Integrated Primary Care &
Psych Mental Health
4300 N University Dr. Bldg. C Suite 103, Sunrise FL 33351
Phone # (954)478-5763
Fax # (954)901-2713
E-mail: integratedpmh@gmail.com

PATIENT INFORMATION

NAME:_____

ADDRESS:_____

CITY: _____ ZIP CODE:_____

PRIMARY TEL NUMBER_____ CELL: _____

E- MAIL ADDRESS: _____

RACE: ____ ETHNICITY:_____SEX____ PREFERRED LANGUAGE_____

MARITAL STATUS ____ SSN _____ DOB:_____

PHARMACY NUMBER: _____

REFERRING PHYSICIAN: _____ TEL _____

Emergency Contact: _____Tel: _____

PRIMARY INSURED:_____

INSURANCE: _____

DOB_____ RELATIONSHIP_____

POLICY NUMBER _____ GROUP _____

Secondary Insurance

INSURANCE: _____

INSURED: _____

DOB_____ RELATIONSHIP _____

POLICY NUMBER _____ GROUP _____

BE ADVISED THAT YOUR INSURANCE HAS NOT GUARENTEED PAYMENT; A DECISION WILL BE MADE UPON RECEIPT OF THE CLAIM. IF YOUR INSURANCE CARRIER DENIES PAYMENT FOR SERVICES RENDERED TO YOU IT IS YOUR RESPONSIBILITY TO PAY ANY REMAINING BALANCE.

COPAYMENTS OR DEDUCTIBLES WILL BE COLLECTED AT THE TIME SERVICES ARE RENDERED WITH NO EXCEPTIONS.

_____ _____

PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

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HIPAA Privacy Rule Receipt of Notice of Privacy Practices Acknowledgement Form

I,_____ (Patient's Name) understand that as part of my health care, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

I have the right to review the facility's Notice of Privacy Practices prior to signing this acknowledgement
This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

_____ /_____ /_____

Printed Name of Patient/Legal Representative | Relationship to patient | Date

_____ /_____ /_____

Signature of Patient/Legal Representative | Relationship to patient | Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Others (please specify):_____

_____ _____

Office Staff Signature | Date

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Informed Consent for Treatment in Adults and Minors

Integrated primary care & Psychiatric Mental health ensures that the rights of all individuals are upheld regarding consenting requirements for physical examination and medication treatment including psychotropics in the treatment of mental disorders. Informed medical consent requirements are described and are carried out in conformance with **Florida Statute 765.106, 766.103**

DEFINITIONS:

Informed Consent: Permission granted by a health care consumer with full knowledge of the risks and benefits of receiving treatment including taking a medication, understanding of possible side effects, alternate treatments, and risk of no use. Consent is voluntary and can be withdrawn at any time.

Psychotropic Medication: medications administered for the purpose of affecting the central nervous system to treat psychiatric disorders or illnesses. These medications include, but are not limited to, anxiolytic agents, antidepressants, mood stabilizers, antipsychotic medications, anti-Parkinson agents, hypnotics, medications for dementia and psychostimulants, and medications used for side effects caused by psychotropic medications.

Anxiolytic Agents: Medications used to treat symptoms of acute anxiety.

Antidepressants: Drugs that treat depression and improve the symptoms

Mood Stabilizers: Medications used to even out the mood swings experienced by a person with bipolar disorder.

Antipsychotic Medications: A class of medications used to treat psychosis and other mental and emotional conditions.

Hypnotics: Medications that are prescribed for insomnia. Psychostimulant: A medication used to improve concentration and impulse control in attention deficit hyperactivity disorder.

Health Care Provider: Under federal regulations, a "health care provider" is defined as: a doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, **nurse practitioner**, nurse-midwife, or a clinical social worker who is authorized to practice by the State and performing within the scope of their practice as defined by State law.

I_____ voluntarily agree to participate in treatment sessions and/or consent to the participation of my child in treatment.

I understand these sessions are confidential and the health care provider will keep confidential anything that the client says with the following exceptions:

1. The client gives written consent to the health care provider to communicate with someone else.
2. The health care provider determines that the client is in danger to self or others.

3. The law requires disclosure, such as in the case of child or elder abuse, or when ordered by a court to disclose such an information.
4. Information shared among health care providers involved in the care of the client about his/her course of care or treatment.
5. Release of information to client's insurance company to determine benefits and to secure payment.

I _____understand that treatment for mental health include medication treatment as well as counseling sessions.

Counseling Sessions:

I understand that it may involve the risk of remembering painful events and can arouse intense emotion of fear or anger. Other feelings of anxiety, depression, frustration, loneliness or helplessness may also be aroused. I understand the benefits of counseling may be that I will better able to handle or cope with family, friends and other relationships, as well as other aspects of social life such as work or school. I may have a better understanding of personal goals and values which could lead to self-growth. However, I understand that there is no guarantee of positive results.

Medication Treatment:

I understand the diagnosis, the nature and purpose of the proposed treatment, as well as the risks and consequences of it. The health care provider has explained the most common side effects of medication treatment, and I do understand that other side effects may occur and that I should promptly notify to the health care provider or my primary clinician of any unexpected changes in my physical or mental condition.

I understand that I will not be forced to take this medication and that I can stop taking it at any time. I also understand that discontinuation of prescribed medication without consultation with the health care provider who prescribed the medication, or my primary clinician could cause my condition to remain improved or worsen.

All questions of special concern to me have been answered, and I authorize the clinician to prescribe the medication. I make this decision to accept the recommended drug treatment voluntarily and without coercion.

Client's signature_____ Date_____

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Client Name: _____

Date of Birth: _____

INFORMED CONSENT FOR TELE-BEHAVIORAL HEALTH SERVICES

Integrated Primary Care & Psych Mental Health provides Tele-Behavioral Health services to clients and families to supplement in-person sessions, as well as, to clients who may otherwise have barriers to receiving in-person treatment. In the event you (the client) and your family, if applicable, decides to use Integrated Primary Care & Psych Mental Health TeleBehavioral Health services, this document provides information on the services and acts as an informed consent for such services as outlined below.

1. Integrated Primary Care & Psych Mental Health uses secure video conferencing for Tele-Behavioral Health services for clients. Secure video conferencing utilizes real-time video and audio communication between the client and Integrated Primary Care & Psych Mental Health provider staff who are in different physical locations.
2. The client must have the following available in order to participate in Tele-Behavioral Health services:
    a. A computer, tablet or mobile device with:
        I. Internet connection
        II. Webcam, su翮 cient to include video any persons in the session
        III. Microphone, su翮 cient to include audio for any person in the session
    b. Private and secure location, which allows you to separate yourself from distractions and any persons not participating in the session who may overhear.
3. Integrated Primary Care & Psych Mental Health uses Zoom (www.zoom.us) for secure video conferencing. Zoom is HIPAA compliant and easy to use. The Zoom program is accessible through a web browser on your computer or a free app download on mobile devices. When you schedule a Tele-Behavioral Health service, you will receive a Zoom invitation and link to the “Zoom Meeting” for your scheduled Tele-Behavioral Health session. Also included in the Zoom invitation are contact numbers which may be used in the event of technical di翮 culties. At the time of your scheduled Tele-Behavioral Health session, your therapist will initiate the session.
4. In the event of disconnection, disruption or other technical di翮 culties, you should attempt to reconnect to the “Zoom Meeting" secure video conferencing through the Zoom invitation. If reconnection is not possible, you should await contact by your therapist at your designated contact phone number to either resolve Zoom connectivity issues and/or to reschedule the session. In the event your therapist does not contact you within ten (10) minutes, you may call into the provided contact numbers within the invitation for support and/or rescheduling of the session.
5. The convenience of Tele-Behavioral Health services along with our tendencies to multi-task while communicating via technology often lead clients to see Tele-Behavioral Health sessions differently than in person services (e.g. try to get their session done “on the go” or while doing other things). Approaching Tele-Behavioral Health services in this fashion frequently leads to distractions, interruptions during sessions, loss of privacy and an overall reduction in e翮 ciency of services. It is very important that you treat your Tele-Behavioral Health services in the same manner as an in-person session. That means that you will need to be in a quiet, private place which is free from distractions and interruptions. If at the time of your session, your therapist finds that you are not in a suitable location for the Tele-Behavioral Health service, your therapist may choose to not continue the session and to reschedule.
6. Integrated Primary Care & Psych Mental Health provider staff/therapists are only permitted to conduct Tele-Behavioral Health services via an agency provided and approved computer/laptop using Zoom secure video conferencing. Integrated Primary Care & Psych Mental Health provider staff/therapists may not utilize other applications or methods (e.g., Skype, FaceTime, etc.) as these do not meet required criteria for agency and HIPAA compliance.

By signing below, I and/or my legal guardian, consent to participating in Integrated Primary Care & Psych Mental Health Tele-Behavioral Health services. Tele-Behavioral Health services include the use of secure video conferencing to allow my Integrated Primary Care & Psych Mental Health provider staff/therapist to diagnose, consult, provide therapeutic intervention and counseling for the purpose of my (the client’s) treatment. I and/or my legal guardian have read and understand this Informed Consent for TeleBehavioral Health services including the following information:

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Client Name: _____

Date of Birth: _____

INFORMED CONSENT FOR TELE-BEHAVIORAL HEALTH SERVICES

1. I have the right to confidentiality with Tele-Behavioral Health services under the same laws that protect the confidentiality of my protected health information (PHI) for in-person therapeutic services, as noted in the Integrated Primary Care & Psych Mental Health Consent for Treatment.
   a. This includes the exceptions to confidentiality related to mandatory reporting of abuse and/or neglect, emergency/crisis situation and/or to cooperate with a lawful investigation.
2. I understand that while behavioral health therapeutic treatment of various kinds have been found to be effective in treating a wide range of mental health and/or substance use condition, there is no guarantee that all treatments for all clients are effective, this includes Tele-Behavioral Health services.
3. I grant permission and authorize Integrated Primary Care & Psych Mental Health to audiotape/videotape my Tele-Behavioral Health therapy sessions for the limited purpose of supervision and fidelity monitoring to the evidenced-based treatment model being provided to the client by the Integrated Primary Care & Psych Mental Health therapist.
   a. I understand Integrated Primary Care & Psych Mental Health utilizes best-practice evidenced-based treatment models for therapeutic services, many of which require fidelity monitoring to ensure adherence to the treatment model. I further understand some evidenced-based treatment models used by Integrated Primary Care & Psych Mental Health utilize audiotaping/ videotaping of therapy sessions as part of the fidelity monitoring and supervision process.
   b. In the event a Tele-Behavioral Health therapy session will be recorded, I understand the Integrated Primary Care & Psych Mental Health provider staff/therapist will inform the client and any persons participating in the session that the session will be recorded PRIOR to beginning to audiotape/videotape the Tele-Behavioral Health session.
   c. I understand that the audiotape/videotape recordings may be reviewed by clinical supervisors of the Integrated Primary Care & Psych Mental Health provider staff/therapist to ensure quality treatment and adherence to the treatment model. I understand that the audiotape/videotape recordings will be erased immediately following the supervisory/evaluation review. I further understand that all supervisors/clinical staff who may review the audiotape/videotape recorded sessions must abide by all ethical guidelines and law, which includes strict maintenance of confidentiality.
4. I understand that Tele-Behavioral Health services have unique and specific risks, including but not limited to the possibility that Tele-Behavioral Health sessions could be disrupted or distorted by technical failures, or could be interrupted, or could be accessed by unauthorized persons. Integrated Primary Care & Psych Mental Health uses HIPAA compliant methods for Tele-Behavioral Health services. However, no use of technology can be 100% protected. I also understand that the confidentiality of any secure video conferencing session within my (the client's) environment, such as allowing unauthorized persons access to any part of the session, is my responsibility and not the responsibility of Integrated Primary Care & Psych Mental Health.
5. I understand that my Chrysalis provider staff/therapist cannot provide emergency services via TeleBehavioral Health. My Integrated Primary Care & Psych Mental Health provider staff/therapist and I will determine an emergency/crisis plan at the on-set of Tele-Behavioral Health services. In the event of an emergency/crisis I understand that I will contact 911 and/or proceed to the nearest hospital emergency room. If I cannot confirm contact with 911, my Integrated Primary Care & Psych Mental Health provider staff/therapist may contact 911 to initiate emergency services.
6. I understand that if my Integrated Primary Care & Psych Mental Health provider staff/therapist or I determine Tele-Behavioral Health services are not, or are no longer, an appropriate intervention for me, recommendations and/or referral for in-person services may be made.
7. I understand that I may revoke my consent **in writing** at any time to the extent that Integrated Primary Care & Psych Mental Health has not already taken action in reliance thereon. When and if revoking my consent, I agree to send the writing to the attention of "Privacy O翻 cer". I understand that if I choose not to revoke this consent, this consent will be valid throughout my entire length of treatment and/or services.

_____	_____	_____
Patient or Guardian Signature-if applicable	Print Name	Date
_____	_____	_____
Patient or Guardian Signature-if applicable	Print Name	Date

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Office Policy

Please be advised that **CANCELLATIONS** require a **24hr** notice.
Same day cancellations are a charged at **$60**

If you fail to show up for your appointment, or Telehealth.

A **NO SHOW** Charge of **$60.00** will automatically be assessed to your account.

By signing below, you acknowledge that you have read and understand the office policy.

_____ _____

Print Patients Name Date

_____ _____

Patient or Legal Guardians Signature Date

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Credit Card Payment Authorization Form

Sign and complete this form to authorize Integrated Primary Care & Psych Mental Health to make a debit to your credit card listed below

---

Please complete the information below:

I _____ authorize Integrated Primary Care & Psych Mental Health to charge my
(full name)

credit card account indicated below for services rendered by a healthcare provider at this location, or for missing a scheduled appointment without giving a 24 hour notice as per the office policy.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name _____

Card Number _____

Expiration Date _____

CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the services/fees described above.
I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Name: _____ DATE:_____

Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

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.

Name: _____ DATE: _____

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.

Name:_____ DATE:_____

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.

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

Total Score_____Levels of Depression

1-10_____These ups and downs are considered normal
11-16_____ Mild mood disturbance
17-20_____Borderline clinical depression
21-30_____Moderate depression
31-40_____Severe depression
over 40_____Extreme depression

Name:_____ DATE:_____

Beck Anxiety Inventory (BAI)

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	Not at all	Mildly, but it didn't bother me much	Moderately – it wasn't pleasant at times	Severely – it bothered me a lot
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding / racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky / unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint / lightheaded	0	1	2	3
Face flushed	0	1	2	3
Hot / cold sweats	0	1	2	3

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	◯	◯	◯	◯	◯
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?	◯	◯	◯	◯	◯
3. How often do you have problems remembering appointments or obligations?	◯	◯	◯	◯	◯
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	◯	◯	◯	◯	◯
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	◯	◯	◯	◯	◯
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?	◯	◯	◯	◯	◯

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?	◯	◯	◯	◯	◯
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?	◯	◯	◯	◯	◯
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?	◯	◯	◯	◯	◯
10. How often do you misplace or have difficulty finding things at home or at work?	◯	◯	◯	◯	◯
11. How often are you distracted by activity or noise around you?	◯	◯	◯	◯	◯
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?	◯	◯	◯	◯	◯
13. How often do you feel restless or fidgety?	◯	◯	◯	◯	◯
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?	◯	◯	◯	◯	◯
15. How often do you find yourself talking too much when you are in social situations?	◯	◯	◯	◯	◯
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?	◯	◯	◯	◯	◯
17. How often do you have difficulty waiting your turn in situations when turn taking is required?	◯	◯	◯	◯	◯
18. How often do you interrupt others when they are busy?	◯	◯	◯	◯	◯

Part B

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____ DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "n" 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 figety 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	0	1	2	3
add columns		+	+	
TOTAL:				

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. 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 _____

Mental Health Intake Form

Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you!

Name_____Date_____

Date of Birth _____ Primary Care Physician_____

Do you give permission for ongoing regular updates to be provided to your primary care physician? _____

Current Therapist/Counselor_____ Therapist's Phone_____

What are the problem(s) for which you are seeking help?
1._____
2._____
3._____

What are your treatment goals?
_____
_____
_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

☐ ☐ **Depressed mood**
☐ ☐ **Unable to enjoy activities**
☐ ☐ **Sleep pattern disturbance**
☐ ☐ **Loss of interest**
☐ ☐ **Concentration/forgetfulness**
☐ ☐ **Change in appetite**
☐ ☐ **Excessive guilt**
☐ ☐ **Fatigue**
☐ ☐ **Decreased libido**
☐ ☐ **Racing thoughts**
☐ ☐ **Impulsivity**
☐ ☐ **Increase risky behavior**
☐ ☐ **Increased libido**
☐ ☐ **Decrease need for sleep**
☐ ☐ **Excessive energy**
☐ ☐ **Increased irritability**
☐ ☐ **Crying spells**
☐ ☐ **Excessive worry**
☐ ☐ **Anxiety attacks**
☐ ☐ **Avoidance**
☐ ☐ **Hallucinations**
☐ ☐ **Suspiciousness**
☐ ☐ _____
☐ ☐ _____

Suicide Risk Assessment
Have you ever had feelings or thoughts that you didn't want to live? ◯ Yes ◯ No.
If YES, please answer the following. If NO, please skip to the next section.
Do you **currently** feel that you don't want to live? ◯ Yes ◯ No
How often do you have these thoughts? _____
When was the last time you had thoughts of dying? _____
Has anything happened recently to make you feel this way? _____
On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____
Would anything make it better? _____
Have you ever thought about how you would kill yourself? _____
Is the method you would use readily available? _____
Have you planned a time for this? _____
Is there anything that would stop you from killing yourself? _____
Do you feel hopeless and/or worthless? _____
Have you ever tried to kill or harm yourself before? _____

Do you have access to guns? If yes, please explain. _____

Name: _____ DATE: _____

Past Medical History:

Allergies_____ Current Weight _____ Height _____

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name Total Daily Dosage Estimated Start Date

_____

_____

_____

_____

_____

_____

_____

_____

Current over-the-counter medications or supplements: _____

_____

Current medical problems: _____

_____

Past medical problems, nonpsychiatric hospitalization, or surgeries: _____

_____

Have you ever had an EKG? ◯ Yes ◯ No If yes, when _____ .
Was the EKG ◯ normal ◯ abnormal or ◯ unknown**?**

For women only: Date of last menstrual period _____ Are you currently pregnant or do you think you might be pregnant? ◯ Yes ◯ No. Are you planning to get pregnant in the near future? ◯ Yes ◯ No
Birth control method _____
How many times have you been pregnant? _____ How many live births? _____

Do you have any concerns about your physical health that you would like to discuss with us? ◯ Yes ◯ No
Date and place of last physical exam: _____

Personal and Family Medical History:

	You	**Family**	**Which Family Member?**
Thyroid Disease	☐	☐	_____
Anemia	☐	☐	_____
Liver Disease	☐	☐	_____
Chronic Fatigue	☐	☐	_____
Kidney Disease	☐	☐	_____
Diabetes	☐	☐	_____
Asthma/respiratory problems	☐	☐	_____
Stomach or intestinal problems	☐	☐	_____
Cancer (type)	☐	☐	_____
Fibromyalgia	☐	☐	_____
Heart Disease	☐	☐	_____
Epilepsy or seizures	☐	☐	_____
Chronic Pain	☐	☐	_____
High Cholesterol	☐	☐	_____
High blood pressure	☐	☐	_____
Head trauma	☐	☐	_____
Liver problems	☐	☐	_____
Other	☐	☐	_____

Name:_____ DATE: _____

Is there any additional personal or family medical history? ( ) Yes ( ) No If yes, please explain:

_____

_____

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

_____

Past Psychiatric History:

Outpatient treatment ◯ Yes ◯ No If yes, Please describe when, by whom, and nature of treatment.

Reason Dates Treated By Whom

_____

_____

_____

Psychiatric Hospitalization ◯ Yes ◯ No If yes, describe for what reason, when and where.

Reason Date Hospitalized Where

_____

_____

_____

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

Dates Dosage Response/Side-Effects

Antidepressants

Prozac (fluoxetine) _____

Zoloft (sertraline) _____

Luvox (fluvoxamine) _____

Paxil (paroxetine) _____

Celexa (citalopram) _____

Lexapro (escitalopram) _____

Effexor (venlafaxine) _____

Cymbalta (duloxetine) _____

Wellbutrin (bupropion) _____

Remeron (mirtazapine) _____

Serzone (nefazodone) _____

Anafranil (clomipramine) _____

Pamelor (nortrptyline) _____

Tofranil (imipramine) _____

Elavil (amitriptyline) _____

Other _____

Mood Stabilizers

Tegretol (carbamazepine)_____

Lithium_____

Depakote (valproate) _____ _____

Lamictal (lamotrigine) _____

Tegretol (carbamazepine) _____

Topamax (topiramate) _____

Other _____

Name: _____ DATE: _____

Past Psychiatric medications (continued)

Antipsychotics/Mood Stabilizers	Dates	Dosage	Response/Side-Effects

Seroquel (quetiapine) _____
Zyprexa (olanzepine) _____
Geodon (ziprasidone) _____
Abilify (aripiprazole) _____
Clozaril (clozapine) _____
Haldol (haloperidol) _____
Prolixin (fluphenazine) _____
Risperdal (risperidone) _____
Other _____

Sedative/Hypnotics

Ambien (zolpidem) _____
Sonata (zaleplon) _____
Rozerem (ramelteon)_____
Restoril (temazepam) _____
Desyrel (trazodone) _____
Other _____

ADHD medications

Adderall (amphetamine) _____
Concerta (methylphenidate) _____
Ritalin (methylphenidate) _____
Strattera (atomoxetine) _____
Other _____

Antianxiety medications

Xanax (alprazolam) _____
Ativan (lorazepam) _____
Klonopin (clonazepam) _____
Valium (diazepam) _____
Tranxene (clorazepate) _____
Buspar (buspirone) _____
Other _____

Your Exercise Level:

Do you exercise regularly? ( ) Yes ( ) No
How many days a week do you get exercise? _____
How much time each day do you exercise? _____
What kind of exercise do you do? _____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	◯ Yes	◯ No	Schizophrenia	◯ Yes	◯ No
Depression	◯ Yes	◯ No	Post-traumatic stress	◯ Yes	◯ No
Anxiety	◯ Yes	◯ No	Alcohol abuse	◯ Yes	◯ No
Anger	◯ Yes	◯ No	Other substance abuse	◯ Yes	◯ No
Suicide	◯ Yes	◯ No	Violence	◯ Yes	◯ No

If yes, who had each problem? _____
_____
Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No If yes, who was treated, what medications did they take, and how effective was the treatment? _____
_____

Name:_____ DATE:_____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ◯ Yes ◯ No
If yes, for which substances? _____
If yes, where were you treated and when? _____
_____
How many days per week do you drink any alcohol? _____
What is the least number of drinks you will drink in a day? _____
What is the most number of drinks you will drink in a day? _____
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____
Have you ever felt you ought to cut down on your drinking or drug use? ◯ Yes ◯ No
Have people annoyed you by criticizing your drinking or drug use? ◯ Yes ◯ No
Have you ever felt bad or guilty about your drinking or drug use? ◯ Yes ◯ No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ◯ Yes ◯ No
Do you think you may have a problem with alcohol or drug use? ◯ Yes ◯ No
Have you used any street drugs in the past 3 months? ◯ Yes ◯ No
If yes, which ones? _____
Have you ever abused prescription medication? ◯ Yes ◯ No
If yes, which ones and for how long? _____
_____

Check if you have ever tried the following:

	Yes	No	If yes, how long and when did you last use?
Methamphetamine	◯	◯	_____
Cocaine	◯	◯	_____
Stimulants (pills)	◯	◯	_____
Heroin	◯	◯	_____
LSD or Hallucinogens	◯	◯	_____
Marijuana	◯	◯	_____
Pain killers (not as prescribed)	◯	◯	_____
Methadone	◯	◯	_____
Tranquilizer/sleeping pills	◯	◯	_____
Alcohol	◯	◯	_____
Ecstasy	◯	◯	_____
Other	◯	◯	_____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Tobacco History:

Have you ever smoked cigarettes? ◯ Yes ◯ No
Currently? ◯ Yes ◯ No How many packs per day on average? _____ How many years? _____
In the past? ◯ Yes ◯ No How many years did you smoke? _____ When did you quit? _____

Pipe, cigars, or chewing tobacco: Currently? ◯ Yes ◯ No In the past? ◯ Yes ◯ No
What kind? _____ How often per day on average? _____ How many years? _____

Name: _____

Family Background and Childhood History: DATE: _____

Were you adopted? ◯ Yes ◯ No Where did you grow up? _____

List your siblings and their ages: _____

_____

What was your father's occupation? _____

What was your mother's occupation? _____

Did your parents' divorce? ◯ Yes ◯ No If so, how old were you when they divorced? _____

If your parents divorced, who did you live with?_____

Describe your father and your relationship with him: _____

_____

Describe your mother and your relationship with her: _____

_____

How old were you when you left home? _____

Has anyone in your immediate family died? _____

Who and when? _____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect? ◯ Yes ◯ No.

Please describe when, where and by whom: _____

_____

Educational History:

Highest Grade Completed? _____ Where? _____

Did you attend college? _____ Where? _____Major? _____

What is your highest educational level or degree attained? _____

Occupational History:

Are you currently: ◯ Working ◯ Student ◯ Unemployed ◯ Disabled ◯ Retired

How long in present position? _____

What is/was your occupation? _____

Where do you work? _____

Have you ever served in the military? _____ If so, what branch and when? _____

Honorable discharge ◯ Yes ◯ No Other type discharge _____

Relationship History and Current Family:

Are you currently: ◯ Married ◯ Partnered ◯ Divorced ◯ Single ◯Widowed

How long? _____

If not married, are you currently in a relationship? ◯ Yes ◯ No If yes, how long? _____

Are you sexually active? ◯ Yes ◯ No

How would you identify your sexual orientation?

◯ straight/heterosexual ◯ lesbian/gay/homosexual ◯ bisexual ◯ transsexual

◯ unsure/questioning ◯ asexual ◯ other ◯ prefer not to answer

What is your spouse or significant other's occupation? _____

Describe your relationship with your spouse or significant other:

_____

Have you had any prior marriages? ◯ Yes ◯ No.If so, how many? _____

How long? _____

Do you have children? ◯ Yes ◯ No If yes, list ages and gender: _____

_____

Describe your relationship with your children: _____

List everyone who currently lives with you: _____

_____

Name: _____

DATE: _____

Legal History:
Have you ever been arrested? _____
Do you have any pending legal problems? _____

Spiritual Life:
Do you belong to a particular religion or spiritual group? ◯ Yes ◯ No
If yes, what is the level of your involvement? _____
Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ◯ more helpful ◯ stressful

Is there anything else that you would like us to know?

_____
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_____

Signature_____Date_____

Guardian Signature (if under age 18) _____ Date _____

Emergency Contact _____ Telephone # _____

For Office Use Only:

Reviewed by _____Date _____

Reviewed by _____Date _____