Psychiatric Associates of Southwest Florida
New Patient Intake Form

This questionnaire is for the purpose of getting to know you better in order to provide the best possible mental health services. Please complete this form as honestly and completely as possible. All the information that you provide us will be confidential as required by State and Federal Law.

Demographics:

First Name: _____ Last Name: _____

Middle Initial: ____ Date of Birth: ____/____/_____ Age: _____Phone: _____

Email: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Sexual Orientation: ( ) Heterosexual ( ) Homosexual ( ) Bisexual ( ) Prefer not to answer

Please check one of the following:

Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed ( ) Engaged ( )

Partner's Name :_____ Occupation: _____

Insurance:

Insurance Company: _____

Member/Policy ID#: _____ Group #: _____

Primary ( )/ Secondary( )

Insurance Company: _____

Member/Policy ID#: _____ Group#: _____

Primary ( )/ Secondary( )

Pharmacy:

Name of Pharmacy: _____ Phone: _____

Address: _____ City: _____

State: _____ Zip: _____ Fax: _____

Intake Questionnaire:

In your own words, describe your current problems as you see them: _____

_____
_____
_____
_____
_____
_____
_____

How long has this been going on? _____

What made you come in at this time? _____

Referring Physician: _____ Phone: _____

If you had difficulties in the past, what have you done to cope? Was it helpful? _____

_____

Average hours of sleep per night: _____

Symptoms (Select all that apply):

- ☐ Persistent loss of interest in previously enjoyed activities
- ☐ Withdrawing from other people
- ☐ Depressed moods
- ☐ Rapid mood changes
- ☐ Anxiety
- ☐ Frequent feelings of guilt
- ☐ Difficulty leaving your home
- ☐ Outbursts of anger
- ☐ Spending increased time alone
- ☐ Feeling numb
- ☐ Irritability
- ☐ Panic attacks
- ☐ Avoiding people, places, activities or specific things
- ☐ Repetitive behaviors or mental acts (i.e., counting, checking doors, washing hands, etc.)
- ☐ Worthlessness
- ☐ Sadness
- ☐ Fear
- ☐ Hopelessness
- ☐ Helplessness
- ☐ Feeling or acting like a different person

Fear of certain objects or situations (i.e., flying, heights, bugs, etc.) ( )Yes ( )No

Please describe: _____

_____

_____

Symptoms:

- ☐ Changes in eating/appetite
- ☐ Eating more ( )/ Eating Less ( )
- ☐ Voluntary vomiting
- ☐ Excessive exercise to avoid weight gain
- ☐ Use of laxatives
- ☐ Binge eating

Are you trying to lose weight? ( )Yes ( ) No Are you trying to gain weight? ( )Yes ( )No

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

- ☐ Difficulty catching your breath
- ☐ Unusual sweating
- ☐ Increased energy ( )/ Decreased energy ( )
- ☐ Tremor
- ☐ Frequent worry
- ☐ Racing thoughts
- ☐ Increase in muscle tension
- ☐ Easily startled, feeling "jumpy"
- ☐ Dizziness
- ☐ Physical sensations others don't have
- ☐ Intrusive memories
- ☐ Difficulty concentrating or thinking
- ☐ Flashbacks
- ☐ Thoughts about harming or killing yourself ( )/ Others ( )
- ☐ Large gaps in memory
- ☐ Nightmares
- ☐ 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
- ☐ Hear voices when no one else is present
- ☐ Unusual visual experiences such as flashes of light, shadows
- ☐ Feeling that your thoughts are controlled or placed in your mind
- ☐ Feeling that the television or radio is communicating with you
- ☐ Difficulty problem solving

- ☐ Dependency on others
- ☐ Inappropriate expression of anger
- ☐ Difficulty or inability to say “no” to others
- ☐ Sense of lack of control
- ☐ Difficulty meeting role expectations
- ☐ Manipulation of others to fulfill your own desires
- ☐ Self-mutilation/cutting
- ☐ Ineffective communication
- ☐ Decreased ability to handle stress
- ☐ Difficulty expressing emotions
- ☐ Concerns about your sexuality

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

_____
_____
_____
_____

Have you seen a counselor, psychologist, psychiatrist, or other mental health professional before? ( ) Yes ( ) No

Reason for seeking help: _____

Name of Therapist: _____

Dates of Treatment: _____

Are you CURRENTLY taking PSYCHIATRIC medications? ( ) Yes ( ) No

Are you CURRENTLY taking NON-PSYCHIATRIC medications? ( ) Yes ( ) No

If yes, please list: (Medication, dosage, first/last time you took it, effect of medication)

_____
_____
_____
_____
_____

Have you previously been on PSYCHIATRIC medications in the past? ( ) Yes ( ) No

If yes, please list: (Medication, dosage, first/last time you took it, effect of medication)

_____
_____
_____
_____

Have you been hospitalized for psychiatric reasons? ( ) Yes ( ) No

If yes, please describe: (Include hospital, dates, reason) _____

_____

_____

_____

_____

Have you ever attempted suicide? ( ) Yes ( ) No

If yes, please describe: _____

_____

_____

_____

List any PRIOR illnesses, operations, and accidents: _____

_____

_____

Medical Conditions:

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

- ☐ Anemia
- ☐ Arthritis
- ☐ Alzheimer
- ☐ Asthma
- ☐ Birth defects
- ☐ Bleeding problems
- ☐ Cancer
- ☐ Currently pregnant- Due _____
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Hearing problems
- ☐ Heart disease
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Intestinal pain
- ☐ Kidney disease
- ☐ Migraines
- ☐ Phlebitis (blood clots)
- ☐ Rheumatic/Scarlet fever

- ☐ Stroke
- ☐ STD
- ☐ Thyroid disease
- ☐ Ulcers

What medications are you taking for the medical conditions you checked off above? (Please include doses, how long you have been taking the medications, and any reactions to each medication)_____
_____
_____
_____

Family History:

Father: Living( ) Deceased( ) How was/is HIS overall health: _____

If **Living**: Current Age _____ Occupation: _____

Frequency of contact with Father: _____

If **Deceased**: YOUR age at time of his death: _____ **FATHER'S** age at time of his death: _____

Mother: Living( ) Deceased( ) How was/is HER overall health: _____

If **Living**: Current Age _____ Occupation: _____

Frequency of contact with Mother: _____

If **Deceased**: YOUR age at time of her death: _____ **MOTHER'S** age at time of her death: _____

Siblings: (Please include name, sex, age, whereabouts, are you close to him/her?)

_____
_____
_____
_____
_____

During your childhood, did you live any significant period of time with anyone other than your natural parents? ( ) Yes ( ) No

If yes, who? (Provide name and relationship to you): _____
_____

Please select any conditions that have been present in your relatives, and list who (i.e., parents, grandparents, children, siblings, aunts/uncles)

- ☐ Nervous problems _____

- ☐ Depression _____
- ☐ Hyperactivity _____
- ☐ Counseling _____
- ☐ Psychiatric medication _____
- ☐ Psychiatric hospitalization _____
- ☐ Suicide attempt _____

Highest grade level completed: _____

Degree obtained, if applicable: _____

How were your grades in school? _____

Did you have disciplinary problems in school? ( )Yes ( ) No

If yes, please explain: _____

_____

_____

Were you considered hyperactive/ADHD in school? ( ) Yes ( ) No

If yes, were/are you on any medication? ( ) Yes ( ) No

If yes, which medication? _____

_____

Do you have any known drug allergies? ( ) Yes ( ) No If yes, please explain:_____

_____

_____

Have you served in the military? ( ) Yes ( ) No

If yes, please describe briefly: _____

_____

Are you currently employed? ( ) Yes ( ) No

What type of work do you do? _____

Do you have a religious affiliation? ( ) Yes, _____ ( ) No

Have you ever been arrested? ( ) Yes ( ) No

If yes, please explain: _____

_____

_____

_____

What kind of social activities do you participate in? _____
_____
_____
_____

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

Have you ever been abused? ( )Physically ( )Emotionally ( )Verbally ( )Sexually ( )Neglected

If yes to any, please describe: _____

_____
_____
_____

Alcohol and Drug Use:

Do you drink? ( ) Yes ( ) No If yes, age of first use? _____

How much/often do you drink? _____

Have you ever ( )passed out/( ) blacked out from drinking? ( ) Yes ( ) No

If yes, how often? _____

Have you ever had the "shakes"? ( ) Yes ( ) No

Have you ever felt you should cut down on your drinking/drug use? ( ) Yes ( ) No

Have people annoyed you by criticizing your drinking/drug use? ( ) Yes ( ) No

Have you ever felt bad or guilty about your drinking/drug use? ( ) Yes ( ) No

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

( ) Yes ( ) No

Do you use tobacco? ( ) Yes ( ) No If yes, how often: _____

Marijuana ( ) Yes ( ) No If yes, age at first use? _____ Use in last 30 days? _____

Cocaine ( ) Yes ( ) No If yes, age at first use? _____ Use in last 30 days? _____

Crack ( ) Yes ( ) No If yes, age at first use? _____ Use in last 30 days? _____

Heroin ( ) Yes ( ) No If yes, age at first use? _____ Use in last 30 days? _____

Ecstasy ( ) Yes ( ) No If yes, age at first use? _____ Use in last 30 days? _____

Methamphetamine ( ) Yes ( ) No If yes, age at first use? _____ Use in last 30 days? _____

Assignment of Benefits- Confirmation:

I hereby assign, transfer, and convey all medical benefits to be paid directly to Psychiatric Associates of SWFL. I recognize it is my responsibility to pay for all non-covered services. I also authorize PASWFL 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.

Please select one of the following and sign:

- ☐ I agree
- ☐ I disagree

Signature: _____ Date: _____

Consent to treat:

By signing this form, I consent to be treated at Psychiatric Associates of Southwest Florida. I understand that I am at Psychiatric Associates of SWFL by my own choice and/or free will. Should I wish to seek treatment at another facility, I am aware that I can sign a medical release of information to have my records sent to another office, at no cost, or I can pay out of pocket for my medical records to be given to me, also upon signing a release of information. The cost for retrieving my medical records is $1 per page for the first 25 pages, and 25 cents for every page after that. I understand that having medical records printed and/or sent to another office may take time, so I will plan my time accordingly.

Patient Name: _____ Date: _____

Signature: _____

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ SSN:_____

I. My Authorization

I authorize the following using or disclosing party:

PSYCHIATRIC ASSOCIATES OF SOUTHWEST FLORIDA, LLC.

to use or disclose the following health information:

- ☐ All of my health information
- ☐ All appointment related information
- ☐ My health information relating to the following treatment or condition: _____
- ☐ My health information covering the period from _____ (date) to _____ (date)
- ☐ Other: _____

The above party may disclose this health information to the following recipient:

Name (or title) and organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

The purpose of this authorization is (check all that apply):

- ☐ To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.
- ☐ To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health information and will stop any future sales if I revoke this authorization.
- ☐ At my request
- ☐ Other: _____

This authorization ends:

- ☐ On _____ (date)
- ☐ When the following event occurs: _____

II. My Rights

_____ I understand that I have the right to revoke this authorization at any time, in writing, except where uses or disclosures have already been made, based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing, and send it to the appropriate disclosing party.

_____ I understand that uses and disclosures already made, based upon my original permission, cannot be taken back.

_____ I understand that it is possible that information use or disclosed with my permission may be redisclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

_____ I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party, or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ Date: _____

If the patient is a minor or unable to sign, please complete the following:

- ☐ Patient is a minor: _____ years of age
- ☐ Patient is unable to sign because: _____

Signature of Authorized Representative: _____ Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient:

- ☐ Parent
- ☐ Legal Guardian
- ☐ Court Order
- ☐ Other: _____

III. Additional Consent for Certain Conditions

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment**. Separate consent must be given before this information can be released.

- ☐ I consent to have the above information released.
- ☐ I do not consent to have the above information released.

Signature of Patient or Authorized Representative: _____

Date: _____ Time: _____ AM/PM

IV. Additional Consent for HIV/AIDS

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given to have this information released.

- ☐ I consent to have the above information released.
- ☐ I do not consent to have the above information released.

Signature of Patient or Authorized Representative: _____

Date: _____ Time: _____ AM/PM

PSYCHIATRIC ASSOCIATES OF SWFL POLICIES AND PROCEDURES

To ensure prompt service, please arrive at least 15 minutes prior to your scheduled appointment time. This will allow sufficient time for paperwork and vitals to be completed prior to your appointment, as well as collecting any needed documents such as Driver's License and Insurance ID's, or payments such as balances and copays.

In consideration of all scheduled patients time, and our providers time, if a patient arrives 15 minutes past their scheduled appointment, the patient will need to be rescheduled for the next available appointment, whether it be on the same day, or for another day. The patient has the option to see another provider the same day, should the provider schedule allow it.

We do understand that there are sometimes unforeseen emergencies that occur. If this happens, all we ask is for a courtesy call as soon as you are aware the emergency has occurred, that way we may inform the provider as soon as possible. The scheduled appointment may be moved down as needed to keep the schedule flowing smoothly for both the providers and the scheduled patients. Please understand, that while we are aware emergencies happen, there may be some circumstances where your appointment will still need to be rescheduled due to meetings or appointments that do not have the ability to be rescheduled. If no courtesy call is made, the appointment may be marked as a No-Show and you may be charged a No-Show fee.

Copayments are always due prior to being seen per your signed agreement with your insurance. If you have an outstanding balance and cannot make the payment in full, it is expected to arrange a payment plan with a billing staff member and keep true to that payment plan. Failure to make payment towards balance may result in the appointment being rescheduled. ALL SELF PAY patients are required to make payment in full prior to being seen. If the appointment is in office, payment is due at the time of check-in. If the appointment is virtual/over the phone, payment is due during confirmation calls the day (or Friday, if appointment lands on a Monday) before.

We appreciate you as a patient and we respect your time, all we ask is for the same respect in return. Your signature below confirms you are aware of these policies and confirm that we are enforcing this to every patient, both new and existing. If you would like to receive a copy of this, please notify a staff member. A copy of this authorization is as valid as the original.

Name _____ Date _____

Signature _____