PATIENT REGISTRATION

Sunshine Psychiatry, LLC

Please answer the following questions to the best of your abilities. These questions are to help the practitioner with the evaluation process. This information is held to our high standards of confidentiality. This questionnaire will take approximately 30 minutes to complete.

Client Information

Last Name:____ First Name:____________________________________ Initial:_______

Birth date: _____/_____/_____ Age:_______ Gender: ____ Male _____Female

Address:____ City:__________________________ State:______ ZIP:__________

Email:____

Phone number: ____

Primary Insurance:____ ID#:____

Subscriber Name:____

Secondary Insurance:____ ID#:____

Referred by:____ Phone: (_____) _______ - __________

Assignment of Benefits:

I herby assign, transfer, and convey all medical benefits to be paid directly to Sunshine Psychiatry, LLC and recognize it is my responsibility to pay for all non-covered services. I also authorize Sunshine Psychiatry, LLC, to release any information necessary to process an insurance claim in the event the patient is a minor, a parent or guardian who will be responsible for the payment of the bill, must accompany the patient. A photocopy of this Assignment will be considered as valid as the original.

Signature:____ Date:____________________________________

HIPPA COMPLIANCE NOTICE

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide only the minimum information on your health care information, treatment, treatment information, payment or health care operations in order to provide health care that is in your best interest. We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories, that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent. You may refuse to consent to the use of disclosure of your Personal Health Information (PHI). If you choose to give consent in this document at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previous signed consent. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Signature:____________________________________ Print Name:_____________________________________ Date:___________

MEDICAL HISTORY

Height: ________________________ **Weight:**________________________

Describe your problem:

____

____

____

Date of Onset: ____

How long has this been going on: ____

Primary Care Physician: ____

Name(s) of other Physician(s) currently seeing: ____

Pharmacy:____ **Phone:** (_____) _______ - __________

Please list all previous operations

Surgery	Approximate Date	Surgeon	Hospital

Past Major Medical Problems:____

Please check if you are currently receiving treatment or have received treatment in the past:

____ Anemia	____ Arthritis	____ Asthma	____ Birth Defects
____ Bleeding Problems	____ Cancer	____ Currently Pregnant	____ Diabetes
____ Epilepsy	____ Eye Problems	____ Hearing Problems	____ Heart Disease
____ Hepatitis	____ Intestinal/gastro	____ Kidney Disease	____ Migraines
____ Phlebitis (blood clots)	____ Rheumatic/Scarlet Fever	____ STD	____ Skin disorder
____ Thyroid Disease	____ Other		

MEDICATIONS	**DOSAGE**	**HOW LONG**	**PRESCRIBING PHYSICIAN**

DRUG ALLERGIES

Drug	**Physical Reaction**

INTAKE QUESTIONNAIRE FOR NEW PATIENTS (Adult)

Marital Status: single married separated divorced

Remarried engaged widowed cohabitating

If applicable, please complete the following:

Partner's name:____ Partners age:_______

Partner's Occupation:____

IF YOU HAVE CHILDREN PLEASE LIST THEIR NAMES AND AGES:

#	Name	Sex	Age	#	Name	Sex	Age
1				4			
2				5			
3				6			

WHO CURRENTLY LIVES IN YOUR RESIDENCE (adults and children)

#	Name	Relation	Sex	Age	#	Name	Relation	Sex	Age
1					4				
2					5				
3					6				

What made you come in at this time?____

____

____

What do you hope to gain from this evaluation and/or counseling?____

____

____

SYMPTOMS

Please **check** any symptoms or experiences that you have had **in the last month:**

____ Difficulty falling asleep
____ Difficulty staying asleep
____ Difficulty getting out of bed
____ Not feeling rested in the morning
____ Nightmares
____ Night terrors
Average hours of sleep per night_______________

____ Persistent loss of interest in previously enjoyed activities
____ Withdrawing from other people
____ Spending increased time alone
____ Sadness
____ Feeling Numb
____ Worthlessness
____ Hopelessness
____ Helplessness
____ Decreased motivation
____ Frequent feelings of guilt
____ Outbursts of anger
____ Irritability
____ Difficulty concentrating or thinking
____ Rapid mood changes
____ Self-mutilation / cutting
____ Thoughts about harming or killing yourself
____ Thoughts about harming or killing someone else
____ Increased energy
____ Decreased energy

____ Anxiety
____ Increased muscle tension
____ Difficulty leaving your home
____ Difficulty catching your breath
____ Tremors
____ Fear
____ Dizziness
____ Frequent worry
____ Unusual sweating
____ Panic attacks
____ Racing thoughts
____ Intrusive memories
____ Repetitive behaviors or mental acts (i.e. counting, checking doors, washing hands)
____ Fear of certain objects or situations (i.e. flying, heights, bugs) Describe:________________________________
____ Avoiding people, places, activities or specific things

____ Experienced/witness Traumatic event
____ Persistent re-experiencing traumatic event
____ Flashbacks
____ Easily started, felling “jumpy”
____ Avoidance behavior
____ Increased vigilance/easily startled

____ Feeling as if you were outside yourself, detached, observing what you are doing
____ Feeling puzzled as to what is real and unreal
____ Persistent, repetitive, intrusive thoughts, impulses, or images
____ Unusual visual experiences such as flashes of light, shadows

____ Physical sensations others don't have

____ Hear voices when no one else is present

____ Feeling that your thoughts are controlled or placed in your mind

____ Feeling or acting like a different person

____ Feeling that the television or the radio is communicating with you

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____ Difficulty problem solving

____ Dependency on others

____ Inappropriate expression of anger

____ Difficulty or inability to say "no" to others

____ Sense of lack of control

____ Abusive relationship

____ Concerns about your sexuality

____ Difficulty meeting role expectations

____ Manipulation of others to fulfill your own desires

____ Large gaps in memory

____ Ineffective communications

____ Decreased ability to handle stress

____ Difficulty expressing emotions

____ Changes in eating/appetite

____ Eating more

____ Voluntary vomiting

____ Excessive exercise to avoid weight gain

____ Are you trying to lose weight?

____ Weight gain: ________ lbs.

____ Excessive exercise

____ Eating Less

____ Use of laxatives

____ Binge eating

____ Weight loss: ________ lbs.

Sexual Orientation: ____ Heterosexual ____ Homosexual ____ Bisexual ____ I choose not to answer

Please describe any other symptoms or experiences you have had problems with:

____

____

____

____

Have you seen a counselor, psychologis, psychiatrist or other mental health professional before?

____ NO ____ YES If so:

Name of therapist:______________________________________ Dates of Treatment

Reason for seeking help:________________________________ ______________________________

Name of therapist:______________________________________ Dates of Treatment

Reason for seeking help:________________________________ ______________________________

Name of therapist:______________________________________ Dates of Treatment

Reason for seeking help:________________________________ ______________________________

Are you **CURRENTLY** taking **PSYCHIATRIC** medication? ____ NO ____ YES If YES, please list:

Medication	Dosage	How long have you beenTaking it?	Has it been helpful?

Are you CURRENTLY taking NON-PSYCHIATRIC medication? ____ NO ____ YES If YES, please list:

Medication	Dosage	How long have you been taking it?

Have you been on PSYCHIATRIC medication in the past? ____ NO _____ YES If YES, please list:

Medication	Dosage	First/Last time you took it	Effect of Medication

Have you been hospitalized for psychiatric reasons? ____ NO ____ YES If YES, describe:

Hospital	Dates	Reason

Have you attempted suicide? ____ NO ____ YES If YES, describe:

____

____

____

Have engaged in any self-harm behaviors? ____ NO ____ YES If YES, describe:_______________________________

____

EMPLOYMENT

Are you currently employed?__________

If yes, employer's name:____

What type of work do you do?___________________________________

Employment History (most recent first):

Type of Job	Dates	Reason for Leaving

Have you been arrested?__________

If yes, please describe:____

Do you have a religious affiliation? ____

If yes, what is it?____

What kind of social activities do you participate in? ____

Who do you turn to for help with your problems?____

Have you ever been abused?

____ Verbally ____ Emotionally ____ Physically ____ Sexually ____ Neglected

Please describe: ____

____

____

FAMILY HISTORY

FATHER: Age:_____ ____ Living ____ Deceased Cause of death:_______________________________

If deceased, HIS age at time of his death: _____ YOUR age at time of his death:_________________________________

Occupation:______________________________ Health:____

Frequency of contact with him:_____________ Are you/have you been close to him?____________________________

MOTHER: Age:_____ ____ Living ____ Deceased Cause of death:_______________________________

If deceased, HER age at time of her death:____ YOUR age at time of her death:_________________________________

Occupation:_____________________________ Health:____

Frequency of contact with her:_____________ Are you/have you been close to her?____________________________

BROTHERS and SISTERS:

Name	Sex	Age	Whereabouts	Are you close to him/her	
				YES	NO
				YES	NO
				YES	NO
				YES	NO

During your childhood, did you live any significant period of time with anyone other than you natural parents? ____ NO ____ YES

If so, please give the person's name and relationship to you

Name:____ Relationship:_____________________________

Please place a check mark in the appropriate box if these are or have been present in your relatives:

	Children	Brothers	Sisters	Father	Mother	Uncle/Aunt	Grandparents
Nervous problems							
Depression							
Hyperactivity							
Counselling							
Psychiatric Medication							
Psychiatric Hospitalization							
Suicide Attempt							
Death by Suicide							
Drinking Problem							
Drug Problem							

SUBSTANCE ABUSE

Alcohol

Do you drink alcohol?________________ If yes, age of first use:______________________

How much do you drink?_____________

How often do you drink?_____________

Have you ever passed out from drinking?_____________ How often?___________________________

Have you ever blacked out from drinking?_____________ How often? __________________________

Have you ever had the "shakes"? ___________________ How often?__________________________

Have you ever felt you should cut down on your drinking / drug use?_____________________________________

Have people annoyed you by criticizing your drinking / drug use?____

Have you ever felt bad or gulty about your drinking / drug use?____

Have you ever drank / used drugs in the morning to steady your nerves or relieve a hangover?___________________

Do you use tobacco?________________________ If yes, how often?___________________

Other Drugs

Please indicate for each drug listed below:

Drug	Ever used?	Age at 1st use	Time Since Last Use	Approx use in last 30 days
Marijuana				
Cocaine				
Crack				
Heroin				
Methamphetamine				
Ecstasy				

Is there anything else you would like us to know about you?:

SUNSHINE PSYCIATRY, LLC

PATIENT HEALTH QUESTIONNAIRE

NAME:____ DATE:______________________________

Date of Birth: ____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "X" to indicate your answer)	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**
Trouble falling or staying asleep, or sleeping too much	**0**	**1**	**2**	**3**
Feeling tired or having little energy	**0**	**1**	**2**	**3**
Poor appetite or overeating	**0**	**1**	**2**	**3**
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	**0**	**1**	**2**	**3**
Trouble concentrating on things, such as reading the newspaper or watching television	**0**	**1**	**2**	**3**
Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	**0**	**1**	**2**	**3**
Thoughts that you would be better off dead, or of hurting yourself	**0**	**1**	**2**	**3**
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card)	Add columns	**+**	**+**	
	TOTAL:			

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	
	Not Difficult ___________
	Somewhat Difficult ___________
	Very Difficult ___________
	Extremely Difficult ___________

SUNSHINE PSYCHIATRY, LLC

Patient's Name:____ Date:____________________________

Date of Birth: ____

Generalized Anxiety Disorder 7-item (GAD-7) Scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score (add your column scores) =				

If you checked off any problems, how difficult have these made if for you to do your work, take care of things at home, or get along with other people?

Not Difficult at all __________________________

Somewhat difficult _________________________

Very difficult ______________________________

Extremely difficult __________________________

OFFICE POLICIES
EFFECTIVE 5/1/2018

1. Medication refills should be requested at time of the patient's appointment. If the patient fails to notify the practitioner that a refill is required before the next appointment, there may be a $25 charge rendered for the service.

2. Should there be a change of pharmacy requested after a prescription is written, there may be a charge of $25 rendered.

3. If a patient is more than 10 minutes late for the scheduled appointment, they may not be seen and the appointment will have to be rescheduled. The patient will be charged with a late cancellation fee of $100 for that appointment.

4. When a patient finds a need to call to change an appointment, they should be aware that there might not be sufficient supplies of medication to last until the next appointment. It is the patient's responsibility to ask for a medication extension at the time of the appointment change. Failure to take this initiative may result in the charge of a fee for this service.

5. Should a patient fail to cancel an appointment at least 24 hours prior to scheduled time, by calling the office, or not show for a scheduled appointment, there will be a $100 fee for this first occurrence; for 2nd occurrence the fee is $125; the 3rd occurrence is $175. Sunshine Psychiatry, LLC, may elect to not make any further appointments after three failures to show. **Please note that NO-SHOW charges are the patient's responsibility and cannot be billed to any insurance company.

6. We will be performing random drug screens two times per year. If you refuse this, Sunshine Psychiatry, LLC, has the right to refuse to provide your psychiatric services.

7. It is our expectation that all accounts will be kept up-to-date at the time of each visit.

Sunshine Psychiatry, LLC

POLICIES & PROCEDURES FOR OUR PATIENTS
RECEIPT ACKNOWLEDGEMENT FORM

By signing below, I acknowledge that I have received, reviewed, understood and will comply with the policies and procedures explained in the Sunshine Psychiatry, LLC, form.

Printed Name:____

Signature:____

Date:____