Years married or together: _______ # of children: _______ Reason for separation: ______________________________________
2. Years married or together: _______ # of children: _______ Reason for separation: ______________________________________
3. Years married or together: _______ # of children: _______ Reason for separation: ______________________________________
4. Years married or together: _______ # of children: _______ Reason for separation: ______________________________________

CULTURAL, RELIGIOUS, SPIRITUAL INFORMATION:

Do you identify with a particular ethnic group? No ☐ Yes ☐ (please name): ______________________________

Do you identify with a particular religious group? No ☐ Yes ☐, which one? ______________________________

Current spiritual preference: ____________________ Would you like to incorporate your religious/spiritual beliefs in counseling sessions? No ☐ Yes ☐, if yes please describe your expectations: ______________________________

____

FAMILY HISTORY:

How many brothers and sisters do you have? _____Brothers _____Sisters. What sibling position are you (1st, 2nd, 3rd…)? __________

Briefly describe how you get along with others in your family? (Brothers, sisters, parents): ______________________________

____

____

Are there any family members you thought may have or have been diagnosed with mental health concerns? No ☐ Yes ☐. If **yes** please identify relationship and concerns (including ADHD, anxiety, depression, etc.): ______________________________

____

____

Have any family members committed suicide? No ☐ Yes ☐, Who? _______________ Relationship __________ When? _____

Is there a history of drug and/or alcohol problems in the family? No ☐ Yes ☐ Who? ______________________________

What substance? ______________________________. Have you witnessed or experienced any physical or emotional abuse? No ☐ Yes ☐, if yes, please explain: ______________________________

____

Have you ever been sexually abused? No ☐ Yes ☐, if yes, please explain: ______________________________

MEDICAL HISTORY:

Primary Care Physician: ______________________________ Address: ______________________________

Phone: __________________ Current prescriptions or over the counter medications: ______________________________

List any current health conditions: ______________________________

How do you rate your general health? Poor ☐ Fair ☐ Average ☐ Good ☐ Excellent ☐

Do you have a history of Strep? No ☐ Yes ☐

When were you most recently diagnosed with Strep?______________________________

Have you ever been diagnosed with Pediatric Autoimmune Neurologic and Psychiatric Disorders Associated with Strep (PANDAS)?

No ☐ Yes ☐ What treatment did you receive related to PANDAS?____

Have you had any head injuries or loss of consciousness: No ☐ Yes ☐, if yes please explain: ____________________

____

Do you have difficulty falling asleep? No ☐ Yes ☐. Staying asleep? No ☐ Yes ☐.

Have there been any changes in eating habits or appetite? No ☐ Yes ☐. Any recent weight loss or weight gain? No ☐ Yes ☐

Is there any other significant medical history not listed above? ____

EDUCATIONAL HISTORY:

What is your highest level of education completed? __________ Any Learning Disabilities? No ☐ Yes ☐ (please explain):

____

Check all that apply regarding your school experience: ☐ gifted classes ☐ School suspensions ☐ Conflicts with peers or teachers

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EMPLOYMENT HISTORY:

Did you ever serve in the U.S. military? No ☐ Yes ☐, Branch and rank: ____________________________________

Active ☐ Veteran ☐. Did you serve in combat? ☐ No ☐ Yes. Did you sustain any injuries? No ☐ Yes ☐, explain: __________

____

Are you currently: Employed ☐, what is your occupation: ______________________ Unemployed ☐, were you fired or downsized? ________________________ College Student ☐, what is your course of study? _________________

Job Skills Training ☐, what is your trade or concentration? ____________________________

LEGAL HISTORY:

Has you ever been arrested, convicted or placed on probation? No ☐ Yes ☐, When? ______ Offense: _______________

Are you currently on probation or parole? No ☐ Yes ☐, describe: ____

____

____

PSYCHIATRIC HISTORY:

Do you currently or in the past have a history of:

☐ Suicide Attempts, when?____

☐ Suicidal Thoughts, when? ____

Have you ever been hospitalized for psychiatric reasons? No ☐ Yes ☐, Where and when: ___________________________

____

Have you been in counseling before? No ☐ Yes ☐, What type and when? ______________________________

____

Please check all categories you have difficulties with: ☐ Depression ☐ Thoughts of Homicide ☐ Thoughts of Suicide

☐ Anxiety/worried/nervous ☐ Sudden Mood Changes ☐ Overly Dependent ☐ Anger Control Problems ☐ Hallucinations:

__hearing voices __seeing things ☐ Not liking self ☐ Withdrawal from others ☐ Overly Suspicious, explain: ____________

____

☐ Problems with: __Spouse ___Children __Friends __Other Adults ☐ Poor Hygiene ☐ Overly sensitive to: __loud sounds

__textures __smells ☐ Obsessions or Compulsions ☐ Serious Trauma ☐ Self-Abusive Behaviors, explain: _____________

____

SUBSTANCE ABUSE HISTORY: ☐ **Not applicable. No history of drug or alcohol abuse.**
Check all that apply: Place (*) next to your substance of preference.

☐Alcohol	Years of use:	Last date used:	Frequency of use:
☐ Cocaine/Crack	Years of use:	Last date used:	Frequency of use:
☐ Marijuana	Years of use:	Last date used:	Frequency of use:
☐ Heroin	Years of use:	Last date used:	Frequency of use:
☐ Prescription Drugs	Years of use:	Last date used:	Frequency of use:
☐ Hallucinogens ☐ Methadone ☐ Uppers/Downers ☐ Other (inhalants, glue, etc)	Years of use:	Last date used:	Frequency of use:

Have you received treatment for substance abuse before? No ☐ Yes ☐, What type of service did you receive? Outpatient ☐

Inpatient ☐ Detox ☐ Other ☐: ____________________

Do you have any other concerns not already addressed? ____

____

Client Signature: ___________________________________ Date: ___________________________________

COUNSELOR USE ONLY

MENTAL STATUS	
Appearance and Behavior:	☐ Clean ☐ Neat ☐ Unkempt ☐ Disheveled ☐ Other:
Looks stated age:	☐ No ☐ Yes ☐ Younger ☐ Older
Eye Contact:	☐ Appropriate ☐ Inappropriate
Orientation:	☐ Time ☐ Place ☐ Person ☐ Situation
Attention:	☐ Adequate ☐ Inadequate ☐ Other:
Perception:	☐ Adequate ☐ Inadequate ☐ Other:
Motor Activity:	☐ Normal ☐ Slowed ☐ Restless ☐ Agitated
Thought Process & Content:	☐ Normal limits ☐ Illogical ☐ Delusional ☐ Hallucinating __visual, __auditory, __tactile ☐ Paranoid ☐ Ruminative ☐ Derailed thinking ☐ Loose association
Cognitive Performance:	☐ Normal ☐ Poor memory ☐ Low self-awareness ☐ Short Attention ☐ Developmental disability ☐ Poor concentration ☐ Impaired judgment ☐ Slow processing
Sensory Modulation Deficits:	☐ None ☐ Speech ☐ Hearing ☐ Vision ☐ Tactile ☐ Taste

Risk Assessment:
Comments:

Danger to: ☐ None Reported or Observed **OR:** ☐ **Self:** ☐ Ideation ☐ Plan ☐ Intent ☐ Attempt ☐ **Others:** ☐ Ideation ☐ Plan ☐ Intent ☐ Attempt

Intervention(s)/Methods Provided:

Response to Intervention(s) and Development of goals and objectives:

Plan and Additional Information (recommendations, consultations):

Provider Signature: ____Date: ______________________

Karen Smigelski, LPC, Supervisor