Oconee Center for Behavioral Health
1360 Caduceus Way Building 400, Suite 102,
Watkinsville, Georgia 30677
Ph: 706-286-8442 Fx: 706-310-6907

New Patient Information Form

Date Filled out: _____ Filled out by: _____

Name: _____ Age: _____

Date of Birth: _____ SSN: _____ ☐ Male ☐ Female

☐ Married ☐ Divorced ☐ Legally Separated ☐ Single ☐ Other

If Child, Guardian's Name: _____ Guardian Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Alt. #: _____

Email Address: _____

How would you like to receive appointment reminders? ☐ Email ☐ Phone Call ☐ Text Message

Referred by: _____

Emergency Contact Name: _____

Emergency Contact Phone #: _____ Alt. #: _____

Emergency Contact Address: _____

City: _____ State: _____ Zip Code: _____

Relationship to Patient: _____

Person Responsible for Payment, If Other Than Patient

Name: _____ Date of Birth: _____

Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Alt. #: _____

SSN #: _____ Employer: _____

Primary Insurance Information

Upon submission, please include a photocopy of your insurance card.

Policy Holder's Name: _____ Policy Holder's DOB: _____

Relationship to Patient: _____

Insurance Co. Name: _____ Ins Co. Phone #: _____

Policy #: _____ Group #: _____

Secondary Insurance Information

Policy Holder's Name: _____ Policy Holder's DOB: _____

Relationship to Patient: _____

Insurance Co. Name: _____ Ins Co. Phone #: _____

Policy #: _____ Group #: _____

Authenticity Statement and Assignment of Benefits

Section I. Authenticity:

I, the undersigned, certify that I am the recipient of all treatments performed by Oconee Center for Behavioral Health, LLC. I certify that all information provided about is true and correct to the best of my knowledge.

Section II. Assignment of Benefits:

I, the undersigned hereby authorize and release Oconee Center for Behavioral Health, LLC to bill my insurance and/ or Medicare on my behalf for the cost of any services received at OCBH, LLC. Further, I authorize and request my insurance company carrier to pay directly to Oconee Center for Behavioral Health, LLC, I understand that I am financially responsible for any claim denial, co-insurance, co-payment, or deductible and agree to payment at the time services are rendered by OCBH, LLC. I understand that if I do not have insurance coverage or my insurance coverage lapses, I will be responsible for the full monetary amount of services rendered by OCBH, LLC.

Printed Name of Patient: _____

Patient Signature: _____ Date: _____

If Signed by Legal Representative, Please Print Name and Relationship Below:

_____

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Consent Form for Release/ Request of Information

Patient Name: _____

Date of Birth: _____ SSN: _____

Legal Guardian if Patient is a Minor: _____

I, _____, give my permission to the Providers, Faculty, and Staff of Oconee Center for Behavioral Health, LLC as well as the person(s) listed below to exchange information and/ or records regarding myself or my dependents. I give my permission for a faxed or photocopied signature to serve as an original regarding this release. The purpose of this release is to request/ release information for the benefit of the patient's diagnosis, treatment planning, continuity of care, family medical leave, disability requests and/ or benefit claims for life/ health insurance application. The information released pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by the privacy act. This authorization may be revoked by the individual signing this consent by providing a written, signed and dated request to withdraw the authorization except to the extent that the action has already been taken.

1.Name: _____

Phone #: _____ Fax #: _____

2.Name: _____

Phone #: _____ Fax #: _____

3.Name: _____

Phone #: _____ Fax #: _____

4.Name: _____

Phone #: _____ Fax #: _____

Printed Patient Name: _____

Signature: _____ Date: _____

Relationship to Patient: _____

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HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that your medical and health information is personal. Protecting your health information is important. We follow strict federal and state laws that require us to maintain the confidentiality of your health information. This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you that relates to your past, present or future physical or mental health condition and related health care services.

Use and Disclosure of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

Treatment: We keep records of the care and services provided to you. Health care providers use these records to deliver quality care to meet your needs. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your doctor may share your health information with a specialist, referring physician or therapist, or hospital staff that will assist in your treatment. Your protected health information may be provided to a physician or a therapist to whom you have been referred or who is providing on-call coverage to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, your protected health information will be provided to the staff of Oconee Center for Behavioral Health, LLC, which manages the billing and records storing in our office. Also, for example, we may disclose information about the services provided to you to claim and obtain payment from your insurance company, managed care company, health plan, or Medicare.

Healthcare Operations: We may use or disclose as needed, your protected health information in order to support the business activities of your physician's or therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of health care students, licensing, outside storage of medical records, and conducting or arranging for other business activities. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of our appointment.

Sharing Your Health Information: There are situations when we are permitted or required to disclose health information without your authorization. These situations are: when state or federal law mandates that certain health information be reported for a specific purpose; for public health purposes, such as contagious disease reporting, investigation or surveillance; for notices to and from the Federal Food and Drug Administration regarding drugs or medical devices; to protect victims of abuse, neglect, or domestic violence; for health oversight activities such as investigations, licensing, audits and inspections; for lawsuits, legal proceedings, and when otherwise required by law; when requested by law

enforcement as required by law or court order; to report criminal activity; to report to coroners, medical examiners, and funeral directors ; for inmates; for organ and tissue donation; for research approved by our review process under strict federal guidelines; to reduce or prevent a serious threat to public health and safety; for worker's compensation or other similar programs if you are injured at work; for specialized government functions such as military activity, intelligence, and national security; for incidental disclosures that are unavoidable by-product of permitted uses or disclosures; and disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

All other uses and disclosures will be made only with your signed consent or authorization. You may revoke this authorization, at any time, in writing except to the extent that your physician of the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: You have the right to inspect and copy your protected health information. Fees may apply. Under limited circumstances, we may deny you access to a portion of your health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing. Your request must state the specific restriction requested and to whom you want the restriction to apply. These requests must be in writing. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and discloser of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. Fees may apply. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our private contact of your complaint.

This notice was published and became effective on or before April 11, 2016. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at 706-286-8442. Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Printed Name of Patient: _____

Patient Signature: _____ Date: _____

If Signed by Legal Representative, Please Print Name and Relationship Below:

_____

Oconee Center for Behavioral Health
1360 Caduceus Way Building 400, Suite 102,
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Ph: 706-286-8442 Fx: 706-310-6907

Patient Rights and Responsibilities

Patient Rights:

Confidentiality is a privilege protected by law and ethics of the counseling profession that allows for strict private discussion of issues that concern you. Exceptions include:

- Disclosure to appropriate authorities or family members when there is sufficient cause to believe that you pose a threat of physical harm to yourself or others.
- Additionally, it is required by law to report any form of child neglect or abuse.

Informed consent refers to your right to an explanation of your condition and treatment that you can understand. You have a right to participate in the planning of your treatment, refuse treatment and file complaints or compliments. Treatment often involves addressing concerns that are distressing and you can discontinue at any time, although this is best done in consultation with your provider of care.

Respect and Non- Discrimination are part of your treatment regardless.

Telephone Consultations: refer to the occasional need to consult briefly by phone. For these necessary and brief consultations, there is no charge. However, if you desire further assistance, we can either schedule an earlier office appointment or more extensive phone consultations; the fees for which are not routinely covered by insurance plans.

Patient Responsibilities:

We value our patients and the time for office visits has been reserved especially for you. We expect our patients to place the same value on our service and time. The Cancellation Policy requires a 12- hour notice for cancelling or rescheduling appointments. Missed appointments or same day cancellations are subject to a fee set forth by each individual provider.

THE OFFICE CAN NOT BE HELD RESPONSIBLE FOR APPOINTMENT REMINDERS. Continued failure to cancel appointments within 12-hours, appointment intervals greater than 12 weeks, or frequent rescheduling of appointments will result in termination of services. *New patients who miss their first appointment without proper notification will not be allowed to reschedule.*

Payment is due at the time of service unless other arrangements have been discussed. It is the patient's responsibility to notify the receptionist of any changes in address, phone number, or insurance. We appreciate the opportunity to serve your behavioral health needs. Please assist us in providing a more efficient service to you by contacting your insurance carrier to understand the extent and limitations of your benefits and to obtain required authorization. We also request that when you attend your session, you be prepared to provide the copay and/ or deductible determined by your carrier. Failure to obtain proper authorization may unfortunately result in additional charges to you.

Printed Name of Patient: _____

Patient Signature: _____ Date: _____

If Signed by Legal Representative, Please Print Name and Relationship Below:

_____

INFORMED CONSENT FOR TELEHEALTH SERVICES

Behavioral health care services are available by two-way, interactive video communications and/or by the electronic transmission of information. Referred to as telehealth (also as "telemedicine," telepsychiatry"), this means that I may be evaluated and treated by a health care provider from a different location. Since this is different than the type of service with which I am familiar, I understand and agree to the following:

DURING THE SESSION:

- The health care provider will be at a different location from me. Non-medical staff personnel or a health care provider ("practitioner") will be at my location with me to assist in the session.

- Details of my medical history, examinations, assessments and tests may be discussed between me, the physician or practitioner.

- I will be informed if any additional personnel are to be present other than myself, individuals accompanying me and the presenting practitioner. I will give my verbal permission prior to additional personnel being present.

- Non-medical personnel may be present to assist in operating video conferencing equipment.

- Video recordings may be taken of the telehealth session but ONLY after I have given my written permission prior to recording. Video recordings and other data, including images, and photos may be kept, viewed, and used for purposes including teaching, training, technical, scientific, research, or administrative purposes.

- The physician or health care provider for whom the on-site examination or treatment is performed will keep a record of the session in my medical record.

POSSIBLE RISKS:

As with any medical procedure, there are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

- In certain cases, information may not be sufficient to allow for medical decision making by the physician and practitioner(s).

- Delays in medical evaluation and treatment could occur due to interruptions and/or failures of the equipment.

- Notwithstanding best efforts to protect patient information, security protocols could fail, causing a breach of privacy of personal medical information.

RELEASE OF INFORMATION: All existing laws regarding access to your medical information and copies of your medical records apply to this telehealth session. Additionally, dissemination of any patient-identifiable images or information from this telehealth interaction to researchers or other entities shall not occur without your consent.

FINANCIAL RESPONSIBILITY: In consideration for the telehealth services rendered to me, I agree to pay the charges not covered by any third-party payer, including any deductible, co-payment, co-insurance, or any charges not covered as a result of my failure to provide notification or obtain pre-authorization for treatment as required by any insurer or third-party payer. Oconee Center for Behavioral Health 1360 Caduceus Way Building 400, Suite 102, Watkinsville, Georgia 30677 Ph: 706-286-8442 Fx: 706-310-6907

PROXY/GUARANTOR: If I have signed this consent agreement on behalf of a person who may be temporarily or permanently incompetent, unable to sign, or a minor, I represent that I have the authority to sign this consent agreement on behalf of this person. This use of the first person in this consent agreement shall include me, and the person for whom I am representing.

CONSENT FOR TELEHEALTH SERVICES: Noting all the above, I understand that my participation in the telehealth process is voluntary and may possibly increase the risk of disclosure of my medical data. I further understand that I have the right to:

- Refuse the telehealth session or stop participation in the telehealth session at any time.

- Limit any physical examination proposed during the telehealth session.

- Request that non-medical personnel leave the room(s) at any time.

- Request that all personnel leave the room(s) to allow private communication with the off-site practitioner(s).

I acknowledge that the health care providers involved have explained the sessions in a satisfactory manner and that all questions that I have asked about the sessions have been answered in a manner satisfactory to me or to my representative. Understanding the above, I consent to the telehealth process described above.

Patient Printed Name: _____

Patient Signature: _____

Date: _____

Please indicate for which Provider you are requesting a New Patient Appointment:

☐ Andrew P. Heidesch, LMFT

☐ Melissa Forschler, LMFT

☐ Bethany Kline, LPC NCC

☐ Dr. Barbara D'Orio, M.D

* A fee of $30 will be charged to the patient for medication refills required due to missed or rescheduled appointments and early refill requests

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Patient Name: _____ Date of Birth: _____ Date Completed: _____

If you are filling this out on behalf of the patient, please answer from the patient's perspective.

Medical History Questionnaire

Chief Complaint: _____
_____
_____

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	☐	☐	☐	☐

Review of Symptoms: 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. If you are filling this out on behalf of the patient, please answer from the patient's perspective.

Constitutional
- ☐ Chronic Pan
- ☐ Loss of Appetite
- ☐ Increase in Appetite
- ☐ Unexplained Weight Loss
- ☐ Weight Gain
- ☐ Fatigue/ Lethargy
- ☐ Unexplained Fever
- ☐ Hot/ Cold Spells
- ☐ Nigh Swears
- ☐ Malaise (Flu-like or Vague Sick Feeling)
- ☐ Sleeping Pattern Disruption
- ☐ None of the above Constitutional Issues
- ☐ Other _____

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)
- ☐ Amaurosis Fugax (Feeling like curtain is pulled over vision
- ☐ None of the above Eye Issues
- ☐ Other _____

_____

Ears, Nose, Mouth & Throat
- ☐ Earache
- ☐ Tinnitus (Ringing in Ears)
- ☐ Decreased Hearing or Loss
- ☐ Frequent Ear Infections
- ☐ Frequent Nose Bleeds
- ☐ Sinus Congestions
- ☐ Runny Nose / Post-Nasal Drip
- ☐ Difficulty Swallowing
- ☐ ☐ Frequent Sore Throats
- ☐ Prolonged Hoarseness
- ☐ Pain in Jaw or Tooth
- ☐ None of the Above Ears, Nose, Mouth or Throat Issues
- ☐ Other _____

Cardiovascular

☐ Chest Pain
☐ Pacemaker
☐ Palpitations (fast or irregular heartbeat)
☐ Swollen Feet or Hands
☐ Fainting Spells
☐ Shortness of Breath w/ Exercise
☐ None of the above Cardiovascular Issues

☐ Other _____
_____
_____
_____
_____

Respiratory

☐ Pain with Breathing
☐ Chronic Cough
☐ Chronic Shortness of Breath
☐ Chronic Wheezing/ Asthma
☐ Excessive Phlegm
☐ Coughing of Blood
☐ Nocturnal Dyspnea (Shortness of Breath at Night)
☐None of the above Respiratory Issues
☐ Other_____
_____
_____
_____

Musculoskeletal

☐ Swelling in Joints
☐Redness of Joints
☐ Other Join Pains or Stiffness
☐Muscle Pain or Stiffness
☐ Muscle Pain or Cramping
☐ Muscle Weakness or Stiffness
☐ Decreased Range of Motion

☐ Back Pain or Stiffness
☐ History of Fractures
☐ Past Injury to Spine or Joints
☐ None of the Above Musculoskeletal Issues

☐ Other _____

Allergic/ Immunologic

☐ Frequent Infections
☐ Hives
☐ Anaphylactic Reactions
☐ None of the above Allergic/ Immunologic Issues
☐ Other _____
_____
_____

Endocrine

☐ Severe Menopausal Symptoms
☐ Cold or Heat Intolerance
☐ Excessive Appetite
☐ Excessive Thirst or Urination

☐ Excessive Sweating
☐ None of the above Endocrine Issues
☐ Other _____

Hematologic / Lymphatic

☐ Blood Clots
☐ History of Blood Transfusion
☐ Excessive Bruising
☐ Excess/ Easy Bleeding (surgery, Dental Work, Brushing Teeth, Scrapes)
☐ Swollen Glands
☐ None of the above Lymphatic Issues
☐ Other _____

Gastrointestinal

☐ Excessive Flatulence or Belching
☐ Abdominal Pain
☐ Jaundice (Yellow Skin)
☐ Recent Loss of Appetite
☐ None of the above Gastrointestinal Issues

☐ Difficulty Swallowing Solids/ Liquids
☐ Constipation
☐ Blood in Stool
☐ Dark or Tarry Stool
☐ Other _____

☐ Change in appearance of Stool
☐ Heartburn
☐ Persistent Nausea / Vomiting
☐ Sensitivity to Milk Products

Genitourinary (General)

☐ Loss of Urine Control (Including Bed-Wetting)

☐ Painful / Burning Urination
☐ Blood in Urine

☐ Increased Frequency of Urination
☐ Up More than Twice a Night to Urinate
☐ Urine Retention

☐ Frequent Urine Infections

☐ None of the above General Genitourinary Issues
☐ Other _____
_____

Genitourinary (Female)

☐ Vaginal Pain, Bleeding, Soreness, Dryness

☐ Unusual Vaginal Discharge
☐ Genital Sores

☐ Heavy or Irregular Periods
☐ No Menses (Periods Stopped)
☐ Currently Pregnant

☐ Sterile / Infertility

☐ Any Other Sexual or Sex Organ Concerns

☐ None of the above Sex-specific Genitourinary Issues
☐ Other _____

Genitourinary (Male)

☐ Trouble Getting / Maintaining Erections

☐ Slow Urine Stream
☐ Scrotal Pain

☐ Lump or Mass in the Testicles
☐ Inability to Ejaculate / Orgasm
☐ Any Other Sexual or Sex Organ Concerns

☐ None of the above Sex-specific Genitourinary Issues
☐ Other _____
_____
_____

Neurological

- ☐ Paralysis
- ☐ Fainting Spells
- ☐ 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
- ☐ None of the above Neurological Issues
- ☐ Other _____

Integumentary (Skin / Breast & Hair)

- ☐ Lesions
- ☐ Unusual Mole
- ☐ Easy Bruising
- ☐ Increased Perspirations
- ☐ Rashes
- ☐ Chronic Dry Skin
- ☐ Itchy Skin or Scalp
- ☐ Hair or Nail changes
- ☐ Hair Loss
- ☐ Breast Tenderness
- ☐ Breast Discharge
- ☐ None of the above Integumentary Issues
- ☐ Other _____

_____

_____

Psychiatric

- ☐ Feeling Depressed
- ☐ Difficulty Concentrating
- ☐ Phobias / Unexpected Fears
- ☐ No Pleasure from Life
- ☐ Anxiety
- ☐ Insomnia
- ☐ Excessive Moodiness
- ☐ Stress
- ☐ Disturbing Thoughts
- ☐ Manic Episodes
- ☐ Confusion
- ☐ Memory Loss
- ☐ Nightmares
- ☐ None of the above Psychiatric Issues
- ☐ Other _____

Substance Abuse History: If you are filling this out on behalf of the patient, please answer the patient's perspective.

Do you have a history of any recreation drug use? ☐ Yes ☐ No

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

Substance 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		

(Continued on Next Page)

Benzodiazepines	☐	☐	_____	_____	☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected	_____	_____
PCP	☐	☐	_____	_____	☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected	_____	_____
Alcohol	☐	☐	_____	_____	☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected	_____	_____
Nicotine	☐	☐	_____	_____	☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected	_____	_____

Substance Abuse Treatment History: If you are filling this out on behalf of the patient, please answer the patient's perspective.

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 Abuse Consequences: If you are filling this out on behalf of the patient, please answer the patient's perspective.

Have you ever 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 need 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?
☐ Using/ consuming more than intended
☐ DUI
☐ Physical fights or assaults
☐ Problems with Money
☐ Other _____

☐ Increased Tolerance
☐ Withdrawal (shakes, sweating, nausea, rapid heart rate)
☐ Seizures
☐ Black outs
☐ Affects on Physical Health
☐ Unintentional overdose
☐ Arrests
☐ Relationship conflicts
☐ Job loss or Problems at Work or School

_____

Inpatient History: If you are filling this out on behalf of the patient, please answer the patient's perspective.

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
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				

Outpatient History: If you are filling this out on behalf of the patient, please answer the patient's perspective.

Do you have a history of outpatient psychiatric treatment? ☐ Yes ☐ No

Provider	Reason for Seeking Treatment	Age of First Treatment	Age of Last Treatment	Outcome	Additional Comments

Suicide/ Self Harm History: If you are filling this out on behalf of the patient, please answer the patient's perspective.

Have you ever tried to harm or kill yourself? ☐ Yes ☐ No

Was your intent to die? ☐ Yes ☐ No

Elaborate: _____

_____

_____

(Continued on Next Page)

How many times in your life has this occurred? _____

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

_____

_____

_____

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

_____

_____

_____

Violence History: If you are filling this out on behalf of the patient, please answer the patient's perspective.

Have you had any history of violent behavior? ☐ Yes ☐ No

If YES, please elaborate: _____

_____

_____

_____

Past Medical History: If you are filling this out on behalf of the patient, please answer the patient's perspective.

Who is your primary care physician? _____

Are you taking any medications currently? (Excluding medications for psychiatric treatment) ☐ Yes ☐ No

If YES, please list medications: _____

_____

_____

_____

Have you had a history of any of the following health problems? (Please Check All That Apply)

☐ Allergies
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Back Problems
☐ Cancer
☐ Cataracts
☐ Chickenpox (as a child)
☐ Chronic Bronchitis
☐ COPD (Emphysema)
☐ Diabetes
☐ Diverticulitis
☐ Fainting Spells/ Passing Out
☐ High Cholesterol
☐ Hearing Loss
☐ Heart Disease
☐ Heart Defect From Birth
☐ Heart Valve Problems
☐ Hemorrhoids
☐ Hepatitis
☐ Hernia
☐ HIV
☐ Hypertension
☐ Hypotension
☐ Inflammatory Bowel Disease
☐ Iron Deficiency
☐ Multiple Sclerosis
☐ Obesity/ Overweight
☐ Parkinson's Disease
☐ Polyps
☐ Seizures
☐ Sexually Transmitted Disease
☐ Sleep Apnea
☐ Stroke/TIA
☐ Testosterone (low)
☐ Thyroid Problems
☐ Tuberculosis or exposure
☐ No problems
☐ Other _____

Have you had a history of surgery un any if the following areas? (Please Check All That Apply)

☐ Back/ Neck
☐ Brain
☐ Cardiac
☐ Ear/ Nose/ Throat
☐ Gall Bladder
☐ Hernia
☐ Hip/ Knee/ Ankle/ Foot
☐ Hysterectomy (Ovaries Removed)
☐ Other _____

☐ Intestine
☐ Kidney
☐ Liver
☐ Lung
☐ Pancreas
☐ Pelvis
☐ Penis
☐ Hysterectomy (Ovaries Retained)

☐ Prostate
☐ Sex Change
☐ Shoulder/ Elbow/ Wrist/ Hand
☐ Stomach
☐ Tonsils
☐ Vagina
☐ Weight Loss
☐ No Surgical History

_____

Psychiatric Medication History: If you are filling this out on behalf of the patient, please answer the patient's perspective.

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	Reasons for Stopping

Patient Allergies: If you are filling this out on behalf of the patient, please answer the patient's perspective.

Do you have any known allergies to medication? ☐ Yes ☐ No

If YES, please fill out your allergy information below:

Medication	Allergic Reaction

Family History: If you are filling this out on behalf of the patient, please answer the patient's perspective.

Do you have any family members with a history of psychiatric illness? ☐ Yes ☐ No

If YES, please elaborate: _____

_____

Is there any additional family medical history? _____

_____

Developmental and Educational History: If you are filling this out on behalf of the patient, please answer the patient's perspective.

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

- ☐ Exposure to drugs or alcohol during pregnancy
- ☐ A Difficult Pregnancy
- ☐ Problems with Delivery
- ☐ None of These
- ☐ Other _____

Did you have any complications after your birth? ☐ Yes ☐ No

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

- ☐ Walking
- ☐ Talking
- ☐ Toilet Training
- ☐ None of These
- ☐ Sleeping Alone
- ☐ Being Away from Parents
- ☐ Making Friends
- ☐ Other _____

Which options below best describe your childhood home atmosphere?

- ☐ Normal
- ☐ Supportive
- ☐ Parental Fighting
- ☐ Other _____
- ☐ Parental Violence
- ☐ Financial Difficulties
- ☐ Frequent Movements

Which of the following challenges were experienced during your childhood?

- ☐ Tantrums
- ☐ Enuresis (Bed Wetting)
- ☐ Encopresis (Fecal Incontinence)
- ☐ Running Away From Home
- ☐ Fighting
- ☐ Stealing
- ☐ Property Damage
- ☐ Fire Setting
- ☐ Animal Cruelty
- ☐ Separation Anxiety
- ☐ Victim of Bullying
- ☐ Depression
- ☐ Death of a Parent/ Caregiver
- ☐ Parental Divorce
- ☐ None of These
- ☐ Other _____

If YES to "Parental Divorce" Please list whom the patient lives with and what percentage of time. <u>We will require a custody agreement be presented for our records upon intake paperwork submission:</u>

_____

_____

_____

_____

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

- ☐ Fighting
- ☐ School Phobia
- ☐ Truancy
- ☐ Detentions
- ☐ Suspensions
- ☐ Expulsions
- ☐ Legal Issues
- ☐ School Refusal
- ☐ Class Failures
- ☐ Repetition of Grades
- ☐ Special Education
- ☐ Remedial Classes
- ☐ None of These

If YES to "Legal Issues," please explain:

_____

_____

Did you have additional schooling outside of the standard classroom setting?

- ☐ Speech Classes
- ☐ Tutoring
- ☐ Other _____
- ☐ Accommodations
- ☐ None of These

Please indicate your highest Level of Education: _____

If you have any further comments about your development or educational history and wish to elaborate further: _____

_____

_____

_____

General Social History: If you are filling this out on behalf of the patient, please answer the patient's perspective.

Which options below best describes your social situation?

- ☐ Supportive Social Network
- ☐ Few Friends
- ☐ Substance-use based friends
- ☐ Other _____
- ☐ No Friends
- ☐ Distant from Family of Origin
- ☐ Family Conflict

Is the child adopted? ☐ Yes ☐ No

If yes, please describe the circumstances of the adoption... **Please submit copy of adoption paperwork upon intake form submission.**

_____

_____

_____

Who do you/the patient currently live with?

☐ Live Alone
☐ Roommates
☐ Partner/ Souse
☐ Other _____
☐ Parent(s)
☐ Sibling(s)
☐ Children

Do you currently participate in spiritual activities? _____

What is your current occupation status? _____

If Patient is minor, please list guardian's occupation(s) _____

What is your current yearly income? _____

What is your longest period of continuous employment? _____

What is your longest period of continuous unemployment? _____

If over 18, Answer the following:

What is your current marital status? ☐ Married ☐ Divorced ☐ Legally Separated ☐ Single ☐ Minor ☐ Other

What is the status of your intimate relationship? _____

What is the satisfaction level of your intimate relationship? _____

What is your sexual orientation? _____

What is current living situation? _____