NP-JK

WELLSPRING CHRISTIAN CLINIC PATIENT REGISTRATION

Patient Name: _____
(Last) (First) (Middle) (Preferred Name)

Address: _____
(Street) (City) (State) (Zip)

LISTING A NUMBER PERMITS WELLSPRING TO CALL THAT NUMBER AND LEAVE A MESSAGE

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____ _____

Which number you would like us to call when making reminder calls? Home Work Cell

Ethnicity: _____ Soc. Sec. #: _____ Date of Birth: _____ Age: _____ Sex: M F Marital Status: S M D W

Employer: _____ Occupation: _____ Full-Time Part-Time Student/School: _____

IF DEPENDENT CHILD – Are custodial parents Married Separated Divorced Other _____
Please list names, relationships, and phone numbers for **ALL** legal guardians

_____

IN CASE OF EMERGENCY PLEASE NOTIFY: _____
(Name) (Phone) (Relationship)

Primary Care Physician: _____
(Name) (Address) (Phone)

Pharmacy: _____ Pharmacy Number: _____

FINANCIALLY RESPONSIBLE PARTY/GUARANTOR INFORMATION

□ **CHECK IF SAME AS ABOVE**

Guarantor Name: _____ Date of Birth: _____ Home Phone: ( ) _____

Guarantor Address: _____
(Street) (City) (State) (Zip)

Guarantor Relationship to Patient: Self Spouse Mother Father Sibling Other Relative Friend Other

Employer: _____ Occupation: _____ Work Phone: ( ) _____ Soc. Sec. #: _____

Driver's License #: _____ Special Arrangements: _____

WELLSPRING DOES NOT ROUTINELY BILL INSURANCE – Information is for reference only

Do you have Medicare or Medicaid? YES NO For legal reasons, Dr. Kimbrough cannot see patients that have Medicare or Medicaid.

Primary Insurance Co. Name: _____ Group ID # _____ Plan # _____

GUARANTOR AGREEMENT: I certify that the above information is true and correct. Whether or not my insurance company reimburses me for part of the cost of my sessions, I agree to take full responsibility for the entire amount due for any and all services rendered by Wellspring Christian Clinic. If the provider is contacted with the insurance company, I will be responsible for the co-pay, deductible, and non-covered services as determined by the insurance plan.

► GUARANTOR SIGNATURE: _____DATE: _____

PATIENT RELEASE OF INFORMATION TO GUARANTOR/THIRD PARTY AGENCY: I authorize Wellspring Christian Clinic to release my financial information to my guarantor or a third party collection agency.

► PATIENT/GUARDIAN SIGNATURE: _____DATE: _____

How did you hear about Wellspring Christian Clinic?

□ Another Client of Wellspring
□ My Doctor
□ My Church
□ My Friend or Family Member
□ Radio Advertisement (WDJC)
□ Internet Website
□ I attended a seminar sponsored by Wellspring
□ My Insurance Company
□ Yellow Pages
□ Birmingham Christian Family Magazine
□ Other (_____)

CLIENT AGREEMENTS AND AUTHORIZATIONS

CHILD AND ADOLESCENT CONSENT FOR TREATMENT

Legal Guardian MUST sign if primary patient is under 18 years old.

Patient (please print): _____ Date of Birth: _____
(Last) (First) (Middle) (mm/dd/yyyy)

I certify that I am the: Father Mother Legal Guardian of the above child/adolescent
I certify that I do have the legal custody of the above named child/adolescent.
I, hereby, give my authorization and consent for the above named child/adolescent to receive outpatient assessment/therapy from: _____

Name (please print): _____

Signature: _____ Date: _____

DIVORCE/LEGAL SEPARATION COLLECTION POLICY

Please sign if primary patient is under 18 years old and legal guardians are separated or divorced.

It is the policy of Wellspring Christian Clinic that the parent/guardian bringing a child/adolescent to our office for treatment is responsible for payment at the time services are rendered. You will be responsible for making prior payment arrangements with the child's/adolescent's other parent or responsible party. Wellspring Christian Clinic assumes no responsibility for collecting payment from the other parent or responsible party with whom you may have financial arrangements for your child's/adolescent's medical care.

I have read, understand and agree to the above policy:

Name (please print): _____

Signature: _____ Date: _____

ALL CLIENTS MUST READ AND SIGN

PRIVACY POLICY: I acknowledge having been offered Wellspring Christian Clinic's "Notice of Privacy Policies" and their "Client Rights Statement" (below and on following pages). My rights include the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record. These are explained in the Policy. My right to make a complaint and file a grievance has also been explained. I understand that I may revoke in writing my consent for release of my health care information except to the extent Wellspring Christian Clinic has already made disclosure with my prior consent. ► (_____)

CONSENT FOR TREATMENT: I hereby consent to the treatment provided by Wellspring Christian Clinic and its employees or designees. I authorize the services deemed necessary or advisable by my caregivers to address my needs. ► (_____)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION: I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of Wellspring Christian Clinic. I authorize Wellspring Christian Clinic to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Wellspring Christian Clinic may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. ► (_____)

► _____ _____ _____
Client or Authorized Person Signature Relationship Date

► _____ _____
Witness Signature Date

Wellspring Christian Clinic, Inc.

Dear Patient,

Thank you for requesting an appointment with me at Wellspring Christian Clinic. Enclosed you will find information regarding our office policies and a detailed patient questionnaire. Please take the time to read and complete these forms so that we may better serve you efficiently.

Office Policies and Procedures:

- Wellspring Christian Clinic's office hours are Monday-Thursday 8:30 am – 5:00 pm, Friday 8:30 am – 4:00 pm
- If you need to cancel an appointment, a minimum advanced notice of one full workday is required so that we will have a chance to fill that slot. You may leave a message with the office staff or on their voicemail. We will charge you a full fee for late cancellations or failures to show. Note: as a *courtesy*, we will call you the business day prior to your appointment to remind you of the time. However, we are sometimes unable to make this call or are unable to reach you. YOU ARE STILL RESPONSIBLE FOR COMING TO YOUR APPOINTMENT OR CANCELLING 24 BUSINESS HOURS IN ADVANCE, even if you do not receive a call.
- Payment is due at the time of service. Cash, check, Visa or MasterCard are accepted. There is a $25 charge for returned checks.
- You have the right to receive confidential treatment. **By law, health care providers have the right and responsibility to break confidentiality if there is suspected child abuse or the intent to harm oneself or another.** Otherwise, your case will only be discussed at your consent. Enclosed you will find questions regarding those you would like to involve in your care and your opportunity to provide that consent with your signature.
- Our office staff will contact you via telephone or U.S. mail for various reasons including appointment reminders, account questions, billing statements, etc. If this presents a problem for you, please discuss with me or the office staff.

Dr. Kimbrough's Specifics:

- For legal reasons, I cannot see Medicare patients.
- I am a Blue Cross/Blue Shield non-preferred provider. I do not contract with any insurance companies. However, most insurance policies will reimburse you in part for my services. I recommend you call your insurance carrier to determine your specific coverage.
- My usual office hours are Monday, Wednesday, and Thursday from 8:00 am – 2:00 pm.
- If you need to reach me outside of these hours, please call the main office number at 977-3003. You may leave a message with the office staff or directly on my voicemail. Either way, I will attempt to respond in a timely manner.

- If you need emergency after-hours care, please report your nearest Emergency Department for immediate assessment and treatment.
- I do not provide in-patient hospital care. If you need such service, you will be referred to another physician for the period of hospitalization.
- If you need more intensive psychiatric care than my particular practice provides, I will be glad to refer you to another physician that offers more comprehensive care.

Please sign below indicating that you have read, understand and agree to the above notifications and that you are consenting to receive treatment by a Wellspring Clinic provider:

_____ _____

Patient/Guardian Signature Date

I look forward to seeing you.

Regards,

Jill S. Kimbrough, M.D.

Jill S. Kimbrough, M.D.
Wellspring Christian Clinic
3104 Blue Lake Drive, Suite 100
Birmingham, AL 35243
205-977-3003

RELEASE OF INFORMATION AND COMMUNICATION CONSENTS (PERMISSIONS)

Please see Notice of Privacy Practices for more information about release of health information.

FAMILY

1. I give permission for Dr. Kimbrough to discuss my diagnosis and my treatment plan with my SPOUSE:

   Name: _____Phone: _____□ Yes □ No
2. I give permission for Dr. Kimbrough to discuss my diagnosis and my treatment plan with my CHILD:

   Name: _____Phone: _____□ Yes □ No
3. I give permission for Dr. Kimbrough to discuss my diagnosis and my treatment plan with my PARENT(s):

   Name: _____Phone: _____□ Yes □ No

OTHER CAREGIVERS

1. I give permission for Dr. Kimbrough to discuss my diagnosis and treatment plan with my MEDICAL DOCTOR:

   Name: _____Phone: _____□ Yes □ No
2. I give permission fo-r Dr. Kimbrough to discuss my diagnosis and treatment plan with my COUNSELOR/THERAPIST:

   Name: _____Phone: _____□ Yes □ No

OTHERS

1. I give permission for Dr. Kimbrough to discuss my diagnosis and treatment plan with:

   Name: _____Relationship: _____Phone: _____□ Yes □ No
2. I give permission for WELLSPRING OFFICE STAFF to discuss APPOINTMENTS and BILLING with:

   Name: _____Relationship: _____Phone: _____□ Yes □ No

If you have restrictions as to what Dr. Kimbrough is NOT to discuss, please indicate these: _____

_____

Note: I agree to indemnify and hold harmless Jill S. Kimbrough, M.D., and the staff at her office from all liability that may arise from the release of my personal information that I authorize above. This release authorizes disclosure to the specified physicians, psychologists, and counselors, copies of my clinical records, office notes, and both medical and psychological test results. Concerning those individuals whom I approved above who are not practicing professionals, this release authorizes Dr. Kimbrough to have conversations and case discussions with them about me. This release will continue to be valid unless it is expressly revoked by written instructions/notification to Dr. Kimbrough. **In the event of an emergency (e.g. intent to harm oneself or another), Federal Law allows Wellspring Christian Clinic to share sufficient information with necessary parties.**

Federal law protects information pertaining to alcohol and drug use. Federal regulation (42 CFR, Part 2) prohibits recipients of this information from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. Authorization for release of information pertaining to alcohol or drug use **IS SPECIFICALLY HERE SO CONFERRED** to Dr. Kimbrough unless I have asked Dr. Kimbrough not to do so in the above instructions and consent specifications.

► Signed: _____ Printed Name: _____
Witness: _____ Date: _____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS

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

We respect client confidentiality and only release confidential information about you in accordance with state and federal law. This notice describes our policies related to the use of the records of your care generated by this clinic.
Privacy Contract:
If you have any questions about this policy or your rights contact the Clinic Director, Dr. Al Saunders, at 205-977-3003.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In order to effectively provide you care, there are times when we will need to share your confidential information with others beyond our clinic. This includes information to be used for:

Treatment We may use or disclose treatment information about you to provide, coordinate, or manage your care or any related services, including sharing information with others outside our clinics that we are consulting with or clinics to which you are being referred.
Payment With your written consent, information will be used to obtain payment for the treatment and services provided. This will include contacting your health insurance company for prior approval of planned treatment, insurance verification, or for billing purposes.
Healthcare Operations We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care, or training our staff.
Information disclosed without your consent: Under state and federal law, information about you may be disclosed without your consent in the following circumstances:
Emergencies Sufficient information may be shared to address the immediate emergency you are facing.
Follow-up Appointment/Care We may be contacting you to remind you of future appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We will leave appointment information on your answering machine unless you tell us not to.
As Required by Law This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and/or neglect such as child abuse or elder abuse.
Coroners We are required to disclose information about the circumstances of your death to a coroner who is investigating it.
Governmental Requirements We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and licensure. Information may also need to be shared with the Food and Drug Administration related to adverse events or product defects. We are also required to share information, if requested, with the Department of Health and Human Services to determine our compliance with federal laws related to health care.
Criminal Activity or Danger to Others If any crime is committed on our premises or if a crime is committed off premises but against our personnel we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement when we believe an immediate danger may occur to someone.

CLIENT RIGHTS STATEMENT

The following rights are extended to each client in the Day Program and the Outpatient Clinic services for all ages without reservation or limitation:

1. The right to confidentiality: The client has the right to every consideration of privacy concerning his or her medical care program, including HIV status and testing. All case discussion, consultation, communications, records, and medical information pertaining to his or her care will be treated as private and confidential;
2. The right to have impartial access to treatment regardless of age, psychological characteristics, sexual orientation, physical condition, race, religion, gender, ethnicity, marital status, HIV status, criminal record, or source of financial support;
3. The right to have personal dignity recognized and respected in the provision of all care and treatment;
4. The right to religious freedom;
5. The right to receive individualized treatment including the provision of an individualized treatment plan based upon information of all assessments, active participation in the development of the treatment plan by the client with periodic review of the plan by staff, and implementation and supervision of the plan by qualified professional staff;
6. The right to make decisions about the treatment plan prior to and during the course of treatment and to refuse a recommended treatment or plan of care to the extent permitted by law and to be informed of the medical consequences of this action. In case of such refusal, the client is entitled to other appropriate care and services that Wellspring Christian Clinic provides or they may transfer to another facility;
7. The right to know the immediate and long-term financial implications of treatment choices, insofar as they are known;
8. The right to obtain from clinician, or other staff involved in direct care, relevant, current, and understandable information concerning diagnosis, treatment, and prognosis. The right to review the records pertaining to his/her treatment and to have the information explained or interpreted as necessary, except when restricted by law. If you request a copy of your records, we may charge you a reasonable fee for copying and mailing your record;

9. The right to know the identity of physicians, nurses, and others involved in their care, as well as when those involved are students, interns, residents, or other trainees;
10. The right to expect that, within its capacity and policies, the practice will make reasonable response to the request of a client for appropriate and medically indicated care and services. Wellspring Christian Clinic must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically appropriate and legally permissible, or when a client has so requested, a client may be transferred to another clinician's care. The clinician to whom the client is to be transferred must first have accepted the client for transfer. The client must also have the benefit of complete information and explanation concerning the need for, risks, benefits, and alternatives to such a transfer;
11. The right to ask and be informed of the existence of business relationships among the clinic, hospital, educational institutions, other health care providers, or payers that may influence the client's treatment and care;
12. The right to consent to or decline to participate in proposed research studies or human experimentation affecting care and treatment or requiring direct client involvement, and to have those studies fully explained prior to consent. A client who declines to participate in research or experimentation is entitled to the most effective care that the clinic can otherwise provide;
13. The right to receive prescribed services within the least restrictive but appropriate environment;
14. The right to assurance and protection of privacy and confidentiality of communication with treatment staff, and of material written in the client's individualized record;
15. The right to be presumed mentally competent unless a court has ruled otherwise;
16. The right to a clean and humane environment in which you are protected from harm, have privacy with regard to personal needs, and are treated with respect and dignity;
17. The right to be free from mistreatment, abuse, neglect, and exploitation;
18. The right to expect reasonable continuity of care when appropriate and to be informed by clinicians and other caregivers of available and realistic client care options;
19. The right to initiate a complaint or grievance, with the assurance of no retaliation, and to be informed of the appropriate grievance process;
20. The right to be informed that Wellspring Christian Clinic has the right to terminate care with a 30 day written notification given to the client with a listing of referrals for continuity of care;
21. The right to request an amendment to your record if you believe something in your record is incorrect or incomplete. Ask for the *Request to Amend Health Information* form.
22. Prior to admission to the Day Program, you have the right to be informed of all program rules and regulations concerning your conduct and course of treatment.
23. If you have a complaint about the services provided, you may file a grievance by doing the following:

Step One:	Discuss the issue with your therapist or doctor. He or she is there to help you with any issue that arises. It is never an inconvenience for them to assist you.
Step Two:	If the therapist or doctor is not able to adequately assist you with your concern and you have still not had your issues resolved, contact the Clinic Director, Dr. Al Saunders at 205-977-3003.

FILING OF COMPLAINTS AGAINST HIPAA-COVERED ENTITIES BELIEVED TO BE NON-COMPLIANT WITH HIPAA PRIVACY RULE

Complaints must be written to the Secretary of HHS, have occurred on or after April 14, 2003, and meet the following requirements:

- Be filed in writing, either on paper or electronically;
- Name the entity that is the subject of the complaint and describe the acts or omission believed to be in violation of the applicable requirements;
- Be filed within 180 days of when the complainant knew or should have known that the act or omission complained of occurred, unless this time limit is waived by the ORC for good cause is shown.

Electronic complaints should be sent to ORCComplaint@hhs.gov. Mailed complaints must be addressed to the ORC regional office that is responsible for matters relating to the Privacy Rule arising in the State or jurisdiction where the covered entity is located.

Region IV (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, or Tennessee)

Office for Civil Rights
U.S. Department of Health and Human Services
Atlanta Federal Center, Suite 3B70
61 Forsyth Street SW
Atlanta, GA 30303-8909

NAME: _____ **DATE:** _____

WELLSPRING DEPRESSION CHECKLIST

Instructions: Put a check (√) to indicate how much each symptom has bothered you in the past several days. Please answer all 25 items.

None – 0 **Some – 1** **Moderate – 2** **A Lot - 3** **Extreme – 4**

	0	1	2	3	4
Thoughts and Feelings					
1. Feeling sad, down in the dumps, or "blue"					
2. Crying or tearfulness					
3. Feeling discouraged or hopeless about the future					
4. Having low self-esteem					
5. Feeling worthless or inadequate					
6. Feeling guilty or shameful					
7. Criticizing yourself or blaming yourself for things					
8. Having difficulty making decisions					
9. Feeling angry, resentful or annoyed					
10. Feeling frustrated					
Activities and Personal Relationships					
11. Loss of interest in family, friends, or colleagues					
12. Feeling lonely					
13. Spending less time with family and friends					
14. Loss of motivation					
15. Loss of interest in work or other activities					
16. Avoiding work or other activities					
17. Loss of pleasure or satisfaction in life					
Physical Symptoms					
18. Tiredness					
19. Difficulty sleeping or sleeping too much (**Circle which**)					
20. Decreased or increased appetite (**Circle which**)					
21. Loss of interest in sex					
22. Worrying about your health					
Suicidal Urges *					
23. Do you have thoughts about death or dying?					
24. Would you like to end your life?					
25. Do you have a plan for harming yourself?					
26. Do you have intent to harm yourself?					
Subtotals (Multiply the number of checks per column by the column number					

_____

*** Anyone with suicidal urges should seek immediate help from a medical health professional.**

NAME: _____ **DATE:** _____

WELLSPRING ANXIETY INVENTORY

Instructions: Put a check (√) to indicate how much each symptom has bothered you in the past several days. Please answer all 25 items.

None – 0 **Some – 1** **Moderate – 2** **A Lot - 3** **Extreme – 4**

	0	1	2	3	4
Anxious Feelings					
1. Anxiety, nervousness, worry, or fearful feelings					
2. Feeling that things around you are strange or foggy					
3. Having sudden unexpected panic spells					
4. Feeling apprehensive or a sense of impending doom					
5. Feeling tense, stressed, "uptight" or on edge					
Anxious Thoughts					
6. Having difficulty concentrating					
7. Racing thoughts					
8. Frightening fantasies, daydreams or flashbacks					
9. Feeling on the verge of losing control					
10. Fears of cracking up or going crazy					
11. Fears of fainting or passing out					
12. Fears of illness, heart attacks or dying					
13. Fears that something terrible will happen					
Anxious Physical Symptoms					
14. Skipping, racing or pounding heart					
15. Chest tightness or pain					
16. Tingling or numbness in the toes or fingers					
17. Butterflies or discomfort in the stomach					
18. Restlessness or jumpiness					
19. Tense muscles					
20. Sweating not brought on by heat					
21. Trembling or shaking					
22. Rubbery or "jelly" legs					
23. Feeling dizzy, lightheaded or off balance					
24. Hot flashes or cold chills					
25. Feeling tired, weak or easily exhausted					
Subtotals (Multiply the number of checks per column by the column number):					

_____

NAME: _____ **DATE:** _____

KEY PROBLEMS

Please "X" the spot below which best describes your opinion about your past few days' performance at work, school, household duties, or in the treatment program:

Unable to Perform	Poor	Adequate	Good	Very Good
0	25	50	75	100

Which are the biggest problems caused by your illness that hurt your functioning and performance?

1._____
2._____
3._____

MEDICATION ISSUES

Please "X" the spots below which best describe your most recent experience with prescribed medicine:

MEDICATION EFFECTIVENESS

No Help	A Little Better	Moderately Better	A Lot Better	Complete Relief
0	25	50	75	100

Which two things has medication helped the most?

1._____
2._____

Which two things do you wish the medicine could better help?

1._____
2._____

MEDICATION SIDE EFFECTS

No Intolerable Side-Effects	A Few	Moderately Bothersome Side-Effects	A Lot	Extreme Side-Effects
0	25	50	75	100

Which are the three most prominent side-effects of your medicine?

1._____
2._____
3._____

Wellspring Patient Evaluation

Who do you live with? _____

Emergency Contact Person: _____

Relation to you: _____ Phone Number: _____

Problem Assessment:

Please describe the problem for which you want to see the doctor: _____

_____

_____

_____

When did this problem develop? _____

Considering your overall condition, how ill (e.g. depressed, anxious) are you at this time?

Please circle the corresponding number on the scale below:

1	2	3	4	5	6	7	8	9	10
Severely Ill				**Moderately Ill**				**Normal (Not Ill)**	

Your current condition is best described as:

____ Continuation of a longstanding problem

____ Recurrence of a previous condition

____ First occurrence with no previous difficulty

Describe how your condition is affecting your level of functioning in your job, family, school, friendships, etc.:

_____

_____

If you are currently being treated for this problem please identify who is treating you and what type of treatment you are receiving. *Check more than one if appropriate.*

____ Psychiatrist	____ Other Medical Doctor	____ Psychologist
____ Other Caregiver	____ Individual Therapy	____ Medication Therapy
____ Social Worker	____ Family Therapy	____ Group Therapy
____ Self-Help Program (AA, Al-Anon, etc…)		____ Other Treatments

Name of Providers: _____

What stressors do you think may have precipitated the problem or worsened it? *Please circle all that apply:*

Marital Issues	Health Issues	Job Issues	Financial Issues
Parent/Child Issues	Recent Losses	Other: _____	

Please describe these stressors: _____

How would you describe your mood over the past few weeks? _____

Have you recently had any thoughts that you would be better off dead?	Y	N
Have you recently had any thoughts of hurting yourself or anyone else?	Y	N
Have you recently come up with a plan to hurt yourself or anyone else?	Y	N
Have you ever tried to hurt yourself or anyone else in the past?	Y	N

If you answered yes to any of the above questions, please explain in detail: _____

_____

_____

_____

Symptoms: *Please circle all that apply:*

Changes in sleep pattern	Changes in appetite	Decreased concentration
Decreased energy	Loss of interest	Guilt/worthless feelings
Loss of weight	Decreased motivation	Hopeless/helpless feelings
Binge eating	Self-induced vomiting	Laxative/diuretic use
Panic attacks	Increased worry	Intrusive repetitive thoughts
Repetitive behaviors	Excessive, unreasonable fear	Hearing voices others don't hear
Seeing visions that others don't see	Feeling other are controlling you	Memory problems
Paranoia	Inattention	Impulsivity
Hyperactivity	Panic Attack	

Substance Use History:

Please place a check in the box after each substance to indicate your typical use during the past year:

SUBSTANCE	Never	Monthly or Less	3-4 Times/Week	4-6 Times/Week	Every Day
Alcohol					
Marijuana/Pot					
Pain Pills					
Cocaine/Crack/Free-Base					
Sleeping Pills (e.g. Xanax)					
Stimulants/Amphetamines (e.g. Ritalin)					
Chrystal Meth/Ice/Crank/Uppers					
Inhalants/Glue/Solvents/Aerosol					
Steroids/Androgens/Roids/Juice					

Do you feel that you have a problem with substance abuse? Yes/No
Have you ever felt the need to cut down on alcohol or drug use? Yes/No
Have you ever felt annoyed by others telling you to cut down on your use? Yes/No
Do you ever feel guilty about alcohol or drug use? Yes/No
Do you sometimes need an eye-opener of alcohol in the morning? Yes/No
Have you had problems in your marriage, at your job, with household chores, or with friends or family due to alcohol or drug use? Yes/No
Have you ever injected yourself with drugs? Yes/No If yes, please explain _____
_____
Have you ever been in a rehab program for treatment of substance abuse? Yes/No

Name of Treatment Center	**Days Treated/Length of Stay**	**How long you were sober afterward**

Do you use any form of tobacco? Yes/No If yes, what? _____
How much tobacco do you use daily? (e.g. packs of cigarettes/day) _____
How long have you used tobacco? _____
How many caffeinated beverages do you drink per day? Tea: _____ Coffee: _____ Soft Drinks: _____ Other: _____

Past Psychiatric History

Have you ever had an emotional or psychiatric problem for which you received *psychiatric* treatment? Yes/No

If yes, please complete this section. If no, you may skip ahead to* Past Medical History *on the next page.

Have you ever been hospitalized with a psychiatric illness? Yes/No

Date Treated Name of provider and location Type of Treatment Reason

1._____
2._____
3._____
4._____
5._____

Have you ever been in outpatient treatment for a psychiatric problem (e.g. Meds, therapy)? Yes/No

Date Treated Name of provider and location of hospital Type of Treatment Reason

1._____
2._____
3._____
4._____
5._____

What treatment has helped? _____
_____
_____

Have you been treated with psychiatric medications in the **past**? Yes/No

If yes, please complete the following:

Drug Name	Usual Daily Dose	Date Started	How long on this medicine	Beneficial Yes/No	Side Effects	Reason for Stopping

Please continue on the back of this page if necessary.

Past Medical History

Please check your current state of general health: Poor_____ Fair _____ Good _____ Excellent _____

Name of medical doctor: _____ Date of last physical exam: _____

Current height: _____ Weight: _____ Blood Pressure: _____

List any chronic medical illness for which you are/have been treated: _____

_____

_____

_____

_____

_____

_____

_____

_____

Method of Birth Control: _____

List any surgeries, traumas, head injuries/loss of consciousness, seizures or broken bone repairs you have had and when these occurred: _____

_____

List any allergies that you have: _____

Are you **currently** taking any medications including nonprescription or over-the-counter drugs? Yes/No
If yes, please complete the following:

Drug Name	**Usual Daily Dose**	**Date Started**	**What it is for**	**Side Effects**	**Dr. Prescribing it**

Please continue on the back if necessary

Family History

Does anyone in your family have a psychiatric illness? Yes/No If yes, please complete the following:

	Anxiety	Depression	Alcohol/ Drugs	Psychosis	Other	Names of Medications Tried	Response to this Medication
Father							
Mother							
Sisters							
Brothers							
Grandparent							
Grandparent							
Uncles							
Aunts							
Child 1							
Child 2							
Child 3							
Others							

Does anyone in your family have diabetes? Yes/No If yes, please identify: _____

_____

Social History

List the members of your family of origin and how you got along with each one:

Family Member **Comment**

_____

_____

_____

_____

_____

_____

_____

_____

What was your birth order? ____ of ____ children. Who primarily raised you? _____

Who were you closest to growing up? _____

How would you describe your childhood? Traumatic Painful Uneventful Good Happy

What were you like as a child (include friends, school, hobbies, and personality)? _____

_____

_____

_____

Social History cont.

Were you ever abused in any way (physical, verbal, emotional, sexual)? Yes/No If yes, please describe:

_____

_____

_____

_____

How would *others* describe your mother? _____

_____

How would *you* describe your mother? _____

_____

What activities did you do with your mother growing up? _____

_____

How would *others* describe your father? _____

_____

How would *you* describe your father? _____

_____

What activities did you do with your father growing up? _____

_____

Education

Please circle you highest level of education achieved:
Below 10th grade, 10-12th grade, dropped out (reason _____), GED,
high school graduate (year: ___), some college (# of years _____), trade school or junior college, college degree, masters degree, MD, PhD, JD, RN

Are you currently in school? Yes/No If yes, where? _____
How was your adjustment to school situations? _____
What type of grades did you make? _____
Were you ever suspended or expelled? Yes/No If yes, please explain: _____

_____

Employment

Do you currently work? Yes/No
If no, when did you last work? _____ Doing what? _____
If yes, describe your current job: _____

_____

Number of hours employed/week: _____
How long have you been at this job? _____
What do you like about this job? _____
What do you dislike about this job? _____
Would you enjoy doing this job on a long term basis? Yes/No
If you could have any job/career, what would you choose and why? _____

_____

Employment cont.

How do you deal with authority figures? _____
Describe your relationship with your co-workers: _____
Describe your job performance: _____
How many jobs have you held in the last five years? _____
Have you ever been fired? Yes/No If yes, please explain: _____
_____
What is your present income source? Job Pension Family Support SSDI/SSI Other: _____
Describe briefly your financial situation: _____
_____
Have you ever filed for bankruptcy? Yes/No If yes, please explain: _____
_____

Legal History

Please explain all that apply:

Charges as a minor: _____
Current charges: _____
Arrests (and how many): _____
Incarcerations (and how many): _____
Parole: _____
Convictions (and how many): _____
Probation: _____
Civil Suits: _____
Child Custody Problems: _____

Marital History

Marital Status: Single ____ Married ____ Separated ____ Divorced ____ Widowed ____
What is your sexual orientation? Heterosexual ____ Homosexual ____ Bisexual ____

If applicable, please fill out the information below:

Age when you married Spouse's age # of years married # of children from marriage Reason for breakup

1st _____
2nd _____
3rd _____
4th _____

Current spouse's name, age and occupation: _____
How well do you and your spouse (or significant other) get along? Circle the appropriate number below:

1 2 3 4 5 6 7 8 9 10
Very Poor Fair/Average Excellent

Marital History cont.

How often do you and your spouse/significant other go out socially? ____ per week ____ per month
How often do you and your spouse/significant other have sexual intercourse? ____ per week ____ per month
Do you have any sexual concerns? Yes/No If yes, please explain: _____
_____
_____

Who is the dominant member of your relationship? ____ You ____Your spouse/significant other
List some of the behaviors of your spouse/significant other that you find agreeable: _____
_____

List some of the behaviors of your spouse/significant other that you find disagreeable: _____
_____

List the names and ages of your children and how you get along with each one:
_____
_____
_____
_____

List others living in your household and their relationship to you: _____
_____

What do you do for fun or recreation? _____
_____

Religion/Cultural Factors

Please list any issues which are important or may have affected you in regard to religion or ethical/cultural background: _____
_____

What is your religious background? _____
Do you currently attend a church, synagogue, or mosque? Yes/No If yes, which? _____
Do you think your religious beliefs have helped you with your problem? Yes/no If yes, please describe:
_____
_____

Do you think your religious beliefs have worsened or complicated your problem? Yes/No If yes, please describe: _____
_____

Support System

Who can you count on for support? *Circle as many as apply*

Parents Spouse Siblings Employer Church Pastor Therapist Neighbor Children
Extended family Close friend Co-worker Self-help Group Community Services Medical Doctor
Other: _____

Would it be beneficial for any family members to be involved in your treatment? Yes/No
If yes, please explain who and why: _____
_____

THANK YOU! PLEASE DO NOT FORGET TO BRING THIS WITH YOU TO YOUR APPOINTMENT
If you do forget it, we may have to reschedule another appointment to ensure that your history is complete.