Queensland Specialist Centre

NEW PATIENT REGISTRATION FORM

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other:

Surname:

First Name: **Middle name:**

Date of Birth: / / (DD/MM/YEAR) **Gender:**

Email Address:

Address: Landline:

Suburb:

Postcode: Mobile:

Next of kin:

Relationship to you:

Landline: Mobile:

Medicare No:

Ref no Next to name: Expiry:

Department of Veterans Affairs Card No:

NDIS No: **NDIS provider email:**

Workcover Claim No:

Please list any allergies

How did you hear about us? **Have you viewed our website?** Yes ☐ No ☐

Suite 3/63 Annerley Rd, Woolloongabba QLD 4102
Tel: 07 3217 3690, Fax:07 3036 6011
admin@qldspecialist.com

- **Please advise us of any future changes of address, phone number, next of kin etc.**

APPOINTMENTS: Your appointments and notes taken here are for treatment purposes. There could be additional costs if you need letters/forms/reports done for third parties e.g. courts, Centrelink, employers, university etc. You will need to discuss costs for completing these with your doctor/therapist.

INFORMATION: All information collected in this practice is treated as "sensitive information" to protect your privacy. Selected information may be disclosed to other health services and agencies involved in your care and management (e.g. Pathology, Radiology, Child Safety Services etc.). Due to privacy laws it is preferred that you arrange your own appointment whenever possible. Information about your care cannot be given to a third party except under special circumstances.

MEDICATIONS: It is your responsibility to make appointments and attend appointments. It is your responsibility to maintain adequate supply of medications prescribed to you and let the doctor know in your appointments if you are running out of medications. If you fail to attend appointments at Queensland Specialist Centre, it is your responsibility to follow up with your treatment with your GP/Family Doctor or any other appropriate health care provider.

EMERGENCY APPOINTMENTS: Queensland Specialist Centre offers routine outpatient services. Our service cannot provide emergency appointments. In case of any emergency, please contact medical emergency dialling 000 or proceed to your nearest hospital emergency department.

CONSENT: Please cross out any of the statements below you do not agree with:

- I consent to use my personal health information by Queensland Specialist Centre for medical treatment and health care.
- I consent to the disclosure of my personal health information by Queensland Specialist Centre to other health care providers or agencies that are involved in my care.

You can withdraw your consent regarding the above two statements at any time in the future.

Doctors in this practice at their discretion can choose to refuse treatment for certain patients.

NO SHOW /CANCELLATIONS POLICY: If you are unable to attend an appointment, please call us & rebook at least 48 hours before your appointment. All late re-bookings & missed appointments will incur a $100 out of pocket fee payable at your next appointment.

- If you have any advice or concerns regarding services we offer, you are welcome to discuss those with our staff or practice manager.
- If you miss an appointment, you will need to call us to book another appointment.

I am happy to receive SMS reminders from the Practice: Yes ☐ No ☐

Signature: _____ **Date:** / /

Suite 3/63 Annerley Rd, Woolloongabba QLD 4102
Tel: 07 3217 3690, Fax:07 3036 6011
admin@qldspecialist.com

DASS 21

NAME _____ DATE _____

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all - NEVER

1 Applied to me to some degree, or some of the time - SOMETIMES

2 Applied to me to a considerable degree, or a good part of time - OFTEN

3 Applied to me very much, or most of the time - ALMOST ALWAYS

		N	S	O	AA	FOR OFFICE USE D	A	S
1	I found it hard to wind down	0	1	2	3			
2	I was aware of dryness of my mouth	0	1	2	3			
3	I couldn't seem to experience any positive feeling at all	0	1	2	3			
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3			
5	I found it difficult to work up the initiative to do things	0	1	2	3			
6	I tended to over-react to situations	0	1	2	3			
7	I experienced trembling (eg, in the hands)	0	1	2	3			
8	I felt that I was using a lot of nervous energy	0	1	2	3			
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3			
10	I felt that I had nothing to look forward to	0	1	2	3			
11	I found myself getting agitated	0	1	2	3			
12	I found it difficult to relax	0	1	2	3			
13	I felt down-hearted and blue	0	1	2	3			
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3			
15	I felt I was close to panic	0	1	2	3			
16	I was unable to become enthusiastic about anything	0	1	2	3			
17	I felt I wasn't worth much as a person	0	1	2	3			
18	I felt that I was rather touchy	0	1	2	3			
19	I was aware of the action of my heart in the absence of physicalexertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3			
20	I felt scared without any good reason	0	1	2	3			
21	I felt that life was meaningless	0	1	2	3			
	TOTALS							

Queensland Specialist Centre

Unit 3 / 63 Annerley Road, Woolloongabba, QLD, 4102
Phone: 07 3217 3690
Fax: 07 3036 6011
www.qldspecialist.com E: admin@qldspecialist.com

Treatment Consent Form

Please read carefully and initial or sign where necessary

Confidentiality

Confidentiality between a client and clinician is protected by federal and state law. Although there are some important exceptions, in general we will not disclose any information about you without your written permission. You will be given a copy of the privacy and confidentiality statement applicable to this practice to obtain information from other services or disclose your information to other services who are involved in your medical care.

Fees and Payments

By signing this form, you agree to be prepared to pay the booking fee unless other arrangements have been made in writing (e.g., work cover, insurance, NDIS etc.). Acceptable forms of payment include cash, and selected credit cards. If you are unable to attend your scheduled appointments due to an emergency, we instruct you to send us an email at least 48 hrs earlier so that we can offer your place to someone who may be in urgent need. During these circumstances, we will be able to offer you either another booking or refund your fee. Otherwise, the fee will not be refunded or carried over to your next appointment.

Cancelations and No-Shows

Queensland Specialist Centre strives to provide personalized care that is tailored to the needs of the individual. To provide such diligent care, it is imperative that patients adhere to the appointment times. If there is a need to cancel or reschedule an appointment, please notify the office at least 48 hours prior to the appointment time. **Patients that fail to cancel or reschedule an appointment 48 hours prior are responsible for payment for the requested visit**. Please note, **two** cancellations/no show appointments without proper notice can result in termination of care and discharge to GP.

Sobriety During Session

We require our clients to be sober from drugs, alcohol, and any other mood-altering substances during scheduled session time. This excludes any medication being taken as prescribed if it does not preclude the ability to participate fully in session. It is the policy of Queensland Specialist Centre that if a client attends a session under the influence of a substance the session will not be held.

Professional Records

Mental health records are standard practice in psychiatry and protected by both law and professional standards. Although you are entitled to review a copy, these records can be misinterpreted given their professional nature. In rare cases when it is deemed potentially damaging for Queensland Specialist Centre to provide you with the full records, they are available to an appropriate mental health professional of your choice. Alternatively, we can review them together and/or treatment summaries can be provided. Please note that professional fees will be charged for any preparation time required to comply with such requests.

CONFIDENTIALITY

Confidentiality is a cornerstone of mental health treatment and is protected by the law. Aside from emergency situations, information can only be released about your care with your written permission. If insurance reimbursement is pursued, insurance companies also often require information about diagnosis, treatment, and other important information (as described above) as a condition of your insurance coverage. Several exceptions to confidentiality do exist that actually require disclosure by law: (1) danger to self – if there is threat to harm yourself, our providers are required to seek hospitalization for the client, or to contact family members or others who can help provide protection; (2) danger to others – if there is threat of serious bodily harm to others, our providers are required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization; (3) grave disability – if due to mental illness, you are unable to meet your basic needs, such as clothing, food, and shelter, our providers may have to disclose information in order to access services to provide for your basic needs; (4) suspicion of child, elder, or dependent abuse – if there is an indication of abuse to a child, an elderly person, or a disabled person, even if it is about a party other than yourself, our providers must file a report with the appropriate state agency; (5) certain judicial proceedings – if you are involved in judicial proceedings, you have the right to prevent your physician from providing any information about your treatment. However, in some circumstances in which your emotional condition is an important element, a judge may require my testimony through a subpoena. Although these situations can be rare, our providers will make every effort to discuss the proceedings accordingly. Queensland Specialist Centre also reserves the right to have a clinical consultation with supervisors or other mental health professionals for the purpose of best practices and treatment efficacy. In these circumstances, your identity will not be revealed, and only important clinical information will be discussed. Please note that such consultants are also legally bound to keep this information confidential.

Contacting Providers

Our providers attempt to be accessible for all urgent issues. If they are not immediately available by office telephone, please leave an email message and we will write back to you when a suitable staff is available.

Emails are generally returned within five business day. However, this will not be assured due to COVID 19 situation.

In situations that require immediate attention, your provider will give you their direct contact information for Acute Mental Health Service at the first visit. You may also contact your GP or "000" for any emergency. Please be judicious when calling after normal business hours. If your call is an emergency, please contact "000" immediately instead of calling the office. Emergency psychiatric services are provided by all the public hospitals through their emergency rooms and do not require appointments.

Queensland Specialist Centre provides assessment and management through a scheduled appointment only.

Termination of Services

Many clients wonder how long treatment will take and how they will know that they are done with services. I encourage you to discuss this with your specialists at any time during the assessment and treatment process. We will support a client's decision to terminate services under any circumstances, though we may discuss with you if you have concerns about terminating prematurely. You have the right to end services at any time. We also reserve the right to terminate services with any particular client if payment is not made in a timely fashion or if, in my clinical judgment, I come to the conclusion that therapy is unproductive or potentially harmful to the client. Terminations will always occur with recommendations for alternative treatment resources and time sufficient to connect to these resources. Any kind of aggression, unreasonable demand, and violence towards will result in immediate termination of treatment and in some cases notification to the Police.

Treatment Consent

Your signature below indicates that you have read the Treatment Consent Form and you agree to abide by its terms during our professional relationship.

Name of patient (print): _____

Name of legal guardian (print): _____
**(Only if patient is under 18 or a dependent adult)*

Signature: _____ Date: _____

Authorization for Release of Information

Client's name: _____ Date of Birth: _____
Address: _____ City, State, And Zip: _____

□ I authorize Queensland Specialist Centre, my provider, _____ to release information

to: _____

Name of Provider or Facility
_____
Address
_____
City, State, Zip Code
_____
Phone # Fax #

□ I authorize Queensland Specialist Centre, my provider, _____ to obtain information

from: _____

Name of Provider or Facility
_____
Address
_____
City, State, Zip Code
_____
Phone # Fax #

PURPOSE OF THIS REQUEST: (check one) □ Healthcare □ Insurance □ Personal

□ Other (please describe) _____

I understand that:

- This authorization is voluntary and refusing to sign will not affect my ability to obtain treatment.
- I may cancel this authorization at any time by submitting a *written* request to Queensland Specialist Centre, except where a disclosure has already been made in reliance to my prior authorization

_____

Date Client Signature or Signature of Parent/Guardian, if under 18

Queensland Specialist Centre

Unit 3 / 63 Annerley Road, Woolloongabba, QLD, 4102
Phone: 07 3217 3690
Fax: 07 3036 6011
www.qldspecialist.com E: admin@qldspecialist.com

ELECTRONIC COMMUNICATION

It is impossible to guarantee the confidentially of email or text message content. By this notice you grant Queensland Specialist Centre, permission to email and text message you. You acknowledge the risks and release Queensland Specialist Centre from liability for the risk of your confidentiality. Our providers typically return text messages and emails within 24 hours during the week. Emails and text messages should be limited to administrative issues such as scheduling. Our providers do not accept friend requests from clients on Facebook, Linked In or other social media websites.

Please sign here that you acknowledge and agree to the above statement:

Name of Patient: _____

Signature: _____

Date: _____

*If patient is under 18 or a dependent adult

Name of Parent/guardian: _____

Signature: _____

Date: _____

Queensland Specialist Centre

Unit 3 / 63 Annerley Road, Woolloongabba, QLD, 4102
Phone: 07 3217 3690
Fax: 07 3036 6011
www.qldspecialist.com E: admin@qldspecialist.com

Psychiatric Intake Form

(All information on this form is strictly confidential)

Name _____ Date: _____

Date Of Birth _____ Age_____ Sex M / F

Primary Care Physician _____ Phone:

Current Psychologist/Counsellor _____ Phone:

Medicare Card Number: _____ Exp: _____

What brings you to seek mental health treatment or consultation?

_____

_____

_____

What are your treatment goals?

_____

_____

_____

Please describe any recent life changes or challenges that have led you to seek treatment:

_____

_____

_____

Current Stressors

Please rank the following stressors in your life from 0 to 5 (0 = not a source of stress, 5 = extremely stress-provoking).

	No stress	A little bit	Sometimes	Usually	Always	Relentlessly
Family	0	1	2	3	4	5
Friends	0	1	2	3	4	5
Finances	0	1	2	3	4	5
House	0	1	2	3	4	5
School	0	1	2	3	4	5
Work	0	1	2	3	4	5
Social media	0	1	2	3	4	5

Symptom Checklist

Please circle the symptoms below that you have been experiencing over the past few weeks. Please indicate with * symptoms that are most distressing to you.

Emotional concerns	**Physical concerns**	**Behavioral concerns**	**Cognitive concerns**
Sadness	Fatigue	Panic attacks	Distractibility
Irritability	Muscle tension	Binging	Forgetfulness
Jealousy	Restlessness	Purging	Racing thoughts
Guilt	Insomnia	Crying	Flashbacks
Worry	Avoidance	Impulsivity	Desire to hurt others
Anger	Excessive energy	Nightmares	Paranoia
Hopelessness	Racing heart	Changes in appetite	Difficulty concentrating
Feeling on edge	Decreased need for sleep	Cutting/self-harm	Thoughts of self-harm
Numbness	Changes in libido	Restricting meals	Hallucinations

Psychiatric History

Have you ever attempted suicide? YES NO

Have you ever received inpatient psychiatric treatment? YES NO
Dates:_____-_____ Facility: _____ Reason:_____

Have you ever received mental health treatment (counselling or medication management)? YES NO
Dates:_____-_____ Provider: _____ Reason:_____

Dates:_____-_____ Provider: _____ Reason:_____

Dates:_____-_____ Provider: _____ Reason:_____

Please list ALL past psychiatric medications

Medication Name Dose(s) Date(s) Response(s) & or Side-effects Provider/Facility

_____

_____

_____

_____

Family Psychiatric History

Has anyone in your family been diagnosed or treated for:

Bipolar disorder	YES	NO	Depression	YES	NO
Schizophrenia	YES	NO	Anxiety	YES	NO
Alcohol abuse	YES	NO	Drug use/abuse	YES	NO
Anger issues	YES	NO	Suicide	YES	NO

If yes, who?_____

What medications were used? _____

Substance Use

Have you ever been treated for drug or alcohol abuse? YES NO

If yes which substance, when and where? _____
How many drinks do you drink per day on average? (please circle) 0 1-2 2-3 3-4 4-5 5-6 6+

Have you ever felt like you should drink less? YES NO

Have people ever criticized your drinking use or annoyed you about drinking? YES NO

Do you ever feel guilty about drinking? YES NO

Do you ever take a drink in the morning to calm your nerves? YES NO

Do you think you might have a problem with alcohol or drugs? YES NO
Have you used any street drugs in the last 3 months? YES NO
If yes, which?_____

Have you used any prescription medication in a way not prescribed? YES NO

If yes, which?_____

Please check if you have ever tried any of the following:

	YES	NO	If yes, how long and when was last use (how old were you)?
Methamphetamine	( )	( )	_____
Cocaine	( )	( )	_____
Stimulants(pills)	( )	( )	_____
Heroine/opium	( )	( )	_____
LSD or hallucin.	( )	( )	_____
Marijuana/THC	( )	( )	_____
Pain medication	( )	( )	_____
Methadone	( )	( )	_____
Sleeping aids	( )	( )	_____
Alcohol	( )	( )	_____
Ecstasy	( )	( )	_____
Bath salts	( )	( )	_____
Flaka	( )	( )	_____

Medical History

Allergies _____ Weight_____ Height_____

Blood pressure (most recent) _____ Last EKG _____

Last Menstrual Period? _____ Was last EKG normal? Yes No

Last physical _____ Last Labs _____

List ALL medications & doses that you are *currently* taking, including supplements, vitamins and over the counter medications.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list ALL **medical conditions** you are or have been treated for:

1._____

2._____

3._____

4._____

Please list ALL **surgeries** you have had:

1._____

2._____

3._____

List NON-Psychiatric **hospitalizations**:

1._____

2._____

3._____

Have you ever had a **traumatic brain injury**? YES NO

Date(s):_____ Treatment(s):_____

Have you ever had **seizures**? YES NO

Dates(s):_____ Treatments(s):_____

Family History

Does your family have a history of any of the following?

	Yes	No	Family member		Yes	No	Family member
High blood pressure	( )	( )	_____	High Cholesterol	( )	( )	_____
Diabetes/sugar	( )	( )	_____	Anemia	( )	( )	_____
Sudden death	( )	( )	_____	Seizures	( )	( )	_____
Thyroid	( )	( )	_____	Liver problems	( )	( )	_____
Kidney problems	( )	( )	_____	Irritable bowel	( )	( )	_____
Crohns disease	( )	( )	_____	Multiple miscarriages	( )	( )	_____
Blood clots	( )	( )	_____	Cancer	( )	( )	_____

Are there any other family medical problems that run in your family? YES NO

If yes, what disease and who did/does it effect? _____

_____

_____

Any family history of mental illness / Self-harm / Suicide / Substance misuse

Social History

Employment: Employed - Unemployed - Retired - Disabled - Homemaker - Student

If employed, which company? _____ Position_____

If student, which school? _____ If retired, from which profession? _____

Sexual orientation: Heterosexual - Homosexual - Bisexual - Other/ Prefer not to disclose

Status: Married - Single - Divorced - Widowed (since _____) - Dating - Prefer not to disclose

Do you have children? YES NO If yes, how many? _____

List ages and genders_____

Living situation- please list everyone that lives with you by relationship

Have you served in the military? YES NO

Branch? _____ Dates served_____

Have you ever been arrested/charged? YES NO

Have you suffered from any major traumatic events in your life? YES NO

If yes please explain if you feel comfortable doing so,_____

_____

Is there anything else we should know about you?

_____

_____

Emergency Contact _____ Relationship _____

Phone Number _____

By signing below, I certify all information is true and correct to the best of my knowledge

Signature _____ Date_____