Name:_____

Family 4 Today / Sojourners Recovery and Wellness Center

Date: _____

PERSONAL INFORMATION – Please Print

Client's SS#: _____

Client's Full Legal Name: Last: _____ First: _____ MI: ___

Client's Address: Street: _____ City: _____ State:____ Zip:_____

Client's Phone Number(s): Home: _____ Work: _____ ext. _____ Cell: _____

E-mail: _____ Client's Date of Birth: _____ Client's Sex: Male: ____ Female: ____

RESPONSIBLE PARTY'S INFORMATION – Please have a Photo ID (i.e. Driver's License) available for copying

Person Responsible for Account: Self: __ Spouse: ___ Parent: ___ Guardian: ___ Lawyer: ___ Worker's Comp: ___ Other: _____

Responsible Party's SS#: _____ Responsible Party's Name: Last: _____ First: _____ MI: __

Responsible Party's Address: Street: _____ City: _____ State:____ Zip: _____

Responsible Party's Phone Number(s): Home: _____ Work: _____ ext. _____ Cell: _____

Responsible Party's E-mail: _____ Responsible Party's Date of Birth: _____

Responsible Party's Sex: Male: ___ Female: ___ If Client is a student: Full Time: ___ Part Time: ___ School: _____

Responsible Party's Employer: _____ Occupation: _____ Date Started: _____

INSURANCE INFORMATION – Please Provide card(s) for copying

1. Primary Insurance Company: _____

Name of Insured: Last: _____ First: _____ MI: ____

Insured's Address: Street: _____ City: _____ State:____ Zip: _____

Insured's Date of Birth: _____ Insured's Sex: Male: _____ Female: _____

Relationship to Client: Self: _____ Spouse:_____ Child: _____ Other: _____

Insured's Employer: _____ Effective Date: _____

Policy Number: _____ Group #: _____

2. Secondary Insurance Company: _____

Name of Insured: Last: _____ First: _____ MI:____

Insured's Address: Street: _____ City: _____ State:____ Zip: _____

Insured's Date of Birth: _____ Insured's Sex: Male: _____ Female: _____

Relationship to Client: Self: _____ Spouse: _____ Child: _____ Other: _____

Insured's Employer: _____ Effective Date: _____

Policy Number: _____ Group #: _____

FOR OFFICE USE ONLY

Entered By: _____ Date: _____

Insurance Card(s)	____ Yes	____ No
Driver's License	____ Yes	____ No
Insurance Verified	____ Yes	____ No

Comments: _____

PERMISSION AND ACKNOWLDGMENT

ACKNOWLEDGEMENT

I have received a copy of the Office Notice of Privacy

Name:_____

TREATMENT AUTHORIZATION The undersigned authorizes the professional staff of Family 4 Today / Sojourners Recovery and Wellness Center to administer behavioral health treatment to the named individual on the reverse side of this form. Furthermore (if applicable) the undersigned affirms that he/she is authorized, and has legal standing consent to treatment on behalf of the patient.

Client's Name: (Please Print) _____

Signature: _____ **Date:** _____

Self: _____ **Spouse:** _____ **Parent:** _____ **Guardian:** _____ **Other:** _____

INFORMATION RELEASE: I agree to allow the release of my information to my Primary Care Physician for (Primary Care Physician) for the purpose of coordinating my care.

Signature: _____ **Date:** _____

INFORMATION RELEASE: I authorize the release of any information to my insurance carrier for the purpose of (Insurance) validating and determining benefits payable.

Signature: _____ **Date:** _____

ACKNOWLEDGEMENT - I understand that I am responsible for payment for any service rendered regardless of whether & the service is covered by an insurance company.

INSURANCE PAYMENT AUTHORIZATION: - I further understand that if my account is past due, that it may be sent to a collection agency and the status of my account reported to the credit bureau.

- I authorize insurance benefits payable to those health care providers described above for services rendered by them.

Signature: _____ **Date:** _____

PERMISSION TO LEAVE MESSAGES There may be instances when your Doctor/Clinician may need to change or reschedule an appointment. To protect your confidentiality, your permission is needed to leave a message at home with anyone other than you.

Family 4 Today / Sojourners Recovery and Wellness Center has my permission to leave a message regarding my scheduled appointment with or by means of:

Please check your choice(s):

Spouse _____ Name: _____

Relative _____ Name: _____

Friend _____ Name: _____

Answering Machine _____ Number: _____

Cell Phone _____ Number: _____

Text Message _____ Number: _____

E-mail Address: _____

Signature: _____ **Date:** _____

Name:_____

Emergency Care Information

Personal Physician: Name: _____ (First / Last) Phone: _____

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

May we contact your personal physician to discuss medical or medication issues and/or coordinate your care? No ___ Yes ___ If yes, please complete/sign information release section on previous page.

Family and/or friends to be contacted in an emergency:

Name: _____ Relationship_____ Phone: _____

Name: _____ Relationship_____ Phone: _____

Current Concerns

Please provide a brief description of the major concerns that led you to seek treatment/therapy at this time:

_____

_____

_____

Previous Psychiatrist/Therapist

Name of clinician:	Phone Number/Address	Treatment dates
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe the problems for which you sought therapy in the past: _____

_____

_____

Your experience with previous therapy: Positive ____ Neutral ____ Limited ____ Negative ____

Have you been hospitalized for psychiatric or substance abuse problems? No ___ If yes, please list:

Facility: _____ Dates: _____ Reason: _____

Facility: _____ Dates: _____ Reason: _____

Do you have any history of suicide attempts or history of assault? No ___ If yes, please describe:

_____

_____

_____

Name:_____

Medications

Please list all current drugs/medications, including over-the-counter:

Name of medication:	Dose	Dates

Please list any previous psychiatric drugs/medications:

Name of medication:	Dose	Dates

Physical Health Status

Do you have any existing medical problems or physical symptoms of concern to you? If so, please describe.

_____

_____

Please indicate any major illnesses, accidents, and/or hospitalizations within the last 5 years:

_____ Date: _____

_____ Date: _____

Allergies (Food/Environment/Drug) – Is your allergy mild, moderate, or severe?

_____

_____

Are you up to date on preventive care (physicals, vaccinations, etc)?

_____

Name:_____

Current Height: _____

Current Weight: _____

Do you smoke? No___ Yes, (#) _____ per day

Do you drink alcohol? No___ Yes, (# drinks) _____ per week

Do you engage in any other substance/drug use? No ___ If yes, please explain:

_____

Do you exercise? Regularly____ Occasionally ____ Rarely ____ Never ____

How is your general food diet? Very healthy____ Questionably healthy____ Not very healthy___ Changes____

How is your general health? Excellent ___ Good ___ Fair ___ Poor ___

Family Background

Have any family members had any moderate to severe psychological or medical problems? If so, please describe:

_____

_____

Please describe your family relationships: _____

_____

Social/Occupational/Family Functioning

Your social network? No close friends ____ One close friend ____ Few friends ____ Many friends _____

How often do you make contact with friends? Regularly____ Occasionally ____ Infrequently____ Never _____

Are you currently in a romantic relationship? ___ No ___ Yes, it is..... Generally positive ____ Neutral _____ Problematic _____

Are you able to talk to others about the concerns that bring you into therapy? No____ Yes ____

What is your living situation? Live alone ____ Live with others, with whom? _____

How do you feel about (select one) work/school?

Pleased _____ Mostly satisfied _____ Mixed _____ Mostly dissatisfied _____ Unhappy _____

Any major dissatisfaction with: Work _____ School _____ Other _____

If so, please explain _____

_____

Please describe any hobbies or recreational activities: _____

Name: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING *0* + _____ + _____ + _____ =Total Score: _____

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 at all	Somewhat difficult	Very difficult	Extremely difficult
○	○	○	○

THE MOOD DISORDER

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found you didn't really miss it?	☐	☐
...you were much more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had much more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family into trouble?	☐	☐
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.*

No Problem Minor Problem Moderate Problem Serious Problem

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	☐	☐
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	☐	☐

Name:_____

Date of Birth: _____

Family 4 Today / Sojourners Recovery and Wellness Center

Attention Clients

When making your appointment, we are reserving a slot of time for your particular needs.

We ask that **if you must change or cancel an appointment, please give us a minimum of 24 hours notice.** This will allow us to care for another client during that time.

There is a $50.00 charge for not showing up for scheduled appointments. Furthermore, showing up more than 15 minutes late without contact, will result in the lose of your appointment time and you to incur the $50.00 fee.

Repeated cancellations or missed appointments will result in loss of future appointment privileges or discharge from the practice.

By initialing below you are indicating that you have read and understood this policy.

Initial _____

Name:_____

Date of Birth: _____

Family 4 Today / Sojourners recovery and Wellness Center

CREDIT CARD AUTHORIZATION

Please complete the following information.

I, _____, am authorizing Family 4 Today / Sojourners Recovery and Wellness Center Staff, to charge my credit card for any services rendered as agreed to in the Treatment Consent Form. I also authorize Family 4 Today / Sojourners Recovery and Wellness Center to charge my card $50 in the event I fail to show for a scheduled appointment, or do not give notification of my inability to attend a scheduled appointment at least 24 business hours in advance (In cases of emergency, this fee can only be waived by the provider).

Furthermore, for outstanding payments of services rendered, I authorize Family 4 Today / Sojourners Recovery and Wellness Center to charge my credit card for the full amount due. I will not dispute for sessions I have received, or that I have not cancelled less than 24 business hours in advance.

I further authorize Family 4 Today / Sojourners Recovery and Wellness Center to disclose information about my attendance/cancellation to my credit card company if I dispute a charge.

I acknowledge that I am aware there is a $25 fee for any declined credit card charge.

Card Type: _____

Card #: _____ Expiration Date: _____ CID: _____

Name as Printed on Card: _____

Relationship to patient: _____

Billing Address: _____
(Street, City, State & Zip)

Signature: _____ Date: _____
(client or financially responsible party)

This form will be securely stored in your clinical file and may be updated upon request at any time. Please note, your credit card will <u>not</u> be charged unless the following conditions apply: no-show for a scheduled appointment, cancellation less than 24 business hours in advance, or participation in treatment (e.g. appointment or phone session) without payment rendered.