THE HEALTHY MIND CENTER

Patient Name: _____ Date:_____

PATIENT INFORMATION FORM for Adults (age >18 years old)

Last Name_____ **First Name**_____ **DOB:** ____/____/____

Home Phone_____**Work Phone**_____**Cell Phone**_____

Please circle the best number to confirm appointments

Address_____**City**_____**Zip Code**_____

Martial Status: ☐ **Single** ☐ **Married** ☐ **Divorced**

Emergency Contact _____ **Relationship** _____ **Phone** _____

Therapist_____ **Phone**_____

Primary Care Physician_____ **Phone**_____

Specialty Physician_____ **Phone**_____

Preferred Pharmacy_____ **Address** _____ **Phone**_____

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Patient Name: _____ Date:_____

Whom may we thank for referring you?_____ Phone_____

Who is financially responsible?_____ Phone_____

(This person must sign both sides of this form)

I will be paying by Cash_____ Check_____ Credit Card_____

I understand and agree that I am responsible for the balance on my account for any professional services rendered. I have read and understand all the information in the "New Patient Packet."

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in above information.

_____ _____

Signature **Date signed**

_____ _____

Financially responsible Party (if different than above) **Date signed**

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FINANCIAL AGREEMENT

1. Fees are payable at the time of service, unless other arrangements are made in advance. A receipt will be given with which you can bill your insurance company.

2. Appointments missed or cancelled less than 24 complete hours prior to the session will be charge the full fee. In case of life-threatening illness or emergency, this does not apply.

3. The following services are billed by the time involved: telephone calls lasting longer than 2-3 minutes (such as those to professionals, family members, or insurance companies), reports and letters, reviewing past records. Please note that all calls to the emergency number (714) 742-0067 are billed according to time, with a minimum charge of $60. Most of these services are NOT reimbursable by insurance companies.

4. The fee for prior authorizations, school forms, and record-copying is $30 and up, depending on the time spent.

5. The fee for checks returned unpaid by the bank is $20.

6. The fee for controlled substance prescriptions issued outside of appointments is $20 (for example, stimulant medications for ADHD).

7. Accounts not paid within 30 days are subject to interest charges of 10% annual percentage rate (or 2% over the U.S. Prime Rate, whichever is greater). Delinquent accounts may be sent to a collection agency, with the patient or responsible party being charged the costs of collection (usually 40% of the total), and any legal fees incurred by the physician in pursuing payment.

8. Please discuss any financial hardship with the office so that appropriate arrangements or referrals can be made.

Please sign and date this form below, acknowledging your reading and acceptance of these policies.

Patient Signature _____ Date_____

Responsible Party_____ Relationship_____

THE HEALTHY MIND CENTER

Patient Name: _____ Date:_____

_____HISTORY QUESTIONNAIRE_____

1. What brings you to the Healthy Mind Center? _____

_____

_____

_____

2. When did this start? _____

3. Are you having any problems with sleep? If so, how? Are you having difficulty falling asleep, staying asleep, or are you sleeping too much?_____

4. Are you having any problems with your appetite?_____

5. How is your energy level? _____

6. Are you having any suicidal thoughts? _____

7. Any feelings of worthlessness, guilt, or helplessness? _____

8. Have you experienced any auditory or visual hallucinations? _____

9. Have you ever experienced any of the following symptoms for that lasted more than 48hrs ?

Decreased need for sleep and still have energy? __ Yes ___No

Felt that you had special powers or famous? __ Yes ___ No

Feeling excessively happy or excited? __ Yes ___ No

Increase in sexual drive? __ Yes ___ No

Excessive shopping, careless with finances __ Yes ___ No

Increase in impulsive behaviors such as gambling __ Yes ___ No

10. Do you have a history of any of the following psychiatric illnesses?

Depression? ___ Yes ___ No

Anxiety? ___ Yes ___ No

Anger? ___ Yes ___ No

Eating disorder? ___ Yes ___ No

ADHD? ___ Yes ___ No

Bipolar Disorder? ___ Yes ____ No

Problems with drugs or alcohol? ___ Yes ____ No

Hearing voices? ___ Yes ____ No

PTSD? ___ Yes ____ No

11. Have you ever been hospitalized for psychiatric reasons? If so when, why, and where?

_____

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12. **Have you had any previous suicide attempts? __ Yes___ No Any self harming behaviors? ___ Yes ____ No.**

13. **Have you seen a psychiatrist and/or therapist before? ___ YES ___ NO**

If so, please provide contact information for your previous psychiatrist.

- **Name of Psychiatrist: _____ Phone number: _____**
- **Name of Therapist: _____ Phone number: _____**
- **What psychiatric medications have you tried? Did it work for you? Any side effects?**

Medication Name	Dosage	Did it work? (Y/N)	Side Effects?

MEDICAL HISTORY

1. **When was the last time you had a physical? _____**
2. **Do you have any medical problems? _____**
3. **Do you have any allergies to medications? _____**

CURRENT MEDICATIONS		
Please list ALL medications that you are now taking. Include non-prescription medications & vitamins or supplements:		
Name of drug	**Dose (include strength & number of pills per day)**	**How long have you been taking this?**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

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Substance Use History					
DRUG CATEGORY (circle each substance used)	Age when you first used this:	How much & how often did you use this?	How many years did you use this?	When did you last use this?	Do you currently use this?
ALCOHOL					Yes □ No □
CANNABIS: Marijuana, hashish, hash oil					Yes □ No □
STIMULANTS: Cocaine, crack					Yes □ No □
STIMULANTS: Methamphetamine—speed, ice, crank					Yes □ No □
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine					Yes □ No □
BENZODIAZEPINES/TRANQUILIZERS: Valium, Librium, Halcion, Xanax, Diazepam, "Roofies"					Yes □ No □
SEDATIVES/HYPNOTICS/BARBITURATES: Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					Yes □ No □
HEROIN					Yes □ No □
STREET OR ILLICIT METHADONE					Yes □ No □
OTHER OPIOIDS: Tylenol #2 & #3, 282'S, 292'S, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid					Yes □ No □
HALLUCINOGENS: LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), nitrous oxide					Yes □ No □
INHALANTS: Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room					Yes □ No □
OTHER: specify)_____ _____ _____					Yes □ No □

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PAST MEDICAL HISTORY

Do you now or have you ever had:

❑ Diabetes
❑ High blood pressure
❑ High cholesterol
❑ Hypothyroidism
❑ Goiter
❑ Cancer (type) _____
❑ Leukemia
❑ Psoriasis
❑ Angina
❑ Heart problems
❑ Heart murmur
❑ Pneumonia
❑ Pulmonary embolism
❑ Asthma
❑ Emphysema
❑ Stroke
❑ Epilepsy (seizures)
❑ Cataracts
❑ Kidney disease
❑ Kidney stones
❑ Crohn's disease
❑ Colitis
❑ Anemia
❑ Jaundice
❑ Hepatitis
❑ Stomach or peptic ulcer
❑ Rheumatic fever
❑ Tuberculosis
❑ HIV/AIDS

Other medical conditions (please list):

PERSONAL HISTORY

Where were your born & raised?

What is your highest education? ❑High school ❑Some college ❑College graduate ❑Advanced degree

Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered/significant other

What is your current or past occupation?

Are you currently working? : ❑ Yes ❑ No Hours/week _____ If not, are you ❑ retired ❑ disabled ❑ sick leave?

Do you receive disability or SSI? ❑ Yes ❑ No If yes, for what disability & how long?_____

Have you ever had legal problems? (specify)

Religion:

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age (s)	Health & Psychiatric	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				

EXTENDED FAMILY PSYCHIATRIC PROBLEMS PAST & PRESENT:

Maternal Relatives: Paternal Relatives:

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SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

Women Only:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

OTHER PROBLEMS:

WOMENS REPRODUCTIVE HISTORY:

Age of first period:
Pregnancies:
Miscarriages:
Abortions:
Have you reached menopause? Y / N At what age?
Do you have regular periods? Y / N

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