DWIGHT W. SIEVERT M.D., INC.

7766 N. Palm Ave., Ste 107
FRESNO, CA 93711
Ph. 559-435-0800 Fax. 559-435-7720

WELCOME TO OUR PRACTICE

Thank you for scheduling your appointment with our providers. We look forward to meeting you!

GENERAL INFORMATION

Please arrive 15 minutes prior to the first appointment with your paperwork completely filled out (prior to your arrival), along with your insurance card(s) and any other paperwork requested by our office.

Directions: Take Herndon to Cedar Avenue. Turn north on Cedar. Turn left at the first light which is Eleventh. Take the second driveway on the right.

It is our office policy that you provide us with payment in full at the time of the first visit, unless you are part of an HMO/PPO that provides us with a specific co-pay amount which you are required to pay at the time of service. Otherwise, please contact our office in advance of your appointment to be told the exact amount you will need to pay at the time of your first visit. We will bill your insurance and, if they pay for your services, we will apply your initial payment towards your account.

Please read and complete all forms!

➔ You will need to bring in:

1. Mental Health Intake questionnaire - **FULLY COMPLETED**
2. Return all other forms in this packet, signed and initialed.
3. A **CLEAR** copy of the **FRONT** and **BACK** of all your insurance card(s) 3 business days prior to your appointment.

➔ It is your responsibility to contact your insurance company to open your case for pre-authorization for treatment and confirm benefits before your first appointment:

1. Call your insurance company and get a prior authorization for **"Outpatient Mental Health"** services.
2. Ask for the **"Insurance Claim Mailing Address"** to submit your mental health claims.

You may also bring this information into the office before your appointment and we will gladly copy your insurance card(s) for you and help you complete the packet. You may also e-mail your completed packet to **DWSMD@mysecurechart.com.**

OFFICE POLICIES

APPOINTMENTS

Patients are seen only by appointment. Before you first visit, please complete all of the forms which have been sent to you and be sure to bring them with you to your first appointment.

You will not be seen in our office unless all forms are filled out prior to your visit.

This will allow the office staff and the providers to serve you in the most time efficient manner possible. If this information cannot be completed prior to your appointment, please arrive one hour early in order to complete the forms. If they are already complete, **please arrive 15 minutes before your first appointment** so that the staff can prepare your chart.

Upon arrival at the office for any appointment, always check in with the receptionist so that the providers can be informed that you arrived.

PRESCRIPTION REFILL POLICY

During your appointment, your provider will write a prescription with the number of refills he/she feels is needed and safe. With your last refill, ensure you have an appointment with your provider for a medication refill at least two weeks before your medication runs out. At the time of your appointment, your provider will review your medications and write for appropriate refills. Medication refills will not be authorized over the phone or by fax.

Please remind your provider if you require a 90 day prescription and clarify the pharmacy we have on record is correct.
Patients are asked to respect the privacy and time concerns of patients who have appointments. In consideration of both patients and providers, patients are reminded not to walk in to the clinic to request a prescription refill. Certain controlled substances may require a monthly appointment.

CANCELLATIONS / MISSED APPOINTMENTS:

When you schedule an appointment, that time is reserved specifically for you. Appointment reminder sheets are printed on your check-out sheet whenever subsequent appointments are scheduled at the office. **It is the patient's responsibility to remember and keep scheduled appointments.** A minimum of 24 hours notice is required for canceling or re-scheduling an appointment.

You will be charged **$100** for missed appointments and appointments which are canceled with less than 24 hours notice.

DISCHARGE:
Three consecutive no shows or three consecutive cancelations will trigger an automatic discharge from our practice unless indicated otherwise by your provider.

FINANCIAL RESPONSIBLITY:

- Co-pays or deductibles are due at time of service.
- A minimum of $20.00 will be collected on all services with a deductible or where a deductible applies. Applicable adjustments will be made once your insurance carrier has paid for services rendered.
- Cash discounts are given only at the time of the appointment when ***paid in full*** at check-in.
- Missed Appointment / Late Cancellation Fees $100.00

PAYMENT:
Co-pays and Deductibles are collected prior to your appointment when you check-in. **If you have no insurance, payment in full is required and must be paid prior to your appointment at the time of check-in.**
Many insurance plans require prior authorization for mental health services. It is the patient's responsibility to obtain the authorization for the first visit. We are happy to bill your Insurance with the information you provide us, however, payment by your insurance company is not guaranteed. If your claim is denied or there is lack of authorization, you are responsible for the billed amount.

CONFIDENTIALITY AND RELEASE OF INFORMATION
Information disclosed within sessions and the written records pertaining to those sessions are confidential and will not be released to anyone without the written consent of the patient or the parent/guardian, in the case of minors and/or dependent adults, except where DW Sievert, M.D., Inc. is mandated by California law to report otherwise confidential information. Circumstances which are required by law to be reported are:

1. Patients who pose an imminent threat of danger to themselves or others.
2. Instances of suspected abuse or neglect of a child (physical, sexual and/or emotional abuse).
3. Instances of suspected abuse or neglect of a dependent adult.

Disclosure may also be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony from DW Sievert, M.D., Inc. In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. Providers will use their clinical judgment when revealing such information.

Disclosure of confidential information may be required by your health insurance or workman's compensation carrier, or HMO/PPO/MCO/EAP in order to process your claims. Only the minimum necessary information will be communicated to the carrier. Providers have no knowledge or control over what insurance companies do with the information submitted and assumes no responsibility for any actions which result from a third party misusing or re-releasing such information without his expressed consent.

As a patient, you have the right to review or receive a summary of your records at any time (with notice of 10 or more working days), except in limited legal or emergency circumstances or when DW Sievert, M.D., Inc. assesses that releasing such information might be harmful in any way. In such circumstances DW Sievert, M.D., Inc. may provide the records to a qualified mental health professional of your choice and that individual may then choose to review the information with you if it is deemed clinically appropriate. You will be charged an appropriate fee for any preparation time which is required to comply with an information request.

All other requests to release information regarding your treatment and your condition must be authorized in writing specifically allowing the release of psychiatric records. DW Sievert, M.D., Inc. will provide you with a Release of Information form or you may choose to place your request in writing. There will be no charge for releasing records to other treating medical or mental health professionals. For all other requests to copy records, there will be a minimum charge of $25.00 to cover the expenses of photocopying, postage and handling.

FINANCIAL AGREEMENT & OFFICE BILLING / INSURANCE POLICIES

1. I understand that professional services are rendered and charged to the patient and not to the insurance company. Not all issues/conditions/problems which are the focus of psychotherapy or an evaluation are reimbursed by insurance companies. It is my responsibility to verify the specifics of my coverage. I am responsible for payment for any services or charges not covered by my insurance. I understand that this office does not assume responsibility for claim denials, claim disputes, or for insurance payment of my account.

2. I agree to pay all deductibles, co-payments, and/or co-insurance amounts not paid by my insurance(s). These will be paid at the time services are rendered, unless other arrangements have been made. Under no circumstances does this office accept liens as payment on an account.

3. I understand that if my insurance(s) require a referral from my primary care physician, DW Sievert, M.D., Inc. must have verification of the referral **prior** to my first appointment. I will bring my insurance information or insurance card(s) to my first appointment so that the office can properly identify my program(s).

4. I authorize the release of information concerning my treatment or the treatment of my dependent(s) to my insurance company(s), including that an insurance company representative may review the clinical record.

5. I authorize direct payment by my insurance company(s) to DW Sievert, M.D., Inc.

6. I accept ultimate responsibility for payment for the services that I or my dependent(s) receive, whether or not my insurance(s) cover these services. This includes, but is not limited to fees for: clinical services or treatment, failed appointments and/or appointments not cancelled with 24 hours notice, report/letter writing, time spent in court or talking with attorneys on my behalf or the behalf of my dependent(s), telephone conversations longer than 5 minutes, site visits, reading records, longer sessions, travel time, etc.

7. I understand that I will receive a statement if I have an outstanding balance on my account, and I am to pay any portion that is my responsibility within 15 days of receipt of a statement. A finance charge of 1% per month may be added to my account if payment is overdue.

8. I understand that there will be a $25.00 service fee for any checks returned by my bank due to nonsufficient funds, closed accounts, etc. I agree to accept full responsibility for such fees. The amount of the returned check, plus the service fee, must be paid within 10 days of written notice.

9. I will notify the Office if any problem arises regarding my ability to make timely payments. If my account is overdue (unpaid) and there is no agreement on a payment plan, I understand that this office can use legal means (court, collection agency, etc.) to obtain payment.

10. I am aware of DW Sievert, M.D., Inc.'s office policy requiring 24 hours notice to cancel an appointment. I understand that I may notify the office staff or the answering service of my intention to cancel an appointment. I further acknowledge that I will be charged $100.00 for any appointment which I or my dependent(s) fail to keep without providing 24 hours notice.

My signature below signifies that I have read, understood, and agree to the above terms of the office policies, this financial agreement and office billing/insurance policies.

_____

Patient Name (Printed)

_____

Responsible Party (Printed) (If patient is a minor or dependent adult)

_____ _____

Signature of Responsible Party Date

DW SIEVERT M.D., INC.

Patient Registration

Are these services Court ordered? ❑ Yes ❑ No

PATIENT INFORMATION ❑ New Patient ❑ Information Update

Patient Name: _____ Social Security #: _____
Date of Birth: _____ Sex: ❑ Male ❑ Female Marital Status: ❑ Married ❑ Single ❑ Other
Address: _____ City: _____ State: _____ Zip: _____
Email Address: _____
Primary Contact Phone: _____ Secondary Phone: _____
Employer: _____ Occupation: _____
Work Address: _____ City: _____ State: _____ Zip: _____
Education Level: _____ Highest Grade Completed: _____
Race: ❑ Asian ❑ Black ❑ Native American ❑ White ❑ More than one race Preferred Language: _____
Ethnicity: ❑ Hispanic ❑ Non-Hispanic
Smoking Status: Current Smoker: ❑ Yes ❑ No History of Smoking: ❑ Yes ❑ No Stop Date: _____
Emergency Contact: _____ Relationship: _____ Phone: _____
Referring Physician: _____ Driver's License #: _____

SPOUSE / PARTNER INFORMATION (If relevant)

Spouse/Partner Name: _____
Date of Birth: _____ Sex: ❑ Male ❑ Female
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Employer: _____ Occupation: _____

FINANCIAL RESPONSIBILITY (Must complete if patient/client is under 18 years of age)

Responsible Party: _____ Social Security #: _____
Relationship to Subscriber: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Employer: _____ Occupation: _____

INSURANCE INFORMATION (Must complete ALL the information below in order to bill your Insurance)

Primary Insurance: _____ Subscriber Name : _____
Subscriber Date of Birth: _____ Subscriber ID #: _____ Group #: _____
Claim Mailing Address: _____ City: _____ State: _____ Zip: _____
Relationship to Patient: _____
Secondary Insurance: _____ Subscriber Name : _____
Subscriber Date of Birth: _____ Subscriber ID #: _____ Group #: _____
Claim Mailing Address: _____ City: _____ State: _____ Zip: _____
Relationship to Patient:

PHARMACY INFORMATION (PLEASE FILL OUT COMPLETELY WITH CORRECT ADDRESS AND PHONE NUMBER)

Pharmacy Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Cross Street: _____ Pharmacy Phone#: _____
Mail Order Pharmacy Phone #: _____ Pharmacy Fax #: _____

SIGNATURE and DATE

Patient or Responsible Party: _____ Date: _____

DWIGHT W. SIEVERT M.D., INC.

7131 N. ELEVENTH ST., SUITE 104
FRESNO, CA 93720
Ph. 559-435-0800 Fax. 559-435-7720

BUPRENORPHINE TREATMENT AGREEMENT

I am requesting that my doctor provide buprenorphine treatment for opioid _____ addiction.
list drug(s)

I freely and voluntarily agree to accept this treatment agreement, as follows:

1. I agree to keep, and be on time to, all my scheduled appointments with the doctor and his assistant.
2. I agree to conduct myself in a courteous manner in the physician's or clinic's office.
3. I agree to pay all office fees for this treatment at the time of my visits. I will be given a receipt that I can use to get reimbursement from my insurance company if this treatment is a covered service. I understand that this medication will cost between $5-10 a day just for medication and that the office visits are a separate charge.
4. I agree not to arrive at the office intoxicated or under the influence of drugs. If I do, the staff will not see me and I will not be given any medication until my next scheduled appointment.
5. I agree not to sell, share or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without recourse for appeal.
6. I understand that the use of buprenorphine/naloxone (Suboxone) by someone who is addicted to opioids could cause them to experience severe withdrawal.
7. I agree not to deal, steal, or conduct any other illegal or disruptive activities in or in the vicinity of the doctor's office.
8. I agree that my medication (or prescriptions) can only be given to me at my regular office visits. Any missed office visits will result in my not being able to get medication until the next scheduled visit.
9. I agree that the medication I receive is my responsibility and that I will keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of the reasons for such loss.
10. I agree not to obtain medications from any physicians, pharmacists, or other sources without informing my treating physician. I understand that mixing buprenorphine with other medications, especially benzodiazepines, such as Valium (diazepam), Xanax (alprazolam), Librium (chlordiazepoxide), Ativan (lorazepam), and/or other drugs of abuse including alcohol, can be dangerous. I also understand that a number of deaths have been reported in persons mixing buprenorphine with benzodiazepines.
11. I agree to take my medication as the doctor, and his assistant has instructed, and not to alter the way I take my medication without first consulting the doctor.
12. I understand that medication alone is not sufficient treatment for ty disease and I agree to participate in the recommended patient education and relapse prevention program, to assist me in my treatment.
13. I understand that my buprenorphine treatment may be discontinued and I may be discharged from the practice if I violate this agreement.
14. I understand that there are alternatives to buprenorphine treatment for opioid addiction including:
    a. Medical withdrawal and drug-free treatment
    b. Naltrexone treatment
    c. Methadone treatment

    My provider will discuss these with me and provide a referral if I request this.

My signature below signifies that I have read, understood, and agree to the above terms of the office policies.

_____ _____
Patient Name (Printed) Date

_____
Patient Signature

_____ _____
Witness Signature Date

TELEPHONE APPOINTMENT REMINDER CONSENT

I _____ give DWIGHT W. SIEVERT, M.D., INC. and members of his staff
Patient Name (print)
working at the location indicated above, my permission to call or text me prior to an appointment to remind me of the appointment date and time.

I would prefer to be called at (check all that apply):

❒ Home _____
May we leave voicemail? ❒ Yes ❒ No

❒ Work _____
May we leave voicemail? ❒ Yes ❒ No

❒ Cell _____
May we leave voicemail? ❒ Yes ❒ No

Yes, this office may leave (check all that apply):
❒ Messages with _____at my Home
❒ Messages with _____at my Work

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken on reliance on it. This consent will last while I am being treated for opioid dependence by the physician practice specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician practice specified above is otherwise notified by me.

_____ _____
Patient Signature Date

SUBOXONE NEW PATIENT

Please complete all information on this form and bring it to your first office visit.

Name _____ Date_____

Date of Birth _____

Reason for seeking treatment:

Substance _____ How long Using _____

How much? _____ How often? _____

Has your drug use ever resulted in medical or legal problems? ❒ Yes ❒ No

Have you ever been treated for substance dependence or misuse (e.g. detoxification program)? ❒ Yes ❒ No

(Please describe setting, legnth) _____

Have you ever tried to quit on your own? ❒ Yes ❒ No Please describe:

Have you ever been treated by a psychiatrist? ❒ Yes ❒ No Please describe treatment reason, setting and length:

Does anyone in your family (mother, father, brother/sister, child, aunt/uncle or grandparent) have a history of Substance abuse? ❒ Yes ❒ No _____

Do you have any medical conditions (diabetes, HIV+, eplepsy, STDs)? ❒ Yes ❒ No _____

Are you currently taking any medications to treat these conditions? ❒ Yes ❒ No List medication and dosage:

Are you pregnant? ❒ N/A ❒ Yes ❒ No ❒ Not sure

Are there any current legal issues we should be aware of (probation, parole)? ❒ Yes ❒ No

Are you currently employed? ❒ Yes ❒ No How many hours per week on average? _____

Please describe your current living arrangements: _____

Other: _____

Is there anything else that you would like us to know?

Signature: _____

Date: _____

Parent/Guardian Signature:
(if under age 18) _____ Date: _____

Emergency Contact: _____ Phone # _____

For Office Use Only:

Reviewed by: _____ Date: _____

DW SIEVERT M.D., INC.

Authorization to Obtain Protected Health Information (PHI)

Patient Name: _____ Date of Birth: _____

I hereby authorize the use or disclosure of PHI on the above named individual which may contain medical, mental health, or substance abuse history and treatment information.

Name of organization or individual authorized to disclose the information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Are there any restrictions on PHI to be disclosed? ❒ Yes ❒ No

_____No one other than myself may have access to my medical records:

May our office leave a message on your answering machine? ❒ Yes ❒ No

I consent to the use or disclosure of my protected health information by DW SIEVERT M.D., Inc. for the purposes of diagnosis of providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of DW SIEVERT M.D., Inc. I understand that diagnosis or treatment of me by DW SIEVERT M.D., Inc. may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information (PHI) is used or disclosed to carry out treatment, payment or healthcare operations of the practice. DW SIEVERT M.D., Inc. is not required to agree to the restrictions that I may request. However, if DW SIEVERT M.D., Inc. agrees to restriction that I request, the restriction is binding on DW SIEVERT M.D., Inc. I have the right to revoke this consent, in writing, at any time, except to the extent that DW SIEVERT M.D., Inc. has taken action in reliance on this consent.

My PHI means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearing house. This PHI relates to my past, present or future physical or mental condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand that the "Notice of Privacy Practices" describes how DW SIEVERT M.D., Inc. may disclose and use my protected health information (PHI). I am encouraged to read the "Notice of Privacy Practices" in full.

Signature: _____ Date: _____
(Patient Signature or Authorized Representative and relationship)

Printed Name: _____

DW SIEVERT M.D., INC.

HIPPA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPPA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This is a read "friendly" version. A complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Print Patient Name: _____

Patient Signature: _____ Date: _____

Mental Health Intake Form

Please complete all information on this form and bring it to your first office visit.

Name _____ Date_____

Date of Birth _____ Primary Care Physician _____

Do you give permission for ongoing regular updates to be provided to your primary care physician?
❒ Yes ❒ No

Current Therapist/Counselor_____Therapist's Phone_____
Referred by:_____
What are the problem(s) for which you are seeking help?

1. _____
2. _____
3. _____

What are your treatment goals?

_____

_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

❒ Depressed mood
❒ Unable to enjoy activities
❒ Loss of interest
❒ Concentration/forgetfulness
❒ Increase in appetite
❒ Decrease in appetite
❒ Excessive guilt
❒ Fatigue
❒ Racing thoughts
❒ Increased libido
❒ Decreased libido
❒ Impulsivity
❒ Increased risky behavior
❒ Decreased need for sleep
❒ Increased need for sleep
❒ Excessive energy
❒ Increased Irritability
❒ Crying spells
❒ Excessive worry
❒ Anxiety attacks
❒ Avoidance
❒ Hallucinations
❒ Suspiciousness
❒ _____
❒ _____

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ❒ Yes ❒ No. If YES, please answer the following. If NO, please skip to the next section.
Do you currently feel that you don't want to live? ❒ Yes ❒ No
How often do you have these thoughts? _____
When was the last time you had thoughts of dying? _____
Has anything happened recently to make you feel this way? _____
On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____
Would anything make it better? _____
Have you ever thought about how you would kill yourself? _____
Is the method you would use readily available? _____
Have you planned a time for this? _____
Is there anything that would stop you from killing yourself? _____
Do you feel hopeless and/or worthless? _____
Have you ever tried to kill or harm yourself before? _____
Do you have access to guns? If yes, please explain. _____

_____

Past Medical History:

Medication Allergies_____ Current Weight _____ Height_____
❒ Mild ❒ Moderate ❒ Severe

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name	Total Daily Dosage	Estimated Start Date

Current over-the-counter medications or supplements: _____

_____

Current medical problems: _____

Past medical problems, nonpsychiatric hospitalization, or surgeries: _____

_____

_____

_____

Have you ever had an EKG? ❒ Yes ❒ No If yes, when _____

Was the EKG? ❒ normal ❒ abnormal ❒ unknown

For women only:

Date of last menstrual period: _____

Are you currently pregnant or do you think you might be pregnant? ❒ Yes ❒ No

Are you planning to get pregnant in the near future? ❒ Yes ❒ No
Birth control method_____ How many times have you been pregnant? _____
How many live births? _____

Do you have any concerns about your physical health that you would like to discuss with us? ❒ Yes ❒ No

Date and place of last physical exam: _____

_____

Personal and Family Medical History:	You	Family	Which Family Member?
Thyroid Disease	❒	❒	
Anemia	❒	❒	
Liver Disease	❒	❒	
Kidney Disease	❒	❒	
Diabetes	❒	❒	
Asthma/respiratory problems	❒	❒	
Stomach problems	❒	❒	
Cancer (type)	❒	❒	

	You	Family	Which Family Member?
Fibromyalgia	❒	❒	
Heart Disease	❒	❒	
Epilepsy (seizures)	❒	❒	
Chronic Pain	❒	❒	
High Cholesterol	❒	❒	
High blood pressure	❒	❒	
Head trauma	❒	❒	
Liver problems	❒	❒	
Other	❒	❒	

Is there any additional personal or family medical history? ❒ Yes ❒ No If yes, please explain:

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

Past Psychiatric History:

Outpatient treatment ❒ Yes ❒ No If yes, Please describe when, by whom, and nature of treatment.

Reason Dates Treated By Whom

Psychiatric Hospitalization ❒ Yes ❒ No If yes, describe for what reason, when and where.

Reason Dates Treated By Whom

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

	Dates	Dosage	Response/Side-effects
Antidepressants			
Prozac (fluoxetine)			
Zoloft (sertraline)			
Paxil (paroxetine)			
Celexa (citalopram)			
Lexapro (escitalopram)			
Effexor (venlataxine)			
Cymbalta (duloxetine)			
Wellbutrin (bupropion)			
Remeron (mirtazapine)			
Serzone (nefazodone)			
Anafranil (clomipramine)			
Pamelor (nortrptyline)			
Trofranil (imipramine)			

Past Psychiatric medications (continued)	Dates	Dosage	Response/Side-effects
Vilbryd			
Fetzima			
Prisiq			
Trazodone (desyrel)			
Elavil (amitriptyline)			
Other:			
Mood Stabilizers			
Tegretol (carbamazepine)			
Lithium			
Depakote (valproate)			
Lamictal (lamotrigine)			
Tegretol (carbamazepine)			
Topamax (topiramate)			
Latuda			
Invega			
Other:			
Antipsychotics/Mood Stabilizers			
Seroquel (quetiapine)			
Zyprexa (olanzepine)			
Geodon (ziprasidone)			
Abilify (aripiprazole)			
Clozaril (clozapine)			
Haldol (haloperidol)			
Prolixin (fluphenazine)			
Risperdal (risperidone)			
Other:			
Sedative/Hypnotics			
Ambien (zolpidem)			
Sonata (zaleplon)			
Rozerem (ramelteon)			
Restoril (temazepam)			
Other:			
ADHD medications			
Adderall (amphetamine)			
Concerta (methylphenidate)			
Ritalin (methylphenidate)			
Strattera (atomoxetine)			
Vyvanse			
Other:			
Anti-anxiety medications			
Xanax (alprazolam)			

Past Psychiatric medications (continued) Dates Dosage Response/Side-effects

Ativan (lorazepam) _____

Klonopin (clonazepam) _____

Valium (diazepam) _____

Tranxene (clorazepate) _____

Buspar (buspirone) _____

Other: _____

Your Exercise Level:

Do you exercise regularly? ❒ Yes ❒ No

How many days a week do you get exercise? _____

How much time each day do you exercise? _____

What kind of exercise do you do? _____

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	❒ Yes	❒ No	Schizophrenia	❒ Yes	❒ No
Depression	❒ Yes	❒ No	Post-traumatic stress	❒ Yes	❒ No
Anxiety	❒ Yes	❒ No	Alcohol abuse	❒ Yes	❒ No
Anger	❒ Yes	❒ No	Other substance abuse	❒ Yes	❒ No
Suicide	❒ Yes	❒ No	Violence	❒ Yes	❒ No

If yes, who had each problem? _____

_____

Has any family member been treated with a psychiatric medication? ❒ Yes ❒ No

If yes, who was treated, what medications did they take, and how effective was the treatment?

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ❒ Yes ❒ No

If yes, for which substances? _____

_____

If yes, where were you treated and when? _____

How many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? ____ What is the most? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

Have you ever felt you ought to cut down on your drinking or drug use? ❒ Yes ❒ No

Have people annoyed you by criticizing your drinking or drug use? ❒ Yes ❒ No

Have you ever felt bad or guilty about your drinking or drug use? ❒ Yes ❒ No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ❒ Yes ❒ No

Do you think you may have a problem with alcohol or drug use? ❒ Yes ❒ No

Have you used any street drugs in the past 3 months? ❒ Yes ❒ No If yes, which ones? _____

_____

Have you ever abused prescription medication? ❒ Yes ❒ No If yes, which ones and for how long? _____

_____

_____

Check if you have ever tried the following:

			If yes, how long and when did you last use?
Methamphetamine	❒ Yes	❒ No	
Cocaine	❒ Yes	❒ No	
Heroin	❒ Yes	❒ No	
LSD or Hallucinogens	❒ Yes	❒ No	
Marijuana	❒ Yes	❒ No	
Pain killers (not as prescribed)	❒ Yes	❒ No	
Methadone	❒ Yes	❒ No	
Tranquilizer/sleeping pills	❒ Yes	❒ No	
Ecstasy	❒ Yes	❒ No	
Alcohol	❒ Yes	❒ No	
Other	❒ Yes	❒ No	

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Tobacco History:

How many packs per day on average? _____ How many years? _____

In the past? ❒ Yes ❒ No How many years did you smoke? _____ When did you quit? _____

Pipe, cigars, or chewing tobacco: Currently? ❒ Yes ❒ No In the past? ❒ Yes ❒ No

What kind? _____ How often per day on average? _____ How many years? _____

Family Background and Childhood History:

Were you adopted? ❒ Yes ❒ No Where did you grow up? _____

List your siblings and their ages _____

_____

What was your father's occupation? _____

What was your mother's occupation? _____

Did your parents' divorce? ❒ Yes ❒ No If so, how old were you when they divorced? _____

If your parents divorced, who did you live with? _____

Describe your father and your relationship with him: _____

_____

Describe your mother and your relationship with her: _____

_____

How old were you when you left home?

Has anyone in your immediate family died? Who and when? _____

_____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect? ❒ Yes ❒ No

Please describe when, where and by whom: _____

_____

Educational History:

Highest Grade Completed? _____ Where: _____

Did you attend college? ❒ Yes ❒ No Where: _____

What is your highest educational level or degree attained? _____

Are you currently: ❒ Working ❒ Student ❒ Unemployed ❒ Disabled ❒ Retired

How long in present position? _____ What is/was your occupation? _____

Where do you work? _____

Have you ever served in the military? ❒ Yes ❒ No If so, what branch and when? _____

Honorable discharge ❒ Yes ❒ No Other type discharge: _____

Relationship History and Current Family:

Are you currently: ❒ Married ❒ Partnered ❒ Divorced ❒ Single ❒ Widowed How long? _____

If not married, are you currently in a relationship? ❒ Yes ❒ No If yes, how long? _____

Are you sexually active? ❒ Yes ❒ No

How would you identify your sexual orientation? ❒ straight/heterosexual ❒ lesbian/gay/homosexual ❒ bisexual ❒ transsexual ❒ unsure/questioning ❒ asexual ❒ other ❒ prefer not to answer

What is your spouse or significant other's occupation? _____

Describe your relationship with your spouse or significant other: _____

_____

Have you had any prior marriages? ❒ Yes ❒ No If so, how many? _____ How long? _____

Do you have children? ❒ Yes ❒ No If yes, list ages and gender: _____

_____

Describe your relationship with your children: _____

_____

_____

List everyone who currently lives with you: _____

_____

Legal History:

Have you ever been arrested? _____

Do you have any pending legal problems? _____

Spiritual Life:

Do you belong to a particular religion or spiritual group? ❒ Yes ❒ No

If yes, what is the level of your involvement? _____

Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ❒ more helpful ❒ stressful

Is there anything else that you would like us to know? _____

_____

_____

_____

_____

_____

Signature: _____

Date: _____

Parent/Guardian Signature:
(if under age 18) _____ Date: _____

Emergency Contact: _____ Phone # _____

For Office Use Only:

Reviewed by: _____ Date: _____