**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Best Phone Number to Contact you and leave a message: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Best way to contact you for appointment reminders? (circle one) email, call, text**

**Therapist Name, Address, and Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**May I share information with this person(s) about your mental health condition? Circle YES or NO**

**Please bring all medication bottles including supplements to your first appointment. Also, if you have any lab work from the past 12 months, medical records you would like reviewed, Neuro-Psych Testing Results, ADHD Evaluations, MRI Results, etc. Please bring all of this with you to your intake appointment. Knowing the names and dosages of your current medications is very important.**

**Medication Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please list all medications and dosages you are currently taking (please include over the counter medications, non-psychiatric medications, herbals and any nutritional supplements)

**PLEASE USE THE BACK OF THIS PAGE IF YOU NEED MORE ROOM FOR MEDICATIONS**

**Medications**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Primary Care Provider Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you see any specialist: Yes/ No**

Specialist Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specialty: Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you consider to be the top three stressors in your life?  
1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mood** *(past 1-2* weeks): Calm Happy Sad Anxious Angry Frustrated Worried Hopeless Helpless Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Behavioral Symptoms** *(circle problems in the past month):  
Sleep*  Enjoying Life *Motivation*  Fatigue *Guilt*  Poor Concentration *Appetite Change* Impulsiveness *Loss of Sex Drive* Racing Thoughts *Can't Stop Talking* Poor Judgment *Strange Thoughts or Behavior* Periods of Very High Energy *Periods of Very Low Energy*

**Mental Health History**

1. Have you been in counseling or mental health treatment before? *Yes / No*

(For example: Counselor, Psychiatrist, Psychologist, Marriage/Family Counselor):

2. Have you ever been hospitalized for mental or emotional problems? *Yes / No*

(For example: nervous breakdown, depression, suicide, mania, schizophrenia, anxiety, drug or

alcohol problems, etc): 3. Has anyone in your family had mental or emotional problems? (For example: nervous

breakdown, depression, suicide, mania, drug or alcohol problems, etc): *Yes / No*

4. Have you ever been referred to Social Services? *Yes / No*

**RISK ASSESSMENT** (Check appropriate line): No Yes Recently Today

1. Been so distressed you seriously wished to end your life? \_\_\_ \_\_\_ \_\_\_ \_\_\_
2. Have you had or do you have:

a. A specific plan of how you would kill yourself? \_\_\_ \_\_\_ \_\_\_ \_\_\_

b. Access to weapons/means of hurting self? \_\_\_ \_\_\_ \_\_\_ \_\_\_

c. Made a serious suicide attempt? \_\_\_ \_\_\_ \_\_\_ \_\_\_  
 d. Purposely have done something to hurt yourself? \_\_\_ \_\_\_ \_\_\_ \_\_\_

e. Heard voices telling you to hurt yourself? \_\_\_ \_\_\_ \_\_\_ \_\_\_

1. Had relatives who attempted or committed suicide? \_\_\_ \_\_\_ \_\_\_ \_\_\_
2. Had thoughts of killing or seriously hurting someone? \_\_\_ \_\_\_ \_\_\_ \_\_\_
3. Heard voices telling you to hurt others? \_\_\_ \_\_\_ \_\_\_ \_\_\_
4. Hurt someone or destroyed property on purpose? \_\_\_ \_\_\_ \_\_\_ \_\_\_
5. Slapped, kicked, punched someone with intent to harm? \_\_\_ \_\_\_ \_\_\_ \_\_\_
6. Been arrested or detained for violent behavior? \_\_\_ \_\_\_ \_\_\_ \_\_\_
7. Been to jail for any reason? \_\_\_ \_\_\_ \_\_\_ \_\_\_
8. Been on probation for any reason? \_\_\_ \_\_\_ \_\_\_ \_\_\_

**Physical Symptoms:** Circle any that have been a problem for you in the last month: *Headaches Dizziness Heart Pounding Muscle Spasms*  *Muscle Tension*  *Numbness*  *Chest Pains*  *Sweating*  *Shortness of Breath Sexual Problems*  *Tics/Twitches*  *Skin Problems*  *Rapid Heart Beat*  *Diarrhea*  *Fatigue*  *Nausea*  *Choking Sensations*  *Vision Changes*  *Fainting Blackouts*  *Chills/Hot Flashes*  *Stomach Aches Trembling/Shaking Mouth Muscle/Joint Pain*

**If Female:** Are you on any form of birth control? Yes / No

Are you, or is there a chance you might be, pregnant? Yes / No

When was your last menstrual period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History:** Check all that apply: **Childhood Adult Recently**

Serious Illnesses \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Serious Injuries \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Serious Head trauma \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

1. Do you currently have problems with pain? *Yes / No*If yes: Where is your pain located? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ how long have you had this pain problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ what things help your pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How intense is your pain today? ***(none)*** *0 I 2 3 4 5 6* 7 *8 9 IO* ***(worst)***Do you ever take more pain medication than prescribed? Yes / No  
Are you currently being treated by another doctor for your pain? Yes / No  
If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nutrition:**

Do you purge, restrict, or overeat? *Yes / No*Have you had any difficulties or concerns related to food intake? *Yes / No*

**Social History**

1. Are your parents divorced? *Yes / No* If yes, how old were you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Briefly describe your childhood *(happy, chaotic, troubled):* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Are childhood events contributing to current problems? *Yes / No*

4. Current Marital Status: *Single Married Divorced Widowed Separated*

5. Number of Years Married: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Total Number of Marriages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Do you have any children? *Yes / No* Ages? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Have you experienced any abuse (physical, sexual, verbal) *Yes / No*

**Social Support**

How satisfied are you with the support you receive from your family/Friends? *Very Unsatisfied* Unsatisfied *Satisfied* Very Satisfied

Have your current difficulties affected your relationships with family/friends/coworkers? *Yes / No*

**Quality of Life:**

Are you satisfied with your quality of life? *Very Unsatisfied* Unsatisfie*d Satisfied* Very Satisfied

Are you able to enjoy leisure/recreational activities? *Yes / No*If no, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Education History:**

Years of education completed? \_\_\_\_\_\_\_\_\_ Degree(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Job History**

1. How many jobs: Have you held? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Been fired from? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How satisfied are you with your current occupation? *Very Unsatisfied* Unsatisfied *Satisfied* Very Satisfied

3. Do you have performance problems or difficulties with your boss? *Yes / No*

**Alcohol Use:** Do you or did you: **In the Past Recently**  
1. Regularly use alcohol (more than twice per month)? Yes/No Yes/No

2. Had trouble (legal, work, family) because of alcohol? Yes/No Yes/No

3. Felt you should cut down on your drinking? Yes/No Yes/No  
4. Been annoyed by people criticizing your drinking? Yes/No Yes/No

5. Felt bad or guilty about your drinking? Yes/No Yes/No  
6. Ever had a drink first thing in the morning? Yes/No Yes/No

**Other Substance Use/Abuse** Do you or did you? **In the Past Recently**

1. Use medications (other than over the counter) that were not prescribed to you? Yes/No Yes/No  
2. Taken more than the recommended daily dose of an over the counter medication? Yes/No Yes/No

3. Taken more than the prescribed dose of your prescription medication? Yes/No Yes/No  
4. Taken or used any illegal substance? Yes/No Yes/No  
5. Used any product or other means to get "high"? Yes/No Yes/No

**Habits:**

1. Do you smoke or chew tobacco regularly? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How many caffeinated drinks do you have per day (coffee, tea, sodas)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. How often do you exercise per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Exercise: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Do you have problems with gambling?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Do you have other potentially harmful habits you want to change? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Goals for Treatment:**

What are your goals for treatment? In other words, what things would you like to see change or be different about yourself? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian Signature (if under 18): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been treated with any of the following medications? Circle all that apply and list any good or bad effects of the medications. If you do not see a medication you have taken, please write it in the margins. If you remember when you took these medications, the doses you used, that would be helpful as well. Sometimes you can get a list from your previous provider or from the pharmacy where you filled the prescriptions.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Medication | Good/Bad Effects | Medication | Good/Bad Effects | Medication | Good/Bad Effects |
| Abilify |  | Librium |  | Topamax |  |
| Ambien/Zolpidem |  | Lithium |  | Tranxene |  |
| Adderall |  | Lunesta |  | Trazodone |  |
| Anafranil/Clomipramine |  | Luvox/Fluvoxamine |  | Trileptal/  Oxcarbazepine |  |
| Antabuse |  | Marplan |  | Trintellix |  |
| Ascendin |  | Mellaril |  | Valium |  |
| Atarax |  | Methadone |  | Viibryd |  |
| Ativan |  | Nardil |  | Vistaril |  |
| Belsomra |  | Norpramine |  | Vivitrol |  |
| Buspar/Buspirone |  | Orap |  | Vraylar |  |
| Campral |  | Pamelor |  | Vyvanse |  |
| Celexa/Citalopram |  | Parnate |  | Wellbutrin/Bupropion |  |
| Chloral Hydrate |  | Paxil/Paroxetine |  | Xanax/Alprazolam |  |
| Clonidine |  | Prosom |  | Zoloft/Sertraline |  |
| Clozaril |  | Propranolol |  | Zyprexa/Olanzapine |  |
| Cogentin |  | Prozac/Fluoxetine |  |  |  |
| Concerta/Methylphenidate |  | Pristiq |  | Tenex/Guanfacine |  |
| Dalmane/Flurazepam |  | Prolixin |  | Spravato |  |
| Depakote/Divalproex |  | Remeron/Mirtazapine |  | Mydayis |  |
| Dexedrine |  | Restoril/Temazepam |  |  |  |
| Doral |  | Rexulti/Brexpiprazole |  |  |  |
| Doxepin |  | Risperdal/Risperidone |  |  |  |
| Effexor/Venlafaxine |  | Ritalin/Methylphenidate |  |  |  |
| Elavil/Amitriptyline |  | Saphris |  |  |  |
| Fanapt |  | Serax |  |  |  |
| Focalin |  | Seroquel/Quetiapine |  |  |  |
| Geodon/Ziprasidone |  | Serzone |  |  |  |
| Halcion |  | Soma |  |  |  |
| Halcion |  | Sonata |  |  |  |
| Haldol/Haldoperidol |  | Stelazine |  |  |  |
| hydroxyzine |  | Strattera |  |  |  |
| Klonopin/Clonazepam |  | Suboxone/Subutex |  |  |  |
| Invega/Paliperidone |  | Symmetrel |  |  |  |
| Lamictal/Lamotrigine |  | Tegretol |  |  |  |
| Latuda |  | Thorazine |  |  |  |
| Lexapro/Escitalopram |  | Tofranil/Imipramine |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

Policy Consent Form

Patient Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

**Fees: All payments for services are due at the time of service.**

**Cash pay rates are as follows**:

* Initial psychiatric evaluation (60-90 minutes): $320
* 15-minute follow-up Psychiatry Medication Management: $125
* 30-minute follow-up Psychiatry Medication Management/brief therapy: $175
* Telepsychiatry rates will generally be discussed with the patient depending on length of time the patient requires.
* A 15% discount will be given to patients who prepay/pay ahead of time instead of carrying over any balance amount.
* **Phone calls:** Brief phone calls {usually less than 5 minutes) to cover issues such as scheduling appointments, reactions to new medications, returning my phone call to you, etc., will not be charged. Extended phone calls or multiple phone calls may be billed an average of $60/15 minutes, and this will be discussed with the patient on a case-by-case basis. All questions or concerns should be brought up at the scheduled appointment. Phone call returns or refill requests can take 2-3 days.
* **Refills:** If you are taking medication, you agree to take medication only as prescribed and not intake any alcohol or illicit drugs. All medication refills should be taken care of at the scheduled appointment. Requests for refills outside of the scheduled appointment time will be charged a fee of $50 per request for a 30-day supply. For a “no-show” appointment or less than 24-hour cancellation refill request, the $50 fee will be charged and a follow-up appointment must be scheduled with the amount of medication called in being enough to get you to that appointment only. For “no-show” or less than 24-hour cancellation appointments, no controlled substances will be refilled until the patient is seen unless this has already been discussed between the provider and patient. Controlled medication refills will only be called in or given during business hours. No refills will be called in after 2PM on Friday. Refill requests made on weekends or holidays will not be accommodated until the office reopens during the normal business hours. You are responsible for monitoring your supply. Controlled medications will not be refilled early if you run out or lose your prescription.
* **Reports, Consultations, and Other Special Documentation:** In the rare circumstance that my services are needed to prepare specific reports or documentation beyond a routine office appointment, the rate will be $300/hour. These services, if needed, will be fully discussed with the patient prior to the service being provided.  
  Cancelled appointments with less than 24 hour notice and no-shows will be billed to you at the full rate of the scheduled visit. This includes the first appointment and you may be asked to provide credit information to hold your first appointment.
* **IT IS EXPECTED THAT PATIENTS WILL NEED TO HAVE A CREDIT CARD ON FILE.**

**Cancellation policy:** Appointments must be cancelled with at least a 24-hour notice. Cancellations made less than 24 hours or missed appointments without notice ("no-shows") will be billed at the full rate of the scheduled visit. Late arrivals will be billed at the full rate without extending the scheduled appointment, and another appointment may be required to complete the service.

**Past Due Accounts:** Payment is due at time of service. Accepted methods of payment include cash, credit card, debit card, and PayPal. There will be a $25 additional charge on all insufficient funds added to the full service fee plus any bank charges. Failure to make payment will result in late fees and possible suspension or termination of treatment. Accounts with more than 90 days balance will be assessed a $25 billing fee per month starting with the first month. Past due accounts may be referred to collections-and will include the amount owed plus reasonable attorney fees and court costs.

**Collaboration of Care with Other Providers:** Communication with other care providers, including your family doctor, therapist, or other clinicians is strongly recommended for the best possible treatment outcome. Please provide their contact information and your consent to communicate with them. Only essential and pertinent medical information will be shared with your providers in accordance with privacy laws. Please talk to me about any concerns.

**Important health information for females-Pregnancy:** All medications pose some danger to the fetus or breast­-feeding child. If you are pregnant, feel you may be pregnant, decide to become pregnant, or no longer practice regular birth control, you must notify me as soon as possible so that we can discuss this in advance of a pregnancy. Waiting until you are pregnant may unnecessarily expose the fetus to dangerous medication. Sometimes, the risks of not treating mental illness are greater than the risks of the medication, but treatment will still only be with the consent of the patient, and you will be asked to sign a written consent stating that you understand the risks before treatment is given.

**Expectation of Treatment Compliance:** Repeated cancelled appointments, at least 2 no-shows/cancellations under 24 hours in a 12-month time frame, or not adhering to the treatment plan such as not taking medication as prescribed or not following through with therapeutic recommendations will disrupt the plan for treatment. If it becomes evident that there is a recurrent pattern of these issues, the first step will be to discuss solutions to see if this is something that can be worked through. If the issues persist after this step, it will be recommended that you seek care with another provider.

**Abuse of Prescription Medications:** Abuse or misuse of medication prescribed by this office to you will not be tolerated. This not only includes taking more medication than prescribed or recommended, but also selling your medication to others, obtaining duplicate prescriptions for controlled substances without our consent, using narcotics while taking your prescribed medication with our knowledge, or buying prescription medication "off the street." At a minimum, if this occurs you will be requested to seek care with another provider, but there may also be risk of legal consequences. Controlled substances will be monitored by the KY Prescription Drug Monitoring Program.

**Photo Copies and Electronic Signatures:** A photocopy of any signed form will be considered as an original copy. An electronic signature will be considered the same as a signature by hand.

**Doctor's Absences and After-Hours Calls:** Any upcoming vacations or other absences will be discussed at scheduled appointments and posted on the office website to help you in planning follow-up appointments and for medication refills. Phone calls will be returned within 24-72 hours except on Friday afternoons and when the office is closed. As noted above, brief telephone calls are not charged, however repeated phone calls and extended calls may result in fees. **This is an outpatient psychiatric practice. We do not provide crisis services, after hour’s consultation, or on-call services. If you have a psychiatric emergency call 911 or go to your nearest emergency department.**

**Privacy, Confidentiality, and Safety:** Personal information shared with us during our sessions is confidential and not shared with anyone without a signed release of information, except under specific legal and safety concerns as defined by laws. If there is an indication of child abuse, risk of danger to self, or risk of danger to others, we are legally bound to report the concerns to the appropriate authorities. As noted above, communication with your other care providers including your family doctor, therapist, or other clinicians is strongly recommended for the best possible treatment outcome. Please provide their contact information and your consent to communicate with them. Only essential and pertinent medical information will be shared with your providers in accordance with privacy laws. Your signed consent is necessary for us to be able to communicate with them.

Consent for Treatment

I consent to and authorize the attending physician, physician's assistant, and/or nurse practitioner to perform healthcare examinations, treatment, and diagnostic testing as deemed medically necessary in their professional judgment.

1. I have read and understand my responsibilities as outlined by the policies of Free To Be Mental Health Services, LLC office as outlined on wwww.free2bmhs.com
2. I acknowledge receipt of the HIPAA Notice of Privacy Practices.
3. I have read and understand the above information.
4. I agree to the terms of the office payment and cancellation policies

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PATIENT SIGNATURE DATE