PATIENT RIGHTS

Your fee is based on the time we spend with you during your visit, the complexity of your condition, and any treatment provided. But proper attention to your care also requires that we spend additional time beyond that which we spend with you in the office. Such time may be used to:

· Create and maintain your permanent medical record.

· Review, interpret, & document all lab test results & communicate those results to you.

· Consult via phone about your case with referring or consulting physicians and other health care providers.

· Provide written reports to your insurance company, your disability company, your employer, Social Security Administration, etc., per your request.

· Conduct medical/psychiatric research relevant to your case.

· Communicate with pharmacies about your prescriptions.

· Complete insurance applications and claim forms. Call your insurance company for benefits, payment information, etc. Obtain pre-certification for all treatment.

· Call your insurance company claims department when payment is not received within state guidelines (45 days).

· Conduct utilization review negotiations with hospitals and insurance companies.

· Dictate, review and manage hospital records.

· Draft letters of medical necessity to obtain medical services or prescriptions you need.

· Arrange for hospital admissions and follow-up consultations with nurses, attending physicians, and house staff.

· Draft reports and forms, including home health care orders and nursing facility orders.

· Respond to your telephone calls and web portal emails.

Our out-patient fees are as follows:

· Initial Evaluation: $275 – includes time with a physician, treatment recommendations for follow-up care including therapy with a social worker or counselor, medication recommendations, and prescriptions as needed.

· Individual Psychotherapy: $200 per 45-60 minute session with a PhD, LPC, LPE or LCSW.

· Medication Management: $100 per 10-15 minute session with an MD Psychiatrist.

· Family Therapy: $195 per 45-60 minute session.

All of these activities add to our cost of doing business. Still, we are committed to providing you the best possible care. We hope this explanation of our fees has been helpful. With you, our patient, we look forward to a lasting and healthy relationship.

YOU DO HAVE THE RIGHT:

·To treatment regardless of race, color, sex, religion, national origin, age, handicap or professional status.

·To be treated with consideration, respect, and individual dignity.

·To know the identity and professional status of individuals providing services to you.

·To an individual treatment plan which shall include the nature of care, procedures and treatment received and to have the plan periodically reviewed and updated in keeping with your health status.

·To participate in planning your treatment and aftercare.

·To obtain information concerning your diagnosis, treatment, and known outcome of your treatment. You have a right to an explanation of your condition, medications, procedures for treatment, alternatives for care or treatment, problems related to recuperation and probability of success.

·To be informed of the risks and side effects of any proposed treatment and the right to be informed of alternative treatments.

·To refuse treatment to the extent permitted by law. Medication and treatment are given only for your welfare. When refusal of treatment by you or your legal representative prevents the provision of appropriate care in accordance with professional standards, the relationship established between you and PAA may be terminated upon reasonable notice.

·To request and receive an itemized and detailed explanation of your total bill for services. You have a right to timely notice prior to termination of your eligibility for reimbursement by any third-party payer for the cost of your care.

·To confidentiality. All communication and records pertaining to your care, including the source of payment for treatment, shall be treated as confidential and will not be given to anyone without proper authorization, except in accordance with state and local laws which require reporting of all cases in which there is abuse or neglect of minors or where there exists a danger to self or others. Legal subpoena by the court cannot be refused and records must be provided. PAA will hand deliver sealed records to the judge in this instance.

Signature:* ×_____

Date:

ACKNOWLEDGEMENT FORM

I acknowledge that a copy of the Notice of Privacy Practices at Psychiatric Associates of Arkansas is available to me at my request and hereby consent to this notice.

Signature: * ×_____

Date:

FINANCIAL POLICY

Thank you for choosing us as your health care provider. The following is a statement of Financial Policy which we require you to read and sign prior to any treatment.

PAYMENT OF DEDUCTIBLES, CO-PAYMENTS AND ANY NON-COVERED SERVICES ARE DUE AT THE TIME OF SERVICE. NON-INSURED PATIENTS ARE EXPECTED TO PAY IN FULL AT THE TIME OF SERVICE.

WE ACCEPT CASH, CHECKS, AND DEBIT/CREDIT CARDS (MC, VISA, AMEX & DISC). THERE IS A $20 RETURNED CHECK FEE.

REGARDING INSURANCE

Your insurance coverage is a contract between you and your insurance company. If we are a contracted provider with your managed care company, we will handle your claims according to our agreement with your particular company. As a courtesy to you, we are happy to file your primary and secondary insurance. If you have more than two insurance companies, you will be responsible for filing the third insurance. **You are responsible for paying all deductibles, co-payments, and any non-covered services at the time of service.**

In the event we accept assignment of benefits, you are still ultimately responsible for all charges. **MEDICARE PATIENTS WILL HAVE A 20% COPAY (even though we take assignment).** Arkansas law requires insurance to pay within 45 days. We will not become involved in disputes with your insurance company. If they have not paid within this time frame, we will expect payment from you. Our practice is committed to providing the best treatment for our patients and we charge what are usual and customary rates. Our fees are as follows: New Patient Initial Evaluation = $275; Individual Psychotherapy = $200; Medication Management = $100; Family Therapy = $195. **Please note: There will be a charge of $200 per hour (billed in 15 minute increments) for filling out any FMLA, disability, or other paperwork if they are not done during an appointment. Prescriptions issued outside of appointments may be billed a $10 fee, depending upon the circumstances.**

MINORS

The adult accompanying a minor is responsible for full payment. This is regardless of any divorce decrees (which is a contract between parents; not between you and your doctor). If an ex-spouse is responsible for a minor's bill, the adult accompanying the minor is responsible for paying the physician fees and then collect reimbursement from the ex-spouse. **PARENTS ARE RESPONSIBLE FOR SENDING CO-PAYMENTS WITH UNACCOMPANIED MINORS AT EACH VISIT. A parent or legal guardian must accompany a minor for their initial visit.**

DELINQUENT ACCOUNTS

I agree to be financially responsible for any unpaid balance due to Psychiatric Associates of Arkansas for services rendered. I understand that even though I have insurance, some diagnosis may not be covered under that insurance plan. If this occurs, I agree to pay the full fee for services.

I grant permission to Psychiatric Associates of Arkansas, its agents or assigns, to discuss my account with and release any information to any third party payer via the U.S. Postal Service, fax, or any electronic media in order to assist in the payment of any balance due, or otherwise verify personal information provided.

Also, it is understood and agreed that Psychiatric Associates of Arkansas reserves the right to assess a monthly finance charge, in accordance with Arkansas Law, to any unpaid balance due. Further, it is agreed that should Psychiatric Associates of Arkansas determine that it is necessary to employ a collection agency to recover any unpaid balance owed, I agree to pay any and all collection fees and costs expended to effect recovery, with such collection fees to be up to 50% of the unpaid balance due, including any and all attorney's fees assessed by any court.

APPOINTMENTS NOT CANCELED 24 HOURS IN ADVANCE ARE CHARGED A MISSED APPOINTMENT FEE OF $50 FOR MISSED INITIAL EVALUATION APPOINTMENTS AND $25 FOR MISSED DOCTOR FOLLOW-UP/MEDICATION MANAGEMENT APPOINTMENTS. PSYCHOTHERAPISTS ARE INDEPENDENT CONTRACTORS AND HAVE THEIR OWN MISSED APPOINTMENT POLICIES, WHICH THEY WILL DISCUSS WITH EACH PATIENT. ***Three missed appointments with no notification could result in dismissal from therapy!***

I UNDERSTAND I AM FULLY RESPONSIBLE FOR ANY OF THESE ABOVE MENTIONED FEES, AS THEY WILL NOT BE BILLED TO MY INSURANCE COMPANY!!

PLEASE READ THE ABOVE FINANCIAL POLICY CAREFULLY BEFORE SIGNING. WITH YOUR SIGNATURE YOU ARE ACKNOWLEDGING YOUR UNDERSTANDING OF OUR FINANCIAL POLICY.

Signature:* ×_____

Date:

BILLING RELEASE

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Psychiatric Associates of Arkansas, PLLC. I further acknowledge that I am financially responsible for payment whether or not service is covered by my insurance policy.

Signature:* x _____

Date:

CONTROLLED SUBSTANCE

We are committed to doing all we can to treat your psychiatric illness. In some cases, benzodiazepines for anxiety or stimulants for the treatment of ADHD may be prescribed. This agreement is a tool to protect both you and the prescriber and establishing guidelines, within the laws, for the proper controlled substance use.

1. All controlled substances have a potential for dependency and abuse. Narcotics (pain pills) are not psychiatric medicines and we do not prescribe them.
2. All benzodiazepines or stimulants must come from the prescriber whose signature appears below, or during his/her absence, by the covering prescribers unless specific authorization is obtained for an exception.
3. NO prescriber is required to provide controlled prescription drugs on the first visit unless warranted for acute issues based on a full assessment by the prescriber. No prescriber is obligated to refill or continue any control prescription drugs at doses prescribed by another prescriber.
4. All patients requesting controlled prescription drugs will be screened through their prescription histories for substance use, misuse, and abuse, including through available state and pharmacy databases. ALL controlled prescription drugs will be monitored, whether they are prescribed at this clinic or by other prescribers.
5. All controlled substances must be obtained from the same pharmacy, where possible. Should the need arise to change pharmacies our office must be informed.
6. The prescribing prescriber has permission to discuss all diagnostic and treatment details with the dispensing pharmacists or other professionals who provide your health care for the purpose of maintaining accountability.
7. You may not share, sell, or otherwise permit others, including spouse or family members, to have access to these medications.
8. You agree to not consume excessive amounts of alcohol in conjunction with prescribed controlled substances. Additionally, you agree to not purchase, obtain or use any illegal drugs.
9. Unannounced urine drug screens may be requested and your cooperation required. Presence of unauthorized substances may result in your discharge from PAA.
10. Controlled medications WILL NOT be replaced if they are lost, stolen, get wet, destroyed, left on an airplane, etc.
11. If the responsible legal authorities have questions concerning your treatment, as might occur if you were obtaining medication at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records.
12. Refills for control prescription drugs will follow state and federal guidelines. Early refills will not be given. Renewals are based on keeping scheduled appointments. Please DO NOT call for controlled prescription refills after hours or on weekends.

13. In the event you are arrested or incarcerated related to legal or illegal drugs, refills on controlled substances will not be given.
14. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by PAA prescribers, including possible dismissal from this clinic.
15. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understood, and accept all its terms.

Signature: * x _____

Date:

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	☐	☐	☐	☐	☐
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?	☐	☐	☐	☐	☐
3. How often do you have problems remembering appointments or obligations?	☐	☐	☐	☐	☐
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	☐	☐	☐	☐	☐
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	☐	☐	☐	☐	☐
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?	☐	☐	☐	☐	☐

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?	☐	☐	☐	☐	☐
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?	☐	☐	☐	☐	☐
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?	☐	☐	☐	☐	☐
10. How often do you misplace or have difficulty finding things at home or at work?	☐	☐	☐	☐	☐
11. How often are you distracted by activity or noise around you?	☐	☐	☐	☐	☐

	Never	Rarely	Sometimes	Often	Very Often
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?	○	○	○	○	○
13. How often do you feel restless or fidgety?	○	○	○	○	○
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?	○	○	○	○	○
15. How often do you find yourself talking too much when you are in social situations?	○	○	○	○	○
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?	○	○	○	○	○
17. How often do you have difficulty waiting your turn in situations when turn taking is required?	○	○	○	○	○
18. How often do you interrupt others when they are busy?	○	○	○	○	○

Part B

Adult Symptom Screener

Please check the box for the answer that best fits your experience.

PART 1: In the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Feeling down, depressed, or hopeless	☐	☐	☐	☐
Little interest or pleasure in doing things	☐	☐	☐	☐

PART 2: In the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐

PART 3: The following questions relate to your experiences over the last 6 months.

	Yes	No
In the past 6 months, did you ever have a spell or an attack when all of sudden you felt frightened, anxious or very uneasy?	☐	☐
In the past 6 months, did you ever have a spell or attack when for no reason your heart suddenly began to race, you felt faint, or you couldn't catch your breath?	☐	☐
Did any of these spells or attacks ever happen in a situation when you were not in danger or not the center of attention?	☐	☐

PART 4: Please respond to the degree that the following problems have bothered you during the past week.

	Not at all	A little bit	Somewhat	Very much	Extremely
Fear of embarrassment causes me to avoid doing things or speaking to people.	☐	☐	☐	☐	☐
I avoid activities in which I am the center of attention.	☐	☐	☐	☐	☐
Being embarrassed or looking stupid are among my worst fears.	☐	☐	☐	☐	☐

PART 5: Please answer each question to the best of your ability.

	Yes	No
Have you experienced any of the following traumatic events: natural disaster (e.g. flood, hurricane, tornado, earthquake), fire, explosion, or industrial accident; transportation accident (e.g. car accident, plane crash); physical assault (e.g. being attached, beaten up); sexual assault (e.g. rape, attempted rape, made to perform any type of sexual act through force or threat of harm); captivity or exposure to a warzone; life threatening illness or injury; sudden, unexpected death of or injury to someone close to you; or serious injury, harm, or death to someone else that you witnessed or caused?	☐	☐
Has this event caused any significant problems or symptoms that lasted for more than a month?	☐	☐

PART 6: Please answer each question to the best of your ability.

Has there ever been a period of time when you were not your usual self and...	Yes	No
...you felt so good or so hyper that other people thought you were not your normal self, or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found you didn't really miss it?	☐	☐
...you were much more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had much more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family into trouble?	☐	☐

PART 7: The following questions relate to your eating habits.

	Yes	No
When you eat, do you make yourself sick because you feel uncomfortably full?	☐	☐
Do you ever worry that you have lost control over how much you eat?	☐	☐
Have you recently lost more than 14 pounds in a 3-month period?	☐	☐
Do you believe yourself to be fat when others say you are too thin?	☐	☐
Would you say that food dominates your life?	☐	☐

PART 8: Please answer the following question to the best of your ability.

	Yes	No
Have you ever been bothered by having to perform some ritual or act over and over that does not make sense?	☐	☐

PART 9: The following questions relate to your alcohol and substance use.

	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week
How often do you have a drink of Alcohol?	☐	☐	☐	☐	☐

	1 to 2	3 to 4	5 to 6	7 to 9	10 or more
How many drinks containing alcohol do you have on a typical day when you are drinking?	☐	☐	☐	☐	☐

	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often do you have 6 or more drinks on one occasion?	☐	☐	☐	☐	☐

PART 10: Please answer the following question to the best of your ability.

	Yes	No
In the past year have you used an illegal drug or used a prescription medication for non-medical reasons?	☐	☐

PART 11: Please answer the questions below, rating yourself on each of the criteria shown using the scale provided. As you answer each question, select the option that best describes how you have felt and conducted yourself over the past 6 months.

	Never	Rarely	Sometimes	Often	Very Often

How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	☐	☐	☐	☐	☐
How often do you have difficulty getting things in order when you have to do a task that requires organization?	☐	☐	☐	☐	☐
How often do you have problems remembering appointments or obligations?	☐	☐	☐	☐	☐
When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	☐	☐	☐	☐	☐
How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	☐	☐	☐	☐	☐
How often do you feel overly active and compelled to do things, like you were driven by a motor?	☐	☐	☐	☐	☐

PART 12: The questions listed below relate to your thoughts and feelings. If the way you have been in recent weeks or months differs from the way you usually are, please answer based on when you were your usual self.

	Yes	No
Do you find that most people will take advantage of you if you let them know too much about you?	☐	☐
Do you generally feel nervous or anxious around people?	☐	☐
Do you avoid situations where you have to meet new people?	☐	☐
Do you avoid getting to know people because you're worried that they may not like you?	☐	☐
Has avoidance of getting to know people due to fear of being disliked affected the number of friends that you have?	☐	☐
Do you keep changing the way you present yourself to people because you don't know who you really are?	☐	☐
Do you often feel like your beliefs change so much that you don't know what you believe any more?	☐	☐
Do you often get angry or irritated because people don't recognize your special talents or achievements as much as they should?	☐	☐

PART 13: Please answer the following questions to the best of your ability.

	Yes	No
Have you had any unusual experiences such as hearing voices, seeing visions, or having ideas you later found out were not true?	☐	☐
Have you had any other experiences, such as mind reading, ESP, thoughts being controlled by others, seeing things on TV that refer to you specifically?	☐	☐

Patient Health Questionnaire (PHQ)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	○	○	○	○
2. Feeling down, depressed, or hopeless	○	○	○	○
3. Trouble falling or staying asleep, or sleeping too much	○	○	○	○
4. Feeling tired or having little energy	○	○	○	○
5. Poor appetite or overeating	○	○	○	○
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	○	○	○	○
7. Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
8. Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	○	○	○	○
9. Thoughts that you would be better off dead, or of hurting yourself in some way	○	○	○	○

*Name:*_____ *Date:*_____

Generalized Anxiety Disorder (GAD-7) Scale

1. Over the last two weeks how often have you been bothered by any of the following problems?

	Not at all (0)	**Several days** (1)	**More than half the days** (2)	**Nearly every day** (3)
a. Feeling nervous, anxious or on edge	☐	☐	☐	☐
b. Not being able to stop or control worrying	☐	☐	☐	☐
c. Worrying too much about different things	☐	☐	☐	☐
d. Trouble relaxing	☐	☐	☐	☐
e. Being so restless that is hard to sit still.	☐	☐	☐	☐
f. Becoming easily annoyed or irritable	☐	☐	☐	☐
g. Feeling afraid as if something awful might happen	☐	☐	☐	☐

Total Score: _____

Stressors

Given the list of categories below, how much stress is each currently causing you?

	None	Mild Stress	Moderate Stress	Severe Stress
Family	○	○	○	○
Friends	○	○	○	○
Relationships	○	○	○	○
Educational	○	○	○	○
Economic	○	○	○	○
Occupational	○	○	○	○
Housing	○	○	○	○
Legal	○	○	○	○
Health	○	○	○	○

Substance History: Substances Used

Substance Abuse History

Do you have a history of any recreational drug use?

○ Yes
○ No

If YES, please fill out the table below to the best of your knowledge:

Substance(s) Used:	YES	NO	Age of First Use	Age of Last Use	How was it taken?	Amount per day	Days per month
Amphetamines / Speed	○	○			☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected		
Barbiturates / Downers	○	○			☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected		
Opiates	○	○			☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected		
Cocaine	○	○			☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected		
Psychedelics (e.g. LSD, Ecstasy, bath salts)	○	○			☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected		
Inhalants (e.g. glue, aerosols)	○	○			☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected		
Cannabis / Marijuana / Hashish	○	○			☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected		
Benzodiazepines	○	○			☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected		
PCP	○	○			☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected		

Substance History: Treatment History

Substance Abuse Treatment History

Did you receive any treatment for substance abuse?

- ○ Yes
- ○ No

If YES, please fill out the table below to the best of your knowledge:

Treatment Type	YES	NO	How many episodes of treatment?	Age of first treatment?	Age of last treatment?	Any additional treatment information?
Inpatient	○	○				
Intensive Outpatient	○	○				
Outpatient	○	○				
12-Step Program	○	○				

Substance History: Consequences of Substance Abuse

Consequences of Substance Abuse

Have you experienced any of these consequences as a result of alcohol consumption or abuse of substances?
(Please check all that apply)

- ☐ No consequences

- ☐ Felt that you needed to cut down on your drinking
- ☐ Been annoyed by others criticizing your drinking
- ☐ Felt guilty about drinking
- ☐ Needing a drink first thing in the morning

- ☐ Increased tolerance
- ☐ Withdrawal (shakes, sweating, nausea, rapid heart rate)
- ☐ Seizures
- ☐ Blackouts
- ☐ Effects on physical health
- ☐ Using/consuming more than intended
- ☐ Unintentional overdose
- ☐ DUI
- ☐ Arrests
- ☐ Physical fights or assaults
- ☐ Relationship conflicts
- ☐ Problems with money
- ☐ Job loss or problems at work/school

Other:

Past Psychiatric History: Inpatient

Inpatient Psychiatric History

Do you have a history of inpatient psychiatric treatment?

- Yes
- No

Please list any past inpatient treatment history below. Start with most recent and list each episode of treatment as a separate line.

Hospital/Facility	Treatment Voluntary?	Primary reason for hospitalization	How old were you?	Treatment Outcome	Additional Comments
	-	- Select One -		- Select One -	
	-	- Select One -		- Select One -	
	-	- Select One -		- Select One -	
	-	- Select One -		- Select One -	
	-	- Select One -		- Select One -	
	-	- Select One -		- Select One -	
	-	- Select One -		- Select One -	
	-	- Select One -		- Select One -	
	-	- Select One -		- Select One -	
	-	- Select One -		- Select One -	

Past Psychiatric History: Outpatient

Outpatient Psychiatric History

Do you have a history of outpatient psychiatric treatment?

- Yes
- No

Please list any past outpatient treatment history below. Start with most recent and list each episode of treatment as a separate line.

Provider	Primary reason for seeking treatment	Age of first treatment	Age of last treatment	Outcome	Additional Comments
	- Select One -			- Select One -	
	- Select One -			- Select One -	
	- Select One -			- Select One -	
	- Select One -			- Select One -	
	- Select One -			- Select One -	
	- Select One -			- Select One -	
	- Select One -			- Select One -	
	- Select One -			- Select One -	
	- Select One -			- Select One -	
	- Select One -			- Select One -	

Past Psychiatric History: Suicide/Self Harm

Suicide/Self-Harm History

Have you ever tried to harm or kill yourself?

- Yes
- No

Was your intent to die?

- Yes
- No

Elaborate below, if desired:

How many times in your life has this occurred?

Most Severe Episode

Please describe your most severe episode including date, method, and consequences:

Month: - Select One -

Year:

Method: - Select One - Other:

Consequences: - Select One - Other:

Most Recent Episode

Please describe your most recent episode including date, method, and consequences:

Month: - Select One -

Year:

Method: - Select One - Other:

Consequences: - Select One - Other:

Past Psychiatric History: Violence

Violence History Assessment

Have you had any history of violent behavior?

- ◯ Yes
- ◯ No

If YES, please elaborate below:

Past Medical History

Past Medical History

Who is your primary care physician?

Are you taking any medications currently? (Excluding medications for psychiatric treatment)

- ◯ Yes
- ◯ No

If YES, please include these medications below:

Have you a history of any of the following health problems? (Please check all that apply)

☐ No Problems	☐ Fibromyalgia	☐ Iron deficiency
	☐ Gall Bladder disease	☐ Kidney Disease
☐ Allergies	☐ Gastritis or Ulcer	☐ Kidney Stones
☐ Anemia (low blood count)	☐ Glaucoma	☐ Liver disease (other)
☐ Arthritis	☐ Gout	☐ Lupus
☐ Asthma	☐ Hearing Loss	☐ Migraine Headaches
☐ Back problems (including disk or spine)	☐ Heart disease	☐ Multiple Sclerosis
☐ Cancer	☐ Heart defect from birth	☐ Obesity / Overweight
☐ Cataracts	☐ Heart valve problems	☐ Parkinson's Disease
☐ Chickenpox (as a child)	☐ Hemorrhoids	☐ Polyps
☐ Chronic Bronchitis	☐ Hepatitis	☐ Seizures
☐ COPD (Emphysema)	☐ Hernia	☐ Sleep apnea
☐ Diabetes	☐ HIV	☐ Stroke/TIA
☐ Diverticulitis	☐ Hypertension (High blood pressure)	☐ Testosterone (low)
☐ Fainting spells/ Passing out	☐ Hypotension (Low blood pressure)	☐ Thyroid problems (hypothyroid/hyperthyroid)
☐ High cholesterol	☐ Inflammatory Bowel Disease	☐ Tuberculosis or exposure to tuberculosis

Other:

Have you a history of surgery in any of the following areas? (Please check all that apply)

- ☐ No surgical history
- ☐ Back/Neck
- ☐ Brain
- ☐ Cardiac
- ☐ Ear/Nose/Throat
- ☐ Gall Bladder
- ☐ Hernia
- ☐ Hip/Knee/Ankle/Foot
- ☐ Hysterectomy (Ovaries Removed)
- ☐ Hysterectomy (Ovaries Retained)
- ☐ Intestine
- ☐ Kidney
- ☐ Liver
- ☐ Lung
- ☐ Pancreas
- ☐ Pelvis
- ☐ Penis
- ☐ Prostate
- ☐ Sex Change
- ☐ Shoulder/Elbow/Wrist/Hand
- ☐ Stomach
- ☐ Tonsils
- ☐ Vagina
- ☐ Weight Loss

Other

Past Medical History 2

Psychiatric Medicine History

Psychiatric Medication History

Have you ever taken any medication for psychiatric treatment?

- ◯ Yes
- ◯ No

If YES, please fill out the table below to the best of your knowledge:

Medication name	Dose	How long? (months)	End Date	Therapeutic effect	Side Effects	Reason for stopping?
				- Select One -		
				- Select One -		
				- Select One -		
				- Select One -		
				- Select One -		
				- Select One -		
				- Select One -		
				- Select One -		
				- Select One -		
				- Select One -		

Patient Allergies

Patient Allergies

Do you have any known allergies to medication?

- Yes
- No

If YES, please fill out your allergy information below:

Medication Allergy	Allergic Reaction

Family Psychiatric History

Family History

Family Psychiatric History

Do you have any family members with a history of psychiatric illness?

- Yes
- No

If YES, please elaborate below:

Family member	Psychiatric Problem(s)			
- Select One -	- Select One -	- Select One -	- Select One -	
- Select One -	- Select One -	- Select One -	- Select One -	
- Select One -	- Select One -	- Select One -	- Select One -	
- Select One -	- Select One -	- Select One -	- Select One -	
- Select One -	- Select One -	- Select One -	- Select One -	
- Select One -	- Select One -	- Select One -	- Select One -	
- Select One -	- Select One -	- Select One -	- Select One -	
- Select One -	- Select One -	- Select One -	- Select One -	
- Select One -	- Select One -	- Select One -	- Select One -	
- Select One -	- Select One -	- Select One -	- Select One -	

Family Medical History

Is there any additional family medical history?

Social History: Developmental and Educational

Developmental and Educational History

During your pregnancy/birth, did your mother have any problems with any of the following:

- [ ] None of these
- [ ] Exposure to drugs or alcohol during pregnancy
- [ ] A difficult pregnancy
- [ ] Problems with delivery

Other:

Did you have any complications after your birth? (e.g. premature birth, jaundice, breathing difficulties)

- ( ) Yes
- ( ) No

Did you have any delays or difficulties in reaching the following developmental milestones?

- [ ] None of these
- [ ] Walking
- [ ] Talking
- [ ] Toilet training
- [ ] Sleeping alone
- [ ] Being away from parents
- [ ] Making friends

Other:

Which options below best describe your childhood home atmosphere?

- [ ] Normal
- [ ] Supportive
- [ ] Parental fighting
- [ ] Parental violence
- [ ] Financial difficulties
- [ ] Frequent moving

Other:

Developmental and Educational History 1

Which of the following challenges were experienced during your childhood?

- [ ] None of these
- [ ] Tantrums
- [ ] Enuresis (bed wetting)
- [ ] Encopresis (incontinence)
- [ ] Running away from home
- [ ] Fighting
- [ ] Stealing
- [ ] Property damage
- [ ] Fire setting
- [ ] Animal cruelty
- [ ] Seperation anxiety

Which of the following best describe problems you may have had in school?

- [ ] None of these
- [ ] Fighting
- [ ] School phobia
- [ ] Truancy
- [ ] Detentions
- [ ] Suspensions
- [ ] Expulsions
- [ ] School refusal
- [ ] Class failures
- [ ] Repetition of grades
- [ ] Special education
- [ ] Remedial classes

Did you have additional schooling outside of the standard classroom setting? (please check all that apply)

- [ ] None of these
- [ ] Speech classes
- [ ] Tutoring
- [ ] Accommodations

Other:

Please select your highest Level of Education:

-Select One-

If you have any further comments about your developmental or educational history and wish to elaborate further, please do so in the space provided below:

Developmental and Educational History 2

Social History: General

General Social History

Which options below best describes your social situation?

- [ ] Supportive social network
- [ ] Few friends
- [ ] Substance-use based friends
- [ ] No friends
- [ ] Distant from family of origin
- [ ] Family conflict

Other:

What is your current marital status? (If a minor, indicate marital status of your parents)

- Select One -

What is the status of your intimate relationship?

- Select One -

What is the satisfaction level of your intimate relationship?

- Select One -

What is your sexual orientation?

- Select One -

What is your current living situation?

- Select One -

Who do you currently live with? (Please check all that apply)

- [ ] Live alone
- [ ] Roommates
- [ ] Parent(s)
- [ ] Partner/Spouse
- [ ] Children

Other:

Do you currently participate in spiritual activities?

-

What is your current occupation status?

- Select One -

What is your current yearly income?

- Select One -

General Social History 1

What is your longest period of continuous employment? (Please include dates and description)
Employment start:

Employment end:

Description:

What is your longest period of continuous unemployment? (Please include dates and description)
Unemployment start:

Unemployment end:

Description:

General Social History 2

Social History: Menstruation and Pregnancy

Menstruation and Pregnancy History

At what age did you begin menstruation?

Which of these best describe your premenstrual symptoms?

- [ ] None of these
- [ ] Dysphoria
- [ ] Cramps
- [ ] Appetite change
- [ ] Bloating
- [ ] Sleep disturbance

Have you ever been pregnant?

- ( ) Yes
- ( ) No

If YES, how many times?

Have you ever given birth?

- ( ) Yes
- ( ) No

If YES, how many times?

Have you had any miscarriages?

- ( ) Yes
- ( ) No

If YES, how many times?

Have you had any abortions?

- ( ) Yes
- ( ) No

If YES, how many times?

Review of Systems

Review of Systems

Please look at the list of physical symptoms below and check off any that you have experienced in the last several days. If you have NOT experienced any symptoms in an area, be sure to check "None of the above" for that area.

Constitutional

- ☐ Chronic pain
- ☐ Loss of appetite
- ☐ Increase in appetite
- ☐ Unexplained weight loss
- ☐ Weight gain
- ☐ Fatigue/Lethargy
- ☐ Unexplained fever
- ☐ Hot or Cold spells
- ☐ Night sweats
- ☐ Sleeping pattern disruption
- ☐ Malaise (Flu-like or Vague sick feeling)

Other:

- ☐ None of the above constitutional issues

Eyes

- ☐ Eye pain
- ☐ Eye discharge
- ☐ Eye redness
- ☐ Blurred or double vision
- ☐ Visual change
- ☐ History of eye surgery
- ☐ Sensitivity to light
- ☐ Scotomas (Blind spots)
- ☐ Retinal hemorrhage (Floaters in vision)
- ☐ Amaurosis fugax (Feeling like a curtain is pulled over vision)

Other:

- ☐ None of the above eye issues

Ears, Nose, Mouth, and Throat

- ☐ Earache
- ☐ Tinnitus (Ringing in ears)
- ☐ Decreased hearing or hearing loss
- ☐ Frequent ear infections
- ☐ Frequent nose bleeds
- ☐ Sinus congestion
- ☐ Runny nose/Post-nasal drip
- ☐ Difficulty swallowing
- ☐ Frequent sore throat
- ☐ Prolonged hoarseness
- ☐ Pain in jaw or tooth
- ☐ Dry mouth

Other:

- ☐ None of the above ear, nose, mouth or throat issues

Cardiovascular

- ☐ Chest pain
- ☐ Pacemaker
- ☐ Palpitations (fast or irregular heartbeat)
- ☐ Swollen feet or hands
- ☐ Fainting spells
- ☐ Shortness of breath with exercise

Other:

- ☐ None of the above cardiovascular issues

Respiratory

- ☐ Pain with breathing
- ☐ Chronic cough
- ☐ Chronic shortness of breath
- ☐ Chronic wheezing/Asthma
- ☐ Excessive phlegm
- ☐ Coughing blood
- ☐ Nocturnal Dyspnea (Shortness of breath at night)

Other:

- ☐ None of the above respiratory issues

Musculoskeletal

- ☐ Swelling in joints
- ☐ Redness of joints
- ☐ Other joint pains or stiffness
- ☐ Muscle pain or cramping
- ☐ Muscle weakness
- ☐ Muscle stiffness
- ☐ Decreased range of motion
- ☐ Back pain or stiffness
- ☐ History of fractures
- ☐ Past injury to spine or joints

Other:

- ☐ None of the above musculoskeletal issues

Gastrointestinal

- ☐ Excessive flatulence or belching
- ☐ Diarrhea
- ☐ Constipation
- ☐ Persistent nausea/vomiting
- ☐ Abdominal Pain
- ☐ Heartburn
- ☐ Difficulty swallowing solids or liquids
- ☐ Recent loss in appetite
- ☐ Sensitivity to milk products
- ☐ Jaundice (yellow skin)
- ☐ Change in appearance of stool
- ☐ Blood in stool
- ☐ Dark/Tarry stool
- ☐ Loss of bowel control

Other:

- ☐ None of the above gastrointestinal issues

Review of Systems 1

Allergic/Immunologic

- ☐ Frequent infections
- ☐ Hives
- ☐ Anaphylaxic reaction

Other:

☐ None of the above allergic or immunologic issues

Endocrine

- ☐ Severe menopausal symptoms
- ☐ Cold or heat intolerance
- ☐ Excessive appetite
- ☐ Excessive thirst or urination
- ☐ Excessive sweating

Other:

☐ None of the above endocrine issues

Hematologic/Lymphatic

- ☐ Blood clots
- ☐ Easy bleeding after surgery or dental work
- ☐ History of blood transfusion
- ☐ Excessive bruising or bleeding
- ☐ Swollen glands (neck, armpits, groin)

Other:

☐ None of the above hematologic or lymphatic issues

Genitourinary (General)

- ☐ Loss of urine control
- ☐ Painful/Burning urination
- ☐ Blood in urine
- ☐ Increased frequency of urination
- ☐ Up more than twice/night to urinate
- ☐ Urine retention
- ☐ Frequent urine infections

Other:

☐ None of the above general genitourinary issues

Genitourinary (Women)

- ☐ Unusual vaginal discharge
- ☐ Vaginal pain, bleeding, soreness, or dryness
- ☐ Genital sores
- ☐ Heavy or irregular periods
- ☐ No menses (Periods stopped)
- ☐ Currently pregnant
- ☐ Sterility/Infertility
- ☐ Any other sexual or sex organ concerns

Other:

☐ None of the above sex-specific genitourinary issues

Genitourinary (Men)

- ☐ Slow urine stream
- ☐ Scrotal pain
- ☐ Lump or mass in the testicles
- ☐ Abnormal penis discharge
- ☐ Trouble getting/maintaining erections
- ☐ Inability to ejaculate/orgasm
- ☐ Any other sexual or sex organ concerns

Other:

☐ None of the above sex-specific genitourinary issues

Neurological

- ☐ Paralysis
- ☐ Fainting spells or blackouts
- ☐ Dizziness/Vertigo
- ☐ Drowsiness
- ☐ Slurred speech
- ☐ Speech problems (other)
- ☐ Short term memory trouble
- ☐ Memory difficulties (loss)
- ☐ Frequent headaches
- ☐ Muscle weakness
- ☐ Numbness/Tingling sensations
- ☐ Neuropathy (numbness in feet)
- ☐ Tremor in hands/shaking
- ☐ Muscle spasms or tremors

Other:

☐ None of the above neurological issues

Integumentary (Skin/Breast and Hair)

- ☐ Lesions
- ☐ Unusual mole
- ☐ Easy bruising
- ☐ Increased perspiration
- ☐ Rashes
- ☐ Chronic dry skin
- ☐ Itchy skin or scalp
- ☐ Hair or nail changes
- ☐ Hair loss
- ☐ Breast tenderness
- ☐ Breast discharge
- ☐ Breast lump or mass

Other:

☐ None of the above integumentary issues

Psychiatric

- ☐ In-depth review of psychiatric system appears earlier in document
- ☐ Feeling depressed
- ☐ Difficulty concentrating
- ☐ Phobias/Unexplained fears
- ☐ No pleasure from life anymore
- ☐ Anxiety
- ☐ Insomnia
- ☐ Excessive moodiness
- ☐ Stress
- ☐ Disturbing thoughts
- ☐ Manic episodes
- ☐ Confusion
- ☐ Memory loss

Other:

☐ None of the above psychiatric issues

Review of Systems 2