CURRENT PROBLEMS AND CONCERNS:

Please mark below, the symptoms which you have experienced in the past 3 months.
Rate the intensity from 1 to 5, with 5 being the most severe.

1= Absent or Low 2=Moderate 3=Severe

- ☐ Depression
- ☐ Feeling hopeless
- ☐ Obsessions/ compulsions
- ☐ Extreme sadness
- ☐ Trouble concentrating
- ☐ Change in sleeping habits
- ☐ Memory problems
- ☐ Lack of energy
- ☐ Change in eating habits
- ☐ Weight changes
- ☐ Feeling stressed
- ☐ Feeling extremely happy
- ☐ Self-esteem problems
- ☐ Easily irritated
- ☐ Change in sexual interest or function
- ☐ Perfectionism
- ☐ Feeling guilty
- ☐ Problems getting along with family
- ☐ Problems with anger
- ☐ Feeling Fearful
- ☐ Trouble doing your job/schoolwork
- ☐ Feeling anxious
- ☐ Acting violently
- ☐ Lack of enjoyment of usual activities/no motivation
- ☐ Feeling tearful
- ☐ Muscle tension
- ☐ Sudden feelings of panic
- ☐ Physical complaints of pain

Thoughts of hurting/killing yourself Thoughts of harming/killing others

Other concerns or symptoms: _____

MEDICAL INFORMATION:

Prescription/Non-Prescription medication(s) you are currently taking:			
Name of Medication	Dosage	Directions (ex. How many times a day, route)	Date of Initial Rx

Medication Allergies:	Other Allergies:

Past/Current Medical Problems, including head injuries, concussions, seizures, surgeries, etc:

Life Style Questionnaire	
Frequency/quantity of alcohol consumption	Amount of caffeine consumption (incl. soda pop)
Frequency/quantity of drug consumption	Frequency/type of physical exercise
Quantity of cigarette smoking	Amount/quality of sleep

Please list the individuals with whom you reside.			
Name	Age	Relationship to Patient	Quality of Relationship
If patient is a minor, status of patient's parents (ex. Legally married, remarried, divorced, etc):			

PREVIOUS MENTAL HEALTH TREATMENT:

Have you ever been in therapy before? Yes No If yes, please describe below:

Name of therapist	Dates of Service
Type/effectiveness of treatment	
Name of therapist	Dates of Service
Type/effectiveness of treatment	

OTHER IMPORTANT INFORMATION:

Any history of abuse (physical, emotional, or sexual)	Yes No Unsure
Any custody issues or other legal issues (Probation, pending charges, etc.)	

INNOVATIVE PSYCHIATRIC SOLUTIONS

Assessment Service Disclosure Statement and Consent to Assessment

Innovative Psychiatric Solutions lawfully and ethically operates an assessment service by a licensed mental health professional. The clinician may refer appropriate patients for outpatient treatment or to a physician for further evaluation or recommend admission to the facility. Before referring and/or assessing a person, the following disclosures must be made to each person seeking treatment or assessment:

- Innovative Psychiatric Solutions is not obligated to provide an assessment by a physician unless deemed necessary by the assessment clinician. Physician assessments are billable services.
- This assessment is voluntary and the client is free to choose whether they want to pursue further treatment.
- The assessment clinician is an employee of Innovative Psychiatric Solutions.
- The assessment is confidential unless the client gives permission in writing to release information.
- Specific mental health professionals the client may be referred to are licensed and meet clinical and ethical standards of the hospital.
- Financial reimbursements are never given or received by Innovative Psychiatric Solutions based on referrals.

I certify that I have read and fully understand the above consent for assessment. I agree to absolve Innovative Psychiatric Solutions and its staff rending the treatment(s) from any liability.

I certify that I am: ____ Patient ____Biological parent with authority to consent for treatment _____Adoptive Parent ____Foster Parent _____Legal Guardian (papers are required)

IN CASES INVOLVING DIVORCE/ADOPTION OR FOSTER PARENT ARRANGEMENT PAPERS MUST BE PRESENTED PRIOR TO CONSENT FOR ASSESSMENT.

I Consent to Assessment I Refuse Assessment

_____ _____

Individual Consenting or Refusing Assessment or Medical Screening Date

_____ _____

_____ _____

Parent/Legal Guardian Date

_____ _____

Witness/Clinician Date