Barnabas Behavioral Healthcare, LLC

Spinal Cord Stimulator Trial *Psychological* Intake

Name: ______________________ Date of Birth: ______________________
Social Security Number: ______________________ Sex: ______________________
Home Phone Number: ______________________ Mobile Phone Number: ______________________
Email Address: ______________________ Referring Physician: ______________________
Permanent Address: ____
Marital Status: ___ Married ___ Divorced ___ Separated ___ Single Never Married ___ Widowed

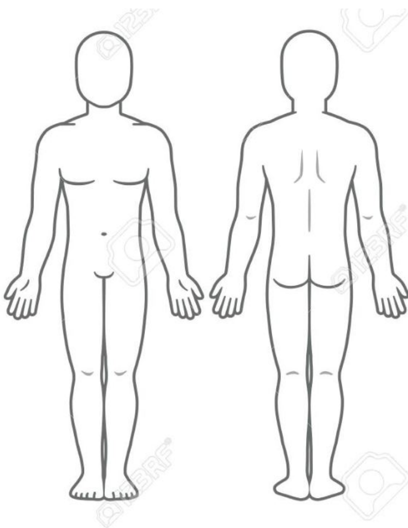
How many children do you have? ___ Number of children over 18 years of age ___
Occupation: ______________________
Employer: ______________________
Highest Level of Education Completed: ______________________
Major (if applicable): ______________________

List any medical problems (other than chronic pain) for which you are currently receiving treatment:

____
____
____
____

Do you smoke?	___ Yes	___ No	How often?	___	How much?	___
Do you drink alcohol?	___ Yes	___ No	How often?	___	How much?	___
Do you use drugs other than those prescribed or misuse drugs obtained by legal prescription?	___ Yes	___ No	How often? What kind?	___ ___	How much?	___ ___ ___

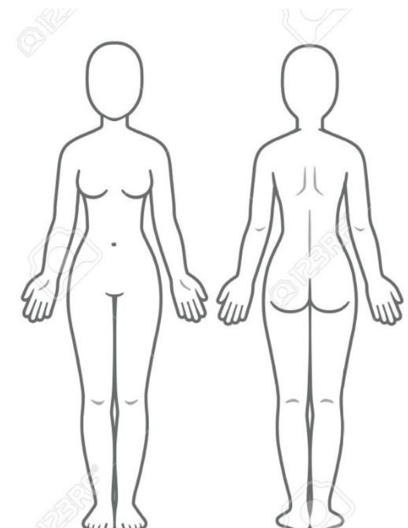
Where is your pain? Please circle the areas below



Male Body

If you know the diagnosis for the indicated areas of chronic pain, please list:

____
____
____
____
____
____



Female Body

How long have you had chronic pain? (best guess if you are not sure)	Number of months:	______	Number of years:	______
Have you had any previous surgeries to address chronic pain? If yes, please list the year of each surgery.	Yes ____ No ____	Dates:	______	

Please indicate any interventions you have tried in the past that did not provide the pain relief you are hoping to receive from the spinal cord stimulator trial.

____	Acupuncture	____	Heat
____	Back Brace	____	Ice
____	Chiropractic therapy	____	Injections
____	Decompression therapy	____	Pain medications
____	Dry needling	____	Physical therapy
____	Electrotherapy	____	TENS unit
____	Exercise	____	Nerve blocks/radiofrequency ablations

Please mark any that apply regarding education about the Spinal Cord Stimulator

______ I have spoken with a medical professional about the Spinal Cord Stimulator
______ I have been given and read a pamphlet with information about the Spinal Cord Stimulator
______ I have been given and watched a DVD with information about the Spinal Cord Stimulator
______ I have conducted my own online research to learn more about the Spinal Cord Stimulator
______ I have attended a seminar about the Spinal Cord Stimulator
______ I have been able to talk to someone who currently has a Spinal Cord Stimulator

In the following area, please mark any description that you view as a strength or a positive trait you possess.

______	Compassionate	______	Kind	______	Gets Along with anyone	______	"People Person"
______	Creative	______	Laid back	______	Good communicator	______	Problem solver
______	Dedicated	______	Loving	______	Good leader	______	Resilient
______	Dependable	______	Loyal	______	Good listener	______	Respectful
______	Determined	______	Optimistic	______	Good teacher	______	Supportive
______	Self-disciplined	______	Organized	______	Hard working	______	Trustworthy
______	Enthusiastic	______	Outgoing	______	Helpful	______	Understanding
______	Generous	______	Passionate	______	Honest	______	Versatile
______	Gentle	______	Patient				

In the following area, please place a check next to each item which indicates an area of concern to you. Please place two checks by items which are most important (you may add comments.)

______	Anxiety	______	Troubling memories	______	Unfairly treated by others
______	Depressed mood	______	Inability to relax	______	Repetitive behaviors
______	Guilt feelings	______	Memory difficulties	______	Drinking or drug problems
______	Over activity	______	Lack of confidence	______	Rely too much on others
______	Weight loss	______	Can't make decisions	______	Suspicious of others
______	Weight gain	______	Bitterness or resentment	______	Recent loss of someone
______	Headaches	______	Periods of over activity	______	Sexual problems/concerns
______	Feelings of inferiority	______	Eating problems	______	Family quarreling
______	Loss of interest	______	Shy or awkward with others	______	Fearful of things or situations
______	Poor sleeping	______	Unable to trust others	______	Religious/spiritual concerns
______	Repetitive ideas	______	Change in eating habits	______	Cardiovascular /heart problems
______	Thought of suicide	______	Fighting/arguing with others	______	Alcohol/drug problem in family
______	Wish to hurt others	______	Can't stand up for myself	______	Unusual/strange experiences
______	Marital relationship	______	Can't say "no" to others	______	Stress from recent event
______	Financial problems	______	Poor adjustment to job/school	______	Divorce/separation difficulty
______	Lonely/too few friends	______	Bad temper/anger problems	______	Troubling habits/thoughts
______	Unhappy most of the time	______	Difficulties with opposite sex	______	Feeling rejected by family
______	Problem with children	______	Stomach or bowel disturbance	______	Other (specify)

Date	______	Patient DOB	______
Patient Name	______	Patient Signature	______
Provider	______	Parent/Guardian Signature	______

Please CLEARLY list any current medications you are taking	**Strength**	**Dose**	**Frequency**
Example- Zithromax Z-Pack	*250 mg*	*2 Pills*	*Daily*

Please list clearly any allergies as it related to medications

Example -Penicillin

Preferred Pharmacy Name ______

Phone Number ______

Address ______

Primary Care Doctor	______	Fax Number	______
Referring Provider	______	Fax Number	______

Barnabas Behavioral Healthcare, LLC

Woundedness Checklist 80

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Please answer each item either True of False. Note that certain items, if true, can be counted more than once for the total score. If, for example, any one statement occurred more than once to you, please down two (or more) responses for that same question. (Example: TT *One of my parents probably came from a dysfunctional home.* – indicates the statement applies to both parents)

Answer	No.	Statement
	1	I certainly don't need anymore hurt in my life
	2	In my family, we didn't speak freely about our real feelings
	3	One of my parents probably came from a dysfunctional home (if both, count two)
	4	I probably came from a dysfunctional home
	5	There are large portions of my childhood that I simply can't remember
	6	My parents seemed to have trouble expressing their love to me and rarely did
	7	My family had definite issues that could not be discussed
	8	One (or both) of my parents had problems with alcohol or drugs (if both, count two)
	9	My parents divorced (if more than once, count each event)
	10	I am divorced (if more than once, count each event)
	11	I don't feel very good about myself
	12	If I could avoid relationships, I would
	13	There has been mental illness diagnosed in my family
	14	I tried not to think very much about what went on in my family
	15	Sometimes I cry for no apparent reason
	16	I don't talk very much about what's really going on inside me
	17	I'm used to living with confusion
	18	My spouse died
	19	My parent(s)is dead. (if both count as two; if stepparent also add one)
	20	I have been mistreated sexually
	21	I have been physically and deliberately harmed by someone who supposedly loved me
	22	A person who supposedly loved me often said some very unkind and cruel things to me
	23	I lost a child (if more than one, count each event) OR I am infertile
	24	I lost a sibling (if more than one, count each event)
	25	I continue to experience sexual difficulties
	26	I experienced disturbing flashbacks, dreams, or recollections about distressing event(s) or time(s)
	27	I don't spend nearly enough time with my spouse or family
	28	I avoid a number of family gatherings
	29	My eating is not really under control
	30	I would like to pursue God but I don't seem to do it
	31	I have experienced an abortion or a miscarriage (if more than one, count each event)
	32	I have been involved in an adulterous sexual relationship (count one for each relationship)
	33	My mate has been unfaithful
	34	I regularly deal with guilt feelings
	35	I know what it is like to feel depressed rather than just "down" on occasions
	36	There has been a time where I seriously considered suicide
	37	Sometimes I feel so terribly lonely and alone
	38	I have a hard time relaxing
	39	I must admit that I'm still bitter or resentful about something that happened to me
	40	I have a hard time really trusting people
	41	There are times when my anger gets too much out of control for the actual situation
	42	I'm sometimes afraid for not obvious reason
	43	I'm no stranger to rejection
	44	I try very hard to please others
	45	I have been neglected by someone that was supposed to have loved me

________	46	My sex life is not what it should be
________	47	I have a hard time understanding or communicating what I'm really feeling
________	48	I've experienced too many failures that I just don't understand
________	49	I've been raped/sexually abused (count one per occurrence)
________	50	I have engaged in pornography (score 1-5; if heavily over time, count as five)
________	51	I have reoccurring nightmares of being chased or harmed
________	52	I often prefer the companionship of food to friends
________	53	I witnessed my parent strike a family member (beyond discipline) on more than a few occasions
________	54	One of my parents seemed distant, or not always available, to me (count as two if both)
________	55	I am ashamed of parts of my life
________	56	I avoid conflict whenever possible
________	57	I definitely avoid people in my church, or work, or social situations who have (or may) hurt me
________	58	I have a hard time saying no
________	59	I have gone through periods when I have withdrawn from people for days at a time
________	60	I am not sure that both of my parents loved and accepted me unconditionally
________	61	I really don't know who I am and where I am going with my life
________	62	I don't take very good care of myself
________	63	I must admit that I don't work very hard to grow as a person
________	64	My dad (or mom) was not always there for me (if both, count as two)
________	65	I have used alcohol or drugs in excess (score 1-5; if heavily over time, count as five)
________	66	There are times when I seem to explode at someone who really didn't deserve that degree of anger
________	67	I have been involved with the occult (score 1-5; if heavily, count as five)
________	68	It is hard for me to feel safe in a close relationship
________	69	I seem to punish myself for reasons I don't understand
________	70	Others have told me that I don't see or accept things the way the really are
________	71	I struggle with being really honest about how I feel with people to whom I would like to be able to share myself
________	72	I probably learned some wrong things about God based upon my dad's ability to reflect God to me
________	73	I have been hurt by my church/support system (past or present)
________	74	I usually feel that what I have to offer isn't really good enough
________	75	I'm not really sure just who I am
________	76	I have experienced times where I really felt out of control of my emotions
________	77	I have a hard time sleeping through the night
________	78	Sometimes I get so nervous, worried, or panicked that I alarm myself (count one per panic event)
________	79	Sometimes my thoughts seem to be way out of control
________	80	There are times that I know I have flagrantly lost contact with reality (count five per event)

Scoring directions: Count each true answer as one point (plus additional points from specific items as instructed).

________ **80B** Over the past 12 months I have experienced a crisis, traumatic event, loss of a loved one, or a lifestyle change

Note: any one area or crisis alone, if prolonged and/or intensive enough, could create significant woundedness suggesting intensive psychotherapy or medical management.

Key:

20 or less	**=**	**Mild woundedness**
21-30	**=**	**Moderate woundedness**
31-40	**=**	**Significant woundedness**
41-50	**=**	**Severe woundedness**
60 or more	**=**	**Extreme woundedness**

Name: ______________________ **I.D.#:** ________________ **Score:** __________

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Barnabas Behavioral Healthcare, LLC

The Drug Abuse Screening Test (DAST)

(Adapted for Chronic Pain, Bariatric and Mental Health Populations)

Directions: *The following questions concern information about your involvement with drugs. Drug abuse refers to (1) use of prescribed or "or over the counter" drugs in excess of the directions, and (2) any non-medical use of drugs. This includes recreational or illegal use, or substances used without your doctors' knowledge. Prescribed medication used properly does not apply. Considers the past year (12 months) and carefully read each statement. Then decide whether your answer is YES or NO and check the appropriate space. Please be sure to answer every question.*

		YES	NO
1	Have you used drugs other than those required for medical reasons?		
2	Have you abused prescription drugs?		
3	Do you abuse more than one drug at a time?		
4	Can you get through the week without using drugs (other than those required for medical reasons?)		
5	Are you always able to stop using drugs when you want to?		
6	Do you abuse drugs on a continuous basis?		
7	Do you try to limit your drug use in certain situations?		
8	Have you had "blackouts" or "flashbacks" as a result of drug use?		
9	Do you ever feel bad about your drug use?		
10	Does your spouse (or parents) ever complain about your involvement with drugs?		
11	Do your friends or relatives know or suspect you abuse drugs?		
12	Has your drug use ever created problems between you and your spouse?		
13	Has and family member every sought help for problems related to your drug use?		
14	Have you ever lost friends because of your drug use?		
15	Have your ever neglected your family or missed work because of your use of drugs?		
16	Have you ever been in trouble at work because of your drug use?		
17	Have you ever lost a job because of your drug use?		
18	Have you ever gotten into fights when under the influence of drugs?		
19	Have you ever been arrested because of unusual behavior while under the influence of drugs?		
20	Have you ever been arrested for driving under the influence of drugs?		
21	Have you ever been involved in illegal activities in order to obtain drugs?		
22	Have you ever been arrested for possession of illegal drugs?		
23	Have you ever experienced withdrawal symptoms as a result of heavy drug intake?		
24	Have you had medical problems as a result of your drug use? (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)		
25	Have you ever gone to anyone for help for a drug problem?		
26	Have you ever been in a hospital for medical problems related to your drug use?		
27	Have you ever been involved in a treatment program specifically related to drug use?		
28	Have you ever been treated as an outpatient for problems related to drug abuse?		

FOR PROFESSIONAL USE ONLY

Patient: ______________________ Date: ______________ Score: __________

Scoring and interpretation: A score of "1" is given for each YES response, except for items 4,5,and 7, which NO response is given a score of "1". Based on data from a heterogeneous psychiatric population, cutoff scores of 6 through 11 are considered to be optimal for screening for substance use disorders. Using a cutoff score of 6 has been found to provide excellent sensitivity for identifying patients with substance use disorders as well as satisfactory specificity (i.e., identification of patients who do not have substance use disorders). Using a cutoff score of <11 somewhat reduces the sensitivity for identifying patients with substance use disorders, but more accurately the patients that do not have a substance abuse disorder. Over 12 is definitely a substance abuse problem. In a heterogeneous psychiatric patient population, most items have been shown to correlate at least moderately well with the total scale scores. The items that correlate poorly with the total scale scores appear to be items 4,7,16 ,20, and 22.

Barnabas Behavioral Healthcare, LLC

BECKS DEPRESSION INVENTORY (*BDI*)
DATE: ______________

Name: ______________________ Marital Status ______________ Age ____ Sex _____
Occupation: ______________________ Education: ______________________

This questionnaire consists of 21 groups of statements with a rating of 0-3 for each. Please circle the number that BEST describes how you have been feeling in the **past week, including today.** If several statements within a group seem to equally apply, circle each one. Be sure to read all the statements in each group before making your choices. Calculate the sum of the circled statement's numerical value in the total score area below.

1
0 I do not feel sad.
1 I feel sad
2 I am sad all the time and I can't snap out of it.
3 I am so sad and unhappy that I can't stand it.

2
0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel the future is hopeless and that things cannot improve.

3
0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2 As I look back on my life, all I can see is a lot of failures.
3 I feel I am a complete failure as a person.

4
0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things the way I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.

5
0 I don't feel particularly guilty
1 I feel guilty a good part of the time.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6
0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7
0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.

8
0 I don't feel I am any worse than anybody else.
1 I am critical of myself for my weaknesses or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.

9
0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10
0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.

11
0 I am no more irritated by things than I ever was.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time.

12 0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13 0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.

14 0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel there are permanent changes in my appearance that make me look unattractive
3 I believe that I look ugly.

15 0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16 0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17 0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18 0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19 0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

20 0 I am no more worried about my health than usual.
1 I am worried about physical problems like aches, pains, upset stomach, or constipation
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think of anything else.

21 0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I have almost no interest in sex.
3 I have lost interest in sex completely.

TOTAL SCORE __________

1-10	These ups and downs are considered normal	21-30	Moderate depression
11-16	Mild mood disturbance	31-40	Severe depression
17-20	Borderline clinical depression	Over 40	Extreme depression

Barnabas Behavioral Healthcare LLC
Notice of Privacy Practices
This notice describes how medical, drug and alcohol and psychological related information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

General Information

Information regarding your health care, including payment for health care, is protected by two federal laws; the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. 1320det seq,, 45 C.F.R. Part 160 & 164 and the Confidentiality Law, 42 U.S.C. 290dd-2, 42 C.F.R. Part 2. Under these laws, Barnabas Behavioral Healthcare LLC may not say to a person outside Barnabas Behavioral Healthcare LLC that you attend the practice, nor may Barnabas Behavioral Healthcare LLC disclose any information identifying you as a client, or disclose any other protected information except as permitted by federal law.

Barnabas Behavioral Healthcare LLC must obtain your written consent before it can disclose information about you for payment purposes. For example, Barnabas Behavioral Healthcare LLC must obtain your written consent before it can disclose information to your health insurer in order to be paid for services. Generally, you must also sign a written consent before Barnabas Behavioral Healthcare LLC can share information for treatment purposes or for health care operations. However, federal law permits Barnabas Behavioral Healthcare LLC to disclose information without your written permission in the following situations:

1. Pursuant to an agreement with a qualified service organization/ business associate
2. For research, audit or evaluations.
3. To report a crime committed on Barnabas Behavioral Healthcare LLC premises or against Barnabas Behavioral Healthcare LLC personnel.
4. To medical personnel in a medical emergency.
5. To appropriate authorities to report suspected child abuse or neglect or domestic violence.
6. As allowed by a court order.

For example, Barnabas Behavioral Healthcare LLC can disclose information without your consent to obtain legal or financial services, or to another medical facility to provide health care to you, as long as there is a qualified services organization/ business associate agreement in place.

Barnabas Behavioral Healthcare LLC may need to share your protected health information with third party "business associates" that perform various activities such as laboratory services and billing partners. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Before Barnabas Behavioral Healthcare LLC can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing at any time.

Your Rights:

Under HIPAA you have the right to request restrictions on certain uses and disclosures of your health information. At your request, Barnabas Behavioral Healthcare LLC will not disclose information to your health insurance plan about any services for which you have paid out-of-pocket. Barnabas Behavioral Healthcare LLC is not required to agree to any other restrictions you request, but if it does agree, then it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical emergency.

You have the right to request that we communicate with you by alternative means or at an alternative location. Barnabas Behavioral Healthcare LLC will accommodate such requests that are reasonable and will not request an explanation from you. Under HIPAA you also have the right to inspect and copy your own health information maintained by Barnabas Behavioral Healthcare LLC, except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal or administrative proceeding or in other limited circumstances.

Under HIPAA you also have the right, with some exceptions, to amend health care information maintained in Barnabas Behavioral Healthcare LLC records, and to request and receive an accounting of disclosures of your health related information made by Barnabas Behavioral Healthcare LLC during the six years prior to your request. You also have the right to receive a paper copy of this notice.

Barnabas Behavioral Healthcare LLC Duties:

Barnabas Behavioral Healthcare LLC will not share your protected health information for marketing or fundraising purposes, nor will we ever sell your protected health information without your prior approval.

Barnabas Behavioral Healthcare LLC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. Barnabas Behavioral Healthcare LLC is required by law to abide by the terms of this notice. Barnabas Behavioral Healthcare LLC reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. You may access a revised version by accessing our website, or you may request a copy by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

Questions and Complaints:

If you want more information about our privacy practices or have questions or concerns, please contact our Compliance Officer Peter Zaepfel at 803-216-0850.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations. You may complain to us using the contact information listed at the end of this Notice. You also may submit a written compliant to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

If you have any questions or comments regarding your Protected Health Information, feel free to contact our Compliance Officer. The contact information is provided below.

Contact Officer: Peter Zaepfel, Corporate Compliance Officer Telephone: 803-216-0850 Fax: 803-216-0420

Address: 409 Evelyn Drive Columbia, South Carolina 29210

Acknowledgement of Receipt of Privacy Practices

I have read, understood, and received a copy of Barnabas Behavioral Healthcare LLC Notice of Privacy Practices and a copy of this form will be retained in my medical chart.

Signed:____Date: _______________

Printed Name: ____

Authorization to Disclose Information

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this content at any time except to the extent that action has been taken in reliance on it. This release will expire 12 months after first signed.

__________ I want this information released to my Primary Doctor/Provider/Referring Doctor

__________ I DO NOT want this information released to my Primary Doctor/Provider/Referring Doctor

Patient ______________________________ Date ____________________

Parent/Guardian ______________________________ Date ____________________

Witness ______________________________ Date ____________________

Consent to Treatment

1. I _________________ (patient name) give permission for **Barnabas Behavioral Healthcare, LLC** to give me psychological treatment/assessments/testing/screenings/medical treatment.

2. I allow **Barnabas Behavioral Healthcare, LLC** to file for insurance benefits to pay for the care I receive.

   I understand that:

   Barnabas Behavioral Healthcare, LLC will have to send my medical record information to my insurance company.

   I must pay my share of the costs.

   I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

   An assessment letter will be sent to my referring provider with the result of my assessment

3. I understand:

   I have the right to refuse any procedure or treatment.

   I have the right to discuss all medical treatments with my clinician.

Patient ______________________________ Date ______________

Parent/Guardian ______________________________ Date ______________