Lesley Arle RN, MN, PMHNP-BC
LL Arle PMHNP PC
3392 Basswood St. NW Salem, OR 97304
Tele: 503-339-7595 Fax: 503-385-1129

REGISTRATION/CLIENT HISTORY

Full LegalName_____Date_____

Birth Date_____ Age now_____ Gender ☐M ☐F SS#_____

Address_____

City_____ St._____ ZIP_____

Relationship Status
☐Single ☐Married ☐Partner ☐Divorced ☐Widowed ☐ Separated

Employer/School_____

Job/Title/Occupation_____

Spouse/Partner Name_____ Birth Date_____

Spouse/Partner Employer_____ Work Phone_____

CONTACT PREFERENCES

Phone(H)_____ (W)_____(C)_____

☐ ok to leave message	☐ ok to leave message	☐ ok to leave message
☐ with details	☐ with details	☐ with details
☐ with call back # only	☐ with call back # only	☐ with call back # only

Emergency Contact/Relationship _____ Phone_____

Written Communications
☐ ok to mail to home address above ☐ ok to fax to_____

☐ ok to mail to work/office address_____

E-mail ☐ ok to e-mail to_____

Other Contact Info We Should Know_____

Signature_____**Date**_____

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Client Name_____

MEDICAL CARE PROVIDERS
(Phone and fax numbers are important for us to get your records)
Name_____Phone_____Fax_____
Address_____

Name_____Phone_____Fax_____
Address_____

MENTAL HEALTH CARE PROVIDERS
Name_____Phone_____Fax_____
Address_____

Name_____Phone_____Fax_____
Address_____

PHARMACY CONTACT INFO
Name_____Phone_____Fax_____
Address_____

INSURANCE INFORMATION
(Primary Insurance)
Insurance Company_____
Address_____City_____St._____Zip_____
Contact #_____Group #_____Subscriber#_____
Primary Insurance Holder_____
Relationship to Client_____ Birth Date_____ SS#_____
Phone_____
Address (if different from client)_____
City_____St._____Zip_____
Employed By_____
Occupation_____

(Secondary Insurance)
Insurance Company_____
Address_____City_____St._____Zip_____
Contact #_____Group #_____Subscriber#_____
Primary Insurance Holder_____
Relationship to Client_____ Birth Date_____ SS#_____
Phone_____
Address (if different from client)_____
City_____St._____Zip_____
Employed By_____
Occupation_____

Effective Date of Insurance_____
Authorization Required?_____ If so, Auth #_____
Deductible for Individual_____ Deductible for Family_____ Deductible Met?_____
Insurance pays _____% of therapy. Client pays _____% of therapy.
Estimated Co pay_____

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Client Name_____

AUTHORIZATION TO RELEASE INFORMATION/ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize Lesley Arle, PMHNP to:

1) Furnish my insurance company with all/any information requested concerning my present claim(s), including records if requested.
2) Bill my primary insurance company, and to accept payment from that company on my behalf, for all services regarding my care.

I acknowledge:

1) I am responsible for all usual and customary fees for all services provided, including counseling sessions, correspondence, consultation, and telephone contact provided on my behalf.
2) I will make my payments by the conclusion of the session. Any amounts due past 90 days without an acceptable payment plan made with this office may cause me to be contacted by a collection agency. I will also owe all the costs incurred in the collection process.
3) If I have insurance coverage, I will pay the deductible or co-pay at the time of the session. Payment may be made cash, check or accepted credit card (Visa or MasterCard only). I understand that your office does not accept responsibility for collecting disputed or unpaid claims by the insurance company.
4) I understand that I am liable for the full fee for any scheduled appointment cancelled without 24 hours notice unless I develop an illness within that time period, in which case I will notify you immediately.
5) I understand that the client's physical boundaries will be respected and that dating or sexual contact between client and therapist in any place or at any time, now or in the future, is inappropriate.

Patient's Signature Date

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Client Name_____

I authorize the following people/organizations to have access to my information. (Please print name(s) of those who have access to the specified information, *along with your initials*, showing you have released this information to them. Be sure to include your spouse if you wish them to make appointments or have access to clinical or financial information.)

Clinical Information	Scheduling Information	Financial Information
1.	1.	1.
2.	2.	2.
3.	3.	3.

Signature_____**Date**_____

REASON FOR COMING IN TODAY/CURRENT PROBLEMS:

DESCRIBE BREIFLY WHAT CHANGES YOU ARE HOPING TO MAKE BY COMING TO THERAPY NOW:

IS THERE ANYTHING ELSE YOU THINK I SHOULD KNOW?

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Client Name_____

CURRENT PSYCHIATIRIC MEDICATIONS

Please include any medication (including herbs, natural products, etc.) that you are taking for depression, anxiety or any other nervous condition or psychiatric symptoms.

Name of Medications	Dose

PAST PSYCHIATRIC MEDICATIONS

Please list any medications you have taken in the past (including any herbs, natural products, etc.) for depression, anxiety or any other nervous condition or psychiatric symptoms.

Name of Medications	Dose

CURRENT NON-PSYCHIATIRIC MEDICATIONS

Please include any medication (including herbs, natural products, etc.) that you are taking for any medical condition (for example pain, infection, high blood pressure, diabetes, etc.)

Name of Medications	Dose

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Client Name_____

PAST NON-PSYCHIATIRIC MEDICATIONS

Please include any medication (including herbs, natural products, etc.) that you are taking for any medical condition (for example pain, infection, high blood pressure, diabetes, etc.)

Name of Medications	Dose

SELF AND FAMILY MEDICAL AND PSYCHIATRIC PAST ILLNESSES

Do you or does any **blood relative** have a history of any of the following illnesses? If so, please check any boxes next to the illnesses that apply.

Anemia	☐ self ☐ family	Thyroid Disease	☐ self ☐ family
Asthma	☐ self ☐ family	High Blood Pressure	☐ self ☐ family
Cancer	☐ self ☐ family	Alcoholism	☐ self ☐ family
Diabetes	☐ self ☐ family	Other Neurological	☐ self ☐ family
Stroke	☐ self ☐ family	Drug Abuse/Dependency	☐ self ☐ family
Seizures	☐ self ☐ family	Anxiety	☐ self ☐ family
Head Injury	☐ self ☐ family	Headaches	☐ self ☐ family
HIV	☐ self ☐ family	Depression	☐ self ☐ family
Liver disease, hepatitis	☐ self ☐ family	Bipolar Illness	☐ self ☐ family
Heart Disease/CHF/CAD	☐ self ☐ family	Schizophrenia	☐ self ☐ family
Lung Disease/COPD, etc	☐ self ☐ family	Other_____	☐ self ☐ family
Kidney Disease	☐ self ☐ family	Gambling, internet, hair-pulling, eating, sexual	☐ self ☐ family
disorders/problems			

HISTORY OF PAST THERAPY AND PSYCHIATRIC HOSPITALIAZATION

Please include hospitalization for any surgeries, medical and psychiatric illness.

Hospital/Provider Name	Date	Effective?

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Client Name_____

ALLERGIES
Please list any medication, food and/or environmental allergies.

_____
_____
_____
_____

HEIGHT_____ WEIGHT_____
RACE/ETHNICITY_____

DRUG AND ALCOHOL HISTORY
Do you use caffeine? ☐Y ☐N Which products and how often?_____
Do you use tobacco? ☐Y ☐N Which products and how often?_____
Do you or did you use recreational drugs? ☐Y ☐N
Do you or did you use alcohol? ☐Y ☐N

Name of Drug/Alcohol	Amount	Dates Taken (Start and Stop Dates)

Are your problems affecting any of the following? (Check all that apply)

☐Handling everyday tasks	☐Recreational activities	☐Legal problems	☐Hygiene
☐Work/school	☐Self-esteem	☐Relationships	☐Health
☐Housing	☐Sexual activity	☐Finances	☐Safety

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Client Name_____

Please rate the importance of the following concerns as they apply to you now. If the issue is NOT a problem for you please leave it blank.

Mild = 1 Moderate = 2 Serious = 3 Severe = 4 Extreme = 5

_____Upset stomach	_____Low self worth	_____Crying spells
_____Family problems	_____ Sweating	_____Withdrawal from people
_____Relationship problems	_____ Loss of pleasure/interest	_____Lightheaded/dizzy
_____Seasonal mood changes	_____Hyperactivity	_____Impulsivity
_____Very talkative	_____Problems at work/school	_____Too many drugs
_____Anxiety/worry	_____Health problems	_____ Excessive alcohol use
_____Suspicion/paranoia/fear	_____Racing thoughts	_____Financial problems
_____Loneliness	_____Poor memory/confusion	_____Flashbacks
_____ Guilt and or shame	_____Legal problems	_____Difficulty making friends
_____Anger/frustration	_____Sadness/depression	_____Nightmares
_____Trouble sleeping	_____Sleeping too much	_____Loss of/change in appetite
_____Sexual problems	_____Fatigue	_____Excessive energy
_____Lack of motivation	_____Difficulty focusing	_____Restlessness/can't sit still
_____Feel ignored/abandoned	_____Pain	_____Frequent arguments
_____Hopelessness	_____Self-harm behaviors	_____Suicidal feelings
_____Thoughts of hurting others	_____Dwelling on problems	_____Loss/gain of weight
_____Obsessive thoughts	_____Social discomfort	_____Aggressive behavior
_____Nervous/tense	_____Panic attacks	_____Shaky/trembling
_____Feeling used by others	_____Hard to/not able to trust	_____Coping with divorce
_____Trouble breathing	_____Hot or cold spells	_____Problems controlling urges
_____Problems controlling thoughts	_____Frequent mood changes	_____Seeing/hearing things others do not

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CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION (PRIMARY CARE)

I, _____DOB_____, hereby authorize Lesley Arle, PMHNP
_____ ☐ To give health records, _____ ☐ To receive health records from
_____ ☐ To exchange verbal information with
Name _____
Address_____
City, State & Zip_____

This information may be used for the following purpose(s):
_____ ☐ Evaluation/assessment, treatment and/or_____
_____ ☐ For the purpose of continuing care and/or_____

Information to be released:
_____☐ All information in the chart
_____☐ Specific information to be released _____

By initialing the spaces below, I specifically authorize the release of the following health information, if such information exists:
_____Mental health related information _____Medical evaluations
_____Genetic testing information _____HIV/AIDS related records
_____Drug/alcohol diagnosis, treatment referral information

As indicated below, the authorization for release extends to care and treatment the client received during:
_____☐ All dates of service _____☐ Service between _____ and _____
This written consent is subject to revocation by the undersigned at any time, except to the extent that action has been taken in reliance hereon. If not earlier revoked, or by other agreement specified below, this consent shall expire in one year or upon
(insert date or event)_____.

Signature_____
Date_____

Signature of Personal Representative_____
Date_____ **Relationship to Client**_____

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CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION
(NON-PRIMARY CARE/OTHER)

I, _____DOB_____, hereby authorize Lesley Arle, PMHNP
_____ ☐ To give health records, _____ ☐ To receive health records from:
_____ ☐ To exchange verbal information with
Name _____
Address_____
City, State & Zip_____

This information may be used for the following purpose(s):
_____ ☐ Evaluation/assessment, treatment and/or_____
_____ ☐ For the purpose of continuing care and/or_____

Information to be released:
_____☐ All information in the chart
_____☐ Specific information to be released _____

By initialing the spaces below, I specifically authorize the release of the following health information, if such information exists:
_____Mental health related information _____Medical evaluations
_____Genetic testing information _____HIV/AIDS related records
_____Drug/alcohol diagnosis, treatment referral information

As indicated below, the authorization for release extends to care and treatment the client received during:
_____☐ All dates of service _____☐ Service between _____ and _____
This written consent is subject to revocation by the undersigned at any time, except to the extent that action has been taken in reliance hereon. If not earlier revoked, or by other agreement specified below, this consent shall expire in one year or upon
(insert date or event)_____.

Signature_____ **Date**_____

Signature of Personal Representative_____
Date_____ **Relationship to Client**_____