GENERAL INFORMATION

Date: _____

Client's Full Name: _____ _____ _____
(first) (middle) (last)

Preferred Name or Nickname: _____ DOB: ____/____/____ Age: ____ Gender: _____

Address Line 1: _____ Address Line 2: _____

City: _____ State: _____ Zip: _____

CONTACT INFORMATION

		May we contact you at this number?		May we leave a voice and/or text message at this number?	
Phone Numbers		Yes	No	Yes	No
Cell					
Home					
Work					
Other					
E-Mail Address:					

CONSENT TO EMAIL OR TEXT USAGE FOR APPOINTMENT REMINDERS & OTHER HEALTHCARE COMMUNICATIONS

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications or information at that email or text address from the Practice.

_____ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

RELATIONSHIP STATUS (circle one) married partnered single divorced separated widowed

Emergency Contact: _____ Relationship: _____
Phone Number: _____ Other Phone Number: _____

Physician: _____ Phone Number: _____
Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Phone Number: _____
Address: _____ City: _____ State: _____ Zip: _____

Do you have a history of military service? Yes No If yes, when?_____

FINANCIAL RESPONSIBILITIES

Person Responsible for Payment: _____

Address: _____ City: _____ State: _____ Zip: _____

_____ I do not have insurance, and/or I decline to utilize or to have my insurance billed. By initialing this statement, I understand I am responsible for the full payment for services rendered.
Please initial

Copay Amount: $_____ Deductible Amount: $_____

Name of Insured: _____ ID # _____

Insurance Company: _____ Insured's Date of Birth _____

Secondary Insurance: _____ Contract # _____

Group # _____ SS# _____

REFERRAL SOURCE

Referred By: _____ Relationship: _____

- ☐ Website
- ☐ Facebook
- ☐ Friend
- ☐ Family Member
- ☐ Friend of the Court
- ☐ Physician
- ☐ Clergy/Church
- ☐ School
- ☐ Other Mental Health Agency/Therapist
- ☐ Attorney/Law Enforcement

FEE SCHEDULE

The initial assessment session is $190 and will last approximately 1½ hours. Additional sessions are $170 per 50-60 minute session. Fees may also vary depending on your circumstances and the nature of services. If it is unclear as to what your fee is, you are encouraged to discuss this with me. No shows or late cancellations (less than 24 hours) may be assessed a fee of $40.

BILLING POLICY

1. I authorize use of this form on all insurance submissions.
2. I authorize the release of information to my insurance company, unless noted otherwise above.
3. I understand that I am responsible for the full amount of my bill for services provided.
4. I understand I will be charged an extra fee of $30 for processing checks returned for insufficient funds.
5. I agree to pay the fee for each service, including co-pays and deductibles, at the time services are rendered.
6. I permit a copy of this form to be used in place of the original.
7. I agree to pay a $40 service charge for late cancellations and for missed appointments.
8. I have been offered a HIPAA Notice, Professional Disclosure, Fee Schedule, and Limitation on Patient Confidentiality.
9. I have been offered a signed copy of this agreement.
10. My signature on this form authorizes my consent to treatment.

SIGNATURE: _____ **DATE**: _____

Safety Violence Screening/Plan

Yes	No	Please check Yes or No for each item listed	If Yes, what is the plan for safety?
		Are you currently or have you ever been in a relationship where you were afraid, threatened or abused by someone?	
		Do you have stress in your relationships?	
		Do you ever feel controlled or isolated by others?	
		Do people in your life blame other for problems, their anger, and their abusive behaviors?	
		Would you consider yourself to have ever been physically, verbally or emotionally abused?	
		Have you or your children ever been threatened or abused?	
		Have you ever experienced sexual violence (forced sexual contact, unsafe sex practices, unwanted touching, etc)?	
		Would you consider yourself to have ever been the aggressor or perpetrator in a relationship (have you been charged or convicted of a domestic or sexually violent crime)?	
		Do you have a safe place to go and resources you and /or your children would need in an emergency?	
		Would you like assistance with: - locating a shelter/housing options - legal referral - identifying helpful community resources - hotline numbers - developing a detailed safety plan - contacting police, hospital, doctor, etc	

On a scale of “1 to 10” (10 being the worst), how would you rate your current living situation: _____

Please describe any areas of concern not addressed above:

_____
_____
_____
_____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" 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
1. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety 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 in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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**
⑤	⑤	⑤	⑤

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T*____ = ____ + ____ + ____)

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

AUDIT-C

1. **How often do you have a drink containing alcohol?**
   - ☐ a. Never
   - ☐ b. Monthly or less
   - ☐ c. 2-4 times a month
   - ☐ d. 2-3 times a week
   - ☐ e. 4 or more times a week

2. **How many standard drinks containing alcohol do you have on a typical day?**
   - ☐ a. 1 or 2
   - ☐ b. 3 or 4
   - ☐ c. 5 or 6
   - ☐ d. 7 to 9
   - ☐ e. 10 or more

3. **How often do you have 6 or more drinks on one occasion?**
   - ☐ a. Never
   - ☐ b. Less than monthly
   - ☐ c. Monthly
   - ☐ d. Weekly
   - ☐ e. Daily or almost daily

AUDIT-C is available for use in the public domain.

DAST-10

This is a list of questions concerning information about your potential involvement with drugs, excluding alcohol and tobacco, during the past 12 months.

When the words “drug abuse” are used, they mean the use of prescribed or over-the-counter medications/drugs in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions *do not include alcohol or tobacco*.

If you have difficulty with a statement, then choose the response that is mostly right.

These questions refer to the past 12 months.	**No**	**Yes**
1. Have you used drugs other than those required for medical reasons?	0	1
2. Do you abuse more than one drug at a time?	0	1
3. Are you always able to stop using drugs when you want to? (If never use drugs, answer “Yes.”	1	0
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	0	1
5. Do you ever feel bad or guilty about your drug use? If never use drugs, choose “No.”	0	1
6. Does your spouse (or parents) ever complain about your involvement with drugs?	0	1
7. Have you neglected your family because of your use of drugs?	0	1
8. Have you engaged in illegal activities in order to obtain drugs?	0	1
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	0	1
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	0	1

TOTAL SCORE=_____

Skinner, H. A. (1982). The Drug Abuse Screening Test. Addictive Behavior, 7(4),363–371.