Michigan Diversion Center
3253 Congress Ave. Saginaw, MI 48602
OFFICE (989) 308-1415 FAX (989) 393-6021

Adult – Welcome Packet

Re: _____

We have included the **Adult Medical, Social History, & Assessment form** for your completion. This form is very important to the assessment process. If you arrive for your appointment without this form completed it may result in an interruption to your allotted appointment time or your appointment may need to be rescheduled.

You may also download this form from our website at midiversion.com.
Appointment times typically last 45 to 60 minutes. The first portion of your initial appointment is completing additional consent forms. Please remember to bring the attached completed **Adult Medical Social History & Assessment Form**. Once your paper work is completed, your therapist will see you.

Please arrive on time to the appointment because there are releases that must be signed prior to you being able to see your therapist.

If you arrive late your appointment may have to be cancelled. It's your responsibility to call and reschedule ASAP. We are an extremely busy practice with limited time slots, so we ask that as soon as you know that you have to cancel or reschedule, please let us know.

If you are unable to keep this appointment, contact the office at (989) 308-1455 asap.

Thank you,

Office Staff

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ADULT MEDICAL AND SOCIAL HISTORY AND ASSESSMENT

**Please complete the following information. This information is essential to make an accurate assessment of your current needs. Complete as much of this assessment as possible and write N/A if something doesn't apply.*

FULL NAME: _____ DATE: _____
Birthdate__/__/__/ Address: _____ City_____
Home phone: _____ Alternate phone: _____
Employer/School:_____ Position:_____ No. of years_____

FAMILY:
Marital Status: ☐ Married ☐ Separated ☐Divorced ☐Re-Married ☐Never Married

Spouses name_____ Maiden name: _____
Marriage Date: __/__/__/ Birthdate: __/__/__/
Present Marriage: Date _____ To whom? _____
Employer: _____ Position: _____ No. of years_____

Other adults in home: _____ Relationship: _____
Birthdate: __/__/__/ Employer: _____ Work phone: _____
Emergency contact person: _____
Address: _____ City: _____ Phone: _____

Children: Name	"X" If out Of home	Birthdate	Type of relationship (close, distant, conflicted)
_____	☐	_____	_____
_____	☐	_____	_____
_____	☐	_____	_____
_____	☐	_____	_____
_____	☐	_____	_____

WORK/SCHOOL:
Job satisfaction and motivation: ☐Strong ☐Neutral ☐Weak ☐Negative
Work Stressors: _____
Difficulties: ☐None ☐Yes

Describe:_____
_____
_____

Work/School relationships: ☐Supportive ☐Cooperative ☐Conflicted ☐Isolated ☐Stressful
_____

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Military Service Branch:_____ Specialty:_____
From:_____ To _____ Where _____
Type of discharge:_____
Experience in the service? ☐Positive ☐Negative ☐Neutral ☐Negative
Difficulties **:** ☐None ☐Yes:
Describe:_____
_____
_____

HEALTH & TREATMENT HISTORY

*Please advise your therapist of any infectious condition that you may have. * - ***Kept Confidential***
Family Physician: _____Date Last Seen: _____

Health History: (If experienced, please indicate your age next to the condition.)

Allergies:	Eye Problems:	Measles:
Arthritis:	High Blood Pressure:	Migraines:
Asthma:	Fainting Spells:	Paralysis:
Bowel Problems:	Food Sensitivity:	Pneumonia:
Chicken Pox:	Diabetes:	Rheumatic Fever:
Convulsions:	Hay Fever:	Hernia:
Delirium:	Heart Problems:	Hearing Problems:
Depression:	Back Problems:	Tonsillitis:
Ear Infections:	Hemophilia:	Tubes in Ears:
Eating Problems:	High Fevers:	Weight Problems:
Eczema:	Hives:	Whooping Cough:
Epilepsy	Mumps:	Tuberculosis:
HIV:	Sleep Problems:	Other
Cancer:	Seizures:	Over Eating:
Headaches:	Thyroid Problems:	Smoking:
Hepatitis:	Diarrhea:	Rectal Bleeding:
Breathing Problems:	Drinking more than 2 drinks/day:	Head Injury:
Use of Inhalants:	STD/STI:	Birth Control:

Accidents: Type and age:_____
Operations: Type and age:_____
Other Hospitalizations: _____

Current medications: _____ Dosage:_____ Feel free to use a separate sheet.
(Physician:_____

Previous Counseling: ☐No ☐Yes
Where:_____When:_____
Medication used?:__Medications used: _____Med Helpful: ☐ No ☐ Yes ☐ Neutral
Outcome of Counseling: ☐ Problem Solved ☐ Some Change ☐ No Change ☐ Problem Worse
What was helpful: _____
What was not helpful: _____

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SIGNIFICANT FAMILY EVENTS

Has your family experienced any of the following in the last two years? **(please check)**
Acute illness: _____ Move of residence: _____ Unemployment: _____ Chronic illness: _____
Re-Marriage: _____ Separation/divorce: _____ Experienced Childhood Abuse or Neglect: _____
Death: _____Disasters: _____Violence: _____Substance abuse: _____Suicide/attempts: _____
Marital discord: _____ Employment changes: _____ Legal problems: _____ Criminal problems: _____
Accidents: _____ Sexual assault: _____ Substance abuse: _____
Prison: _____ Other: _____

Please describe any other events that may contribute to the present problem:
_____
_____
_____

FAMILY CIRCUMSTANCES

Please apply a ✓ or and ✗ to any of the circumstances that appear to fit your family. This will assist the therapist in better understanding the factors that may affect your level of functioning.

Family Circumstances	Not a problem	A little problem	Moderate	Quite A Bit	Extreme
Marital Conflict					
Disagreement regarding child rearing approaches					
Substance abuse					
Divorce/Separation					
Poverty – Financial Challenges					
Single Parent Family					
Poor housing/neighborhood					
History of violence in the family					
Poor communication in the family					
Parent absent/not involved with your child					
Your Child's Parent in jail or prison					
Unemployment					
You are a Grandparent raising the youth					
Legal issues					
You are a Parent that feels depressed and overwhelmed					
You feel powerless to influence spouse or child					
Lack of support from partner or family members					
No present medical care					

PROBLEM/SYMPTOM CHECKLIST

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Below is a list of problems or symptoms. Place x in the box that best applies to the problem or symptom that is listed.

Problems/symptoms	Not a problem	A little problem	Moderate	Quite A Bit	Extreme
Defiant at home, not following home rules					
Frequent arguing at home, conflict with family members					
Controlling temper, outburst of anger					
Fire setting					
Hurting animals					
Defiant at work/school, not following work/school rules, authority					
Avoiding work/school, attendance problems, truancy					
Poor work/academic performance, not completing assigned work					
Attention problems					
Hyperactivity, impulsivity					
Fighting a work/school, conflicts with coworkers/peers					
Depression, feeling of hopelessness					
Apathy, lack of interest in things					
Not sleeping loss of appetite					
Seldom communicates with family members					
Suicidal feelings talk or behavior					
Tendency to withdraw and keep to self and self-isolate					
Low self-esteem, feels bad about self, little confidence					
Reaction to marital separation or divorce (self or parents)					
Sexual assault of others					
Conduct problems-theft, assault, lying, destroying property					
Violence or threat of violence toward others					
Frequent physical symptoms or complaints					
Reaction to death or other loss, grief reaction					
Victim of physical or sexual abuse					
Not eating properly, eating disorders, anorexia, or bulimia					
Reaction to traumatic events, post-traumatic stress					
Excessive worrying, anxiety or panic attacks					
Drug or alcohol problems					
Hearing voices, seeing things, unreal thoughts or beliefs					
Mood swings, unstable moods					
Unsafe sexual activity, poor judgment, promiscuity					

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Your present concerns about yourself: _____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

When did these concerns begin? _____

_____
_____
_____
_____
_____

Other information you would like us to know?

_____
_____
_____
_____
_____

Completed by: _____ Date: _____
Name Relationship

Reviewed by: _____ Date: _____
Therapist