The Present Center for Mindfulness and Healing LLC
www.presentcenter.net
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2607 North Harrison Street
Wilmington DE 19802

2 Cub Lake Road
Byram NJ 07821

# Psychological Assessment

<table>
<tr><td colspan="4">Basic Information</td></tr>
<tr><td colspan="4">Legal Name</td></tr>
<tr><td colspan="4">How would you like to be addressed?</td></tr>
<tr><td>Address</td><td>City</td><td>State</td><td>Zip</td></tr>
<tr><td>Home Phone</td><td>Cell Phone</td><td colspan="2">Work Phone</td></tr>
<tr><td colspan="4">Email address</td></tr>
<tr><td colspan="4">How would you prefer we contact you?</td></tr>
<tr><td colspan="2">Date of Birth</td><td colspan="2">Gender and Preferred Pronouns</td></tr>
<tr><td colspan="2">Occupation</td><td colspan="2">Employer</td></tr>
<tr><td colspan="4">Primary Language:</td></tr>
<tr><td colspan="2">Handedness:</td><td colspan="2">Referred by:</td></tr>
<tr><td colspan="4">Relationship Status:<br><br>__Single __Partnered __Married __Separated __Divorced<br><br>__ It's Complicated</td></tr>
<tr><td colspan="4">Ethnic Identification (select as many as apply):<br>□ European-American<br>□ African-American<br>□ Asian-American<br>□ Latino/a<br>□ Native-American<br>□ Other:________________________________________</td></tr>
</table>

| Why are you completing this paperwork? |
| --- |
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| Religion/Spiritual practices: |
| --- |
| What religious beliefs were you raised with? |
| |
| What are your current religious/spiritual beliefs? |
| |
| |
| How often do you attend religious services? |

**Marital Status and History:**

| Name of partner | Married or partnered? | Years of relationship | Relationship ended because…(divorce, separation, death) | If applicable, circumstances around partner's death |
| --- | --- | --- | --- | --- |
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Presently, are you
□ Single □ Married □ Widowed □Divorced □ In a relationship
□Living with partner □ It's complicated

How long have you been in your current relationship?

How would you describe your current relationship?

Have you ever been in a relationship in which you experienced domestic violence (hitting, beating, belittling, shaming in front of others, overly controlling and restrictiveness, etc)? If so, please describe.

Who resides in your home currently?

Besides your own children, who else are your raising or have you raised?

Names, ages, and parentage of your children:

| Name of Child | Date of Birth | Child's Other Parent(s) | Who helps you raising your children? | What kind of relationship do you have with your child? |
|---|---|---|---|---|
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| Names, ages of grandchildren. | | | |
|---|---|---|---|
| Name of Grandchild's Parent | Name of Grandchild | Approx age/DOB | Quality of relationship you have with grandchild |
| | | | |
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| Early History |
| --- |
| Where were you born? |
| |
| Where were your parents born? |
| |
| Where were your grandparents born? |
| |
| How often did you move around as a child? |
| |
| Who raised you? Were you ever raised by people other than your parents, and if so, by whom? How come? |
| |
| |
| |

| Important people in your life | | | | | |
| --- | --- | --- | --- | --- | --- |
| Parent | Name | DOB | DOD and circumstances of their passing | Quality of relationship | Physical or mental health issues |
| Mother | | | | | |
| Father | | | | | |
| Stepmother | | | | | |
| Stepfather | | | | | |
| Paternal grandmother | | | | | |
| Paternal grandfather | | | | | |
| Maternal grandfather | | | | | |
| Maternal grandmother | | | | | |
| Other important figure | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Other important figure | | | | | |
| Other important figure | | | | | |
| Other important figure | | | | | |
| Other important figure | | | | | |
| Other important figure | | | | | |

Parents

Year parents married/became partnered:

Year parents divorced/separated:

| Parent | Name | Occupation | Level of Education | Quality of relationship | Physical or mental health issues |
|---|---|---|---|---|---|
| Mother | | | | | |
| Father | | | | | |
| Stepmother | | | | | |
| Stepfather | | | | | |
| Paternal grandmother | | | | | |
| Paternal grandfather | | | | | |
| Maternal grandfather | | | | | |
| Maternal grandmother | | | | | |
| Other important figure | | | | | |
| Other important figure | | | | | |
| Other important figure | | | | | |

| Were you abused or neglected as a child? | | | | | | |
|---|---|---|---|---|---|---|
| | Name | Physical abuse | Sexual abuse | Emotional abuse | Neglect | Other |
| Mother | | | | | | |
| Father | | | | | | |
| Stepmother | | | | | | |
| Stepfather | | | | | | |
| Paternal grandmother | | | | | | |
| Paternal grandfather | | | | | | |
| Maternal grandfather | | | | | | |
| Maternal grandmother | | | | | | |
| Other important figure | | | | | | |
| Brother | | | | | | |
| Sister | | | | | | |
| Aunt | | | | | | |
| Uncle | | | | | | |
| Foster care acquaintance | | | | | | |
| Teacher | | | | | | |
| Priest/religious figure | | | | | | |

Were any of your siblings abused?___________________________________________________________

Did you witness any abuse perpetrated on others as a child?__________________________________

Describe the ways your family disciplined you, and the ways they reinforced/rewarded good behaviors___________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

| Siblings | | | | | |
|---|---|---|---|---|---|
| | Name | DOB | DOD and circumstances of passing | Occupation | Quality of relationship |
| Brother | | | | | |
| Brother | | | | | |
| Stepbrother | | | | | |
| Sister | | | | | |
| Sister | | | | | |
| Stepsister | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Do any of your relatives suffer from mental health issues or addictions, including gambling disorder?___________________________________________________________________________

Are you aware of any complications in your birth, or during gestation?

______________________________________________________________________________________

______________________________________________________________________________________

How old were you when you took your first steps? ___________________________________________

Were there any delays or other challenges with walking?_____________________________

How old were you when you said your first words?

______________________________________________________________________________________

______________________________________________________________________________________

Were there any delays or other challenges with speech and language?______________

| Education | | | |
|---|---|---|---|
| School Type | Name of School | Years Attended | Graduated/degree? |
| Elementary | | | |
| Elementary | | | |
| Elementary | | | |
| Middle | | | |
| Juniior High | | | |
| High school | | | |
| High school | | | |
| College | | | |
| College | | | |
| Vocational college | | | |
| Vocational college | | | |
| Graduate school | | | |
| Graduate school | | | |
| Post-graduate | | | |
| Other | | | |

Did you have any difficulty learning to read, to do math, or any other academic task?________________________________________________________________________

Were you repeated or did you skip a grade?_______________________________________

Did you enjoy school as a youngster? Why or why not?

____________________________________________________________________________

____________________________________________________________________________

| Work History | | | | |
|---|---|---|---|---|
| Job Title/Description | Company | Years | Left because… | Other |
| | | | | |
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What was the best job you ever had, and why?

______________________________________________

______________________________________________

______________________________________________

What was the worst job you ever had, and why?

______________________________________________

______________________________________________

______________________________________________

What job did you always wish you had?

______________________________________________

______________________________________________

| Military Service | | | | | |
|---|---|---|---|---|---|
| Branch | Dates of Service | MOS | Rank | Were you injured in service | Nature of Discharge |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Were you deployed?

| Dates of deployment | Place of deployment | Active combat? | Trauma? |
|---|---|---|---|
| | | | |
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Did you experience Military Sexual Trauma (MST) in the service? ______________________________

Did you experience racism in the service? __________________________________________________

Did you experience sexism in the service? __________________________________________________

Were you exposed to burn pits or other chemical exposures in the service? ___________________

Did you receive the anthrax series vaccines before deployment? _____________________________

Did you enlist or were you drafted? ________________________________________________________

## MEDICAL INFORMATION

| Primary Care Provider: | |
|---|---|
| Name of Provider | Type of Health Care Practice |
| Address | |
| Email/Website Address | |
| Phone | Fax |

| Additional Health Care Provider 1 | |
|---|---|
| Name of Provider | Type of Health Care Practice |
| Which Conditions are Treated By this Provider? | |
| Address | |
| Email/Website Address | |
| Phone | Fax |

| Additional Health Care Provider 2 | |
|---|---|
| Name of Provider | Type of Health Care Practice |
| Which Conditions are Treated By this Provider? | |
| Address | |
| Email/Website Address | |
| Phone | Fax |

| Additional Health Care Provider 3 | |
|---|---|
| Name of Provider | Type of Health Care Practice |
| Which Conditions are Treated By this Provider? | |
| Address | |
| Email/Website Address | |
| Phone | Fax |

Current Height_______________ Current Weight_______________

What do you wish your weight to be?____________________

Have you used tobacco? □ Yes □ No

When was your last use? _____________________________________

If you use habitually, how much do you use?__________________

Do you use nutrasweet/aspartame?_□ Yes □ No

Have you had trouble with gambling or recreational spending?

□ Yes □ No

Do you have trouble with other addictions/compulsions? □ Yes □ No

| Health in Family: Please indicate if you or someone in your family has suffered from any of the following health care concerns: | | | | | |
|---|---|---|---|---|---|
| Illness/condition | You | | Others in Your Family | | |
| | Current | Past | Mother | Father | Other relative |
| Physical Health Concerns | | | | | |
| General | | | | | |
| Headaches | | | | | |
| Pain | | | | | |
| Glasses/contacts/visual impairment | | | | | |
| Hearing impairment | | | | | |
| Sleep disturbances | | | | | |
| Fatigue | | | | | |
| Ear infections | | | | | |
| Sinus issues | | | | | |
| Skin Conditions | | | | | |
| Rashes | | | | | |
| Athletes foot | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Other fungus | | | | | |
| Warts/skin tags | | | | | |
| Ringworm | | | | | |
| Psoriasis | | | | | |
| Lice | | | | | |
| Scabies | | | | | |
| Cancer | | | | | |
| Sunburn | | | | | |
| Eczema | | | | | |
| Dry skin | | | | | |
| Oily skin | | | | | |
| Acne (adolescent, adult) | | | | | |
| Other | | | | | |
| Allergies | | | | | |
| Scents, oils, lotions, etc | | | | | |
| Detergents | | | | | |
| Foods | | | | | |
| Additives | | | | | |
| Medications | | | | | |
| Latex | | | | | |
| Animal fur/dander | | | | | |
| Other | | | | | |
| Muscles/joints | | | | | |
| Rheumatoid arthrtitis | | | | | |
| Psoriatic arthritis | | | | | |
| Osteoarthritis | | | | | |
| Broken bones | | | | | |
| Dislocated bones | | | | | |
| Scoliosis | | | | | |
| Problem disks | | | | | |
| Subluxations | | | | | |
| Fusions | | | | | |
| Lupus | | | | | |
| TMJ/jaw pain | | | | | |
| Cramps | | | | | |
| Weak or sore muscles | | | | | |
| Bursitis/ stiff or painful joints | | | | | |
| Tendonitis | | | | | |
| Lower back pain | | | | | |
| Other back pain | | | | | |

| Hip pain | | | | | |
|---|---|---|---|---|---|
| Neck pain | | | | | |
| Fibromyalgia/myalgia | | | | | |
| Other | | | | | |
| Nervous System/Brain | | | | | |
| Epilepsy | | | | | |
| Seizures | | | | | |
| Alzheimer's dementia | | | | | |
| Frontotemporal dementia | | | | | |
| Dementia but unknown what kind | | | | | |
| Head injuries | | | | | |
| Loss of consciousness | | | | | |
| Concussions | | | | | |
| Dizziness | | | | | |
| Ringing in ears | | | | | |
| Numbness/tingling | | | | | |
| Sciatica | | | | | |
| Tumors | | | | | |
| Multiple Sclerosis | | | | | |
| Learning difficulties | | | | | |
| Cognitive impairment | | | | | |
| Other | | | | | |
| Circulatory/heart | | | | | |
| Aneurism | | | | | |
| Rheumatic fever | | | | | |
| Heart valve issue | | | | | |
| Varicose veins | | | | | |
| Red, flush skin | | | | | |
| Irregular heartbeat | | | | | |
| A-fib | | | | | |
| Rapid heartbeat | | | | | |
| Blood clotting/DVT | | | | | |
| Fingertips turn blue | | | | | |
| Swollen ankles | | | | | |
| Embolism | | | | | |
| Stroke | | | | | |
| Heart attacks | | | | | |
| Heart disease | | | | | |
| High blood pressure | | | | | |
| Low blood pressure | | | | | |

| Reynauds | | | | | |
|---|---|---|---|---|---|
| High cholesterol | | | | | |
| High triglicerides | | | | | |
| Cold all the time | | | | | |
| Other | | | | | |
| Respiratory | | | | | |
| Asthma | | | | | |
| COPD | | | | | |
| Emphysema | | | | | |
| Fainting | | | | | |
| Shortness of breath | | | | | |
| Other | | | | | |
| Digestive/urinary | | | | | |
| Eating disorder | | | | | |
| Irritable bowel disease | | | | | |
| Crohn’s Disease | | | | | |
| Feel sleepy after meals | | | | | |
| Chronic diarrhea | | | | | |
| Gallbladder pain/attacks | | | | | |
| Pain between shoulder blades | | | | | |
| Bad breath | | | | | |
| Urinary tract infections | | | | | |
| Sweat has strong odor | | | | | |
| Bowel resections | | | | | |
| Gas/belching within an hour of eating | | | | | |
| Colitis | | | | | |
| Ulcerative colitis | | | | | |
| Kidney disease/issue | | | | | |
| Heartburn/acid reflux | | | | | |
| Other | | | | | |
| Women’s Health | | | | | |
| Endometriosis | | | | | |
| Cysts | | | | | |
| Yeast infections | | | | | |
| Premenstrual Dysphoria | | | | | |
| Reproductive cancers | | | | | |
| Infertility | | | | | |
| Irregular menstruation | | | | | |
| Hysterectomy | | | | | |

| Pregancies to term | | | | | |
|---|---|---|---|---|---|
| Pregnancy losses | | | | | |
| Abortions | | | | | |
| Other | | | | | |
| Other Conditions | | | | | |
| Diabetes I | | | | | |
| Diabetes II | | | | | |
| Fibrotic tumors | | | | | |
| Hyperthyroid | | | | | |
| Hypothermia | | | | | |
| Hypothyroid | | | | | |
| Irritable bowel disease | | | | | |
| Kidney disease | | | | | |
| Hepatitis (A,B,C) | | | | | |
| Polio | | | | | |
| Lyme disease | | | | | |
| Other serious injury | | | | | |
| Surgeries | | | | | |
| Cancers | | | | | |
| HIV/AIDS | | | | | |
| Other | | | | | |
| Mental Health Concerns | | | | | |
| Alcoholism | | | | | |
| Anorexia | | | | | |
| Anxiety/panic attacks | | | | | |
| Attention deficit disorder | | | | | |
| Bipolar disorder | | | | | |
| Bulimia | | | | | |
| Compulsions | | | | | |
| Depression | | | | | |
| Dissociative experiences | | | | | |
| Drug use/abuse | | | | | |
| Learning disorder | | | | | |
| Obsessive thoughts or behaviors | | | | | |
| Paranoia | | | | | |
| Psychiatric hospitalizations | | | | | |
| PTSD | | | | | |
| Schizophrenia/psychosis | | | | | |

| Sleep problems | | | | | |
|---|---|---|---|---|---|
| Tobacco use | | | | | |

Please give age, lists of any illnesses, or if deceased. If deceased, list causes of death and age of death:

Mother:

______________________________

______________________________

Father:

______________________________

______________________________

Siblings:

______________________________

______________________________

______________________________

______________________________

Mother's parents:

______________________________

______________________________

______________________________

Father's parents:

______________________________

______________________________

______________________________

# Medical Information

## PAIN

Please check the areas of pain or discomfort on the figures below.

Use a 0-10 scale to rank your pain from 0 (no pain at all) to 10 (the worst pain imaginable).

You can use the letters below to identify the type of sensation. Feel free to add any others you wish.

A = Ache

B = Burning

M = Memory Site

N = Numbness

P = Pins and needle

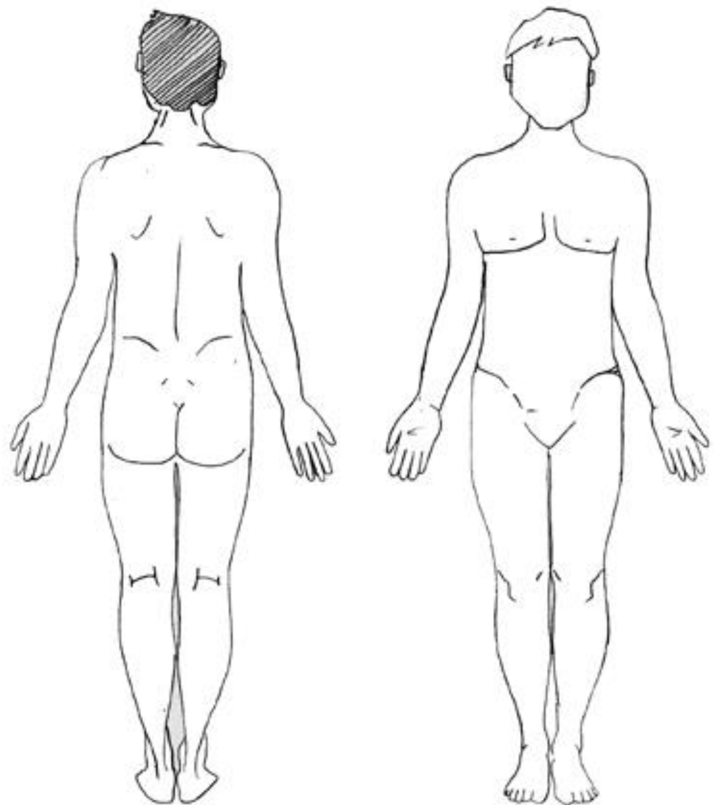
S = Sharp

Sc = Scar or surgery

St = Stabbing

R = Radiating

T = Trauma



Additional Information:

________________________________________

________________________________________

What Helps the Pain?

________________________________________

What Makes it Worse?

________________________________________

| Please list any medications, pharmaceuticals that you are currently or have previously have taken: | | | | |
|---|---|---|---|---|
| Medication | Dose | Frequency | For? | How long? |
| Eg, Zoloft | 200 mg | At night before bed | Depression, migraine | Since 2011 |
| | | | | |
| | | | | |
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| Please list any supplements, herbs, vitamins, minerals, amino acids, and hormones that you are currently or have previously taken | | | | | |
|---|---|---|---|---|---|
| Supplement | Manufacturer | For? | Dosage | Frequency | How long? |
| Eg, Vitamin C | Solgar | Immune support | 500 mg | 1x/day | Since 2017 |
| | | | | | |
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| Please indicate if you have received any of the following treatments. | | | | | |
|---|---|---|---|---|---|
| | Type of Treatment/Provider | Conditions Treated | Duration of Treatment | Frequency of Treatment | Did it help? |
| | Chiropractic | | | | |
| | Dietician | | | | |
| | Health Coaching | | | | |
| | Energy Therapy/Reiki | | | | |
| | Nutritional Counseling | | | | |
| | Psychotherapy | | | | |
| | Supervised treatment with psychadelics | | | | |

Additional Health History

List and include dates and treatments. Add pages if necessary

Surgeries

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
_____________________________________________

Accidents

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________

Major Illnesses

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________

| Please delineate your history of psychological counseling. Begin with most recent, working backward. | | | | | |
|---|---|---|---|---|---|
| Provider Name | Provider Type (counselor, psychologist, psychiatrist) | Years of Treatment | Type of Treatment (Addictions counseling, mental health therapy, medication management, etc) | Treated for??(Reason you sought care) | Other Notes: why treatment ended, special details about care, etc. |
| | | | | | |
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| Hospitalization History<br><br>Please delineate your mental health hospitalization history, beginning with the most recent hospitalization. Please include any treatment in Intensive Outpatient Programs, or IOP. You may also include hospitalizations for substance use struggles. | | | | |
|---|---|---|---|---|
| Dates of admission and discharge | Name of Hospital/Facility/Program | Reason for admission | Conditions of discharge | Voluntary/involuntary? |
| | | | | |
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| Drug and Alcohol Use History<br><br>Please indicate which drugs you have tried, used habitually, and any with which you have struggled. | | | | |
|---|---|---|---|---|
| Drug Used | Age of first use | Amount used within last month | Last use was… | Any treatment for use? |
| | | | | |
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Self-Harm

Have you ever thought about hurting yourself? ______________________________________________

Have you ever thought about ending your life? ______________________________________________

Have you ever been hospitalized because of suicidal thoughts or feelings?

______________________________________________________________________________

Have you ever hurt yourself or engaged in self-injury such as by cutting

yourself?______________________________________________________________________

Have you ever required medical treatment for self-injury? ____________________________________

When was the last time you engaged in self-injury? ___________________________________________

Have you ever required medical treatment due to thinking about or attempting to end your own

life or hurting yourself? ________________________________________________________________

When is the last time you thought about ending your own life, dying, or hurting yourself?

______________________________________________________________________________

If recent, how many times in a week are you experiencing these thoughts and feelings?

______________________________________________________________________________

Have you ever attempted suicide? _______________________________________________________’

If so, by what means?_____________________________________________________________

How many times have you attempted suicide? ________________________________________

| Please note any serious medical procedures | | | | |
|---|---|---|---|---|
| Procedure | Date(s) | What was it for? | Doctor coordinating? | Helpful? |
| E.g., Hysterectomy | July 2015 | Endometriosis | Dr. Yan | After I healed, yes. But there were serious complications. |
| | | | | |
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History of Homelessness

Have you ever been homeless?

______________________________________________________________________________

For how long were you homeless?

______________________________________________________________________________

How did you become homeless?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

How did you find your way out of homelessness?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

| Do you currently have any legal concerns or legal issues/cases pending?<br><br>Please share your history of legal concerns and incarceration | | | | |
|---|---|---|---|---|
| Date of arrest | Alleged crime | Where crime allegedly occurred | Were you incarcerated? | Dates of incarcerations |
| | | | | |
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| What kinds of activities and exercises do you do? | | | | |
|---|---|---|---|---|
| Activity | Minutes | 1-2x week | 2-4x week | 5+x week |
| Artwork<br>(painting, drawing, photography, ceramics, sewing, etc) | | | | |
| Animal husbandry (caring for pets and service animals, feeding and playing with them, etc) | | | | |
| Biking (in and outdoors) | | | | |
| Car and/or motorcycle maintenance, restoration, etc. | | | | |
| Church (attending, teaching classes, going to religious study) | | | | |
| Cleaning (vacuuming, laundry, dishes, tidying up) and taking care of home | | | | |
| Cooking | | | | |
| Dancing (line, ballet, tap, hip-hop, etc) | | | | |
| Eating | | | | |
| Exercise classes (Zumba, step aerobics, etc) | | | | |
| Gardening (and yardwork) | | | | |
| Golfing | | | | |
| Horseback riding | | | | |
| Hiking and camping | | | | |
| Gaming | | | | |
| Internet "surfing" | | | | |
| Meditation | | | | |
| Music(singing, instrument, writing) | | | | |

| | | | | |
|---|---|---|---|---|
| Pilates | | | | |
| Reading | | | | |
| Running | | | | |
| Shopping (groceries, clothing, household goods, etc) | | | | |
| Swimming | | | | |
| Tai Chi/chi gong | | | | |
| Tennis | | | | |
| Skiing | | | | |
| Visiting with friends and family | | | | |
| Volunteering (hospitals, nursing homes, animal shelters, food banks, etc) | | | | |
| Walking | | | | |
| Watching (Netflix, Hulu, TV, Movies, etc) | | | | |
| Weight lifting | | | | |
| Woodworking | | | | |
| Working at a paying job (including preparing for professional work) | | | | |
| Writing (fiction, non-fiction, poetry, etc) | | | | |
| Yoga | | | | |
| Other | | | | |