Patient Name Date :

Kenfield Walters Intl LLC
PH. (248) 737-0388

New Patient Information: Adult Form

Last:	First:	Middle:
DOB:	Sex: ☐M ☐F	SS#:
CELL:	Home:	**Email:**
Address St.:	City:	Zip:
	Emergency **Contact**	
Last:	First:	Relationship: Ph. #:
	Insurance Information	
Primary Insurer:	ID:	Group #:
Secondary Insurer:	ID#:	Group #:
Policy Holder:	Relationship:	DOB:
SS #:	Employer:	Ph #:
	BENEFIT INFORMATION	
Please verify your benefits prior to your first appointment.	**Deductibles and co-pays are due at the time services are rendered.**	**F Code:**
Policy Effective Date:		
Copay: $	**Deductible: $**	**Deductible Remaining: $** **Individual:** **Family:**
Authorization: Y N	**Auth. Code:**	**Units: 96130** **96131**
REASON FOR APPOINTMENT:		

Financial Policies

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Payment of services is considered a part of your treatment and is expected at *each session*. We accept most insurances and provide Zelle© instructions on the Patient Forms page of our website: www.KenfieldWalters.com, The option to use Pay Pal is available to you 24/7 with a 4% charge for transaction fees. Make checks payable to "Kenfield Walters Intl LLC" and request a mailing address from our office.

KWI accepts most insurances but each patient is responsible for payment of services in full at the time that services are rendered until the *annual deductible,* if applicable, is fully paid, and for co-payments at each session as stipulated in the insurer benefit package.

Please initial in the designated places to signify that you have read and agree to each of the policies below:

X_____ I agree to a charge of $140.00 for missed appointments and for cancellations given within less than a 48-hour notification. (This does not apply to Evaluation Services. See Evaluation Signature Documents for that applicable cancellation window. Please ensure that you read and complete these signature documents prior to the evaluation.

X_____ I agree to pay immediately a $35.00 "returned check fee" in addition to replacing the amount of a check returned by my bank.

X_____ I agree to report to KWI any changes in my contact information (address, phone #, etc.), insurance, or responsible party prior to the next session appointment. I understand that I alone am responsible for knowing my benefit coverages.

X_____ KWI does not carry balances for any services. I agree that if my account remains unpaid for any services more than 30 days, KWI may take legal action to collect the balance at my expense. I agree, as my sole responsibility, to pay *all* attorney fees and court costs for both parties in any dispute *at the time of the hearing.*

X_____ I understand that I am financially responsible for services provided, whether reimbursed by my insurer or not. *Any* service fees not covered by my insurer are my sole responsibility.

A FEE MAY BE CHARGED FOR ADDITIONAL SERVICES
X_____Patient Initials_____Date:

Initialed Acknowledgement of Receipt of HIPAA Privacy Practices
X_____ I hereby **initial** here to acknowledge that I have been apprised of the availability of a copy of Kenfield Walters Intl LLC "Privacy Policy" that can be downloaded in its entirety at http://www.kenfieldwalters.com on the "Patient Forms" page."
Consent for Treatment
X_____ hereby consent to receive treatment for therapeutic/psychological services through Kenfield Walters Intl LLC. I have been notified that the "Consent for Treatment" form can be downloaded at http://www.kenfieldwalters.com on the "Patient Forms" page."
Initialed Coordination of Care with Primary Care Physician

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I, X (Patient Initials) _____ ☐ Authorize / ☐ Do Not Authorize, the release of any information to my physician by Kenfield Walters Intl LLC and the release of any information to Kenfield Walters Intl LLC by:

Physician Name:	Ph. #:	Fax #:

Address:	City:	MI	Zip:

X Patient/Guardian Signature:	X Date:

Please check Current symptoms:

☐ Anger	☐ Hyperactivity
☐ Anxiety	☐ Irritability
☐ Appetite Change	☐ Mood Swings
☐ Crying Spells	☐ Paranoia
☐ Decreased Concentration	☐ Racing Thoughts
☐ Excessive Worry	☐ Sleep Problems
☐ Feeling Hopeless	☐ Suicidal Feelings
☐ Weight Change	☐ Homicidal Thoughts
☐ Depression	☐ Overwhelmed
☐ Delusions	☐ Hallucinations
☐ Self-esteem issues	☐ Grief/loss
	Other:

Current concerns:

☐ Abuse History: _____
☐ Academic Issues
☐ Behavior Issues
☐ Financial Problems
☐ Health Issues
☐ Legal Issues
☐ Grief/Loss
☐ Relationship Issues
☐ Sexual Issues
☐ Substance Abuse: _____
☐ Work Issues
Other:

Depression Scale: Patient Mental Health Questionnaire – Circle one answer/number for each question.

Over the past two weeks, how often have you been troubled by any of the following problems?

	Not at all	Sev-eral days	More than half of the time	Nearly every day
1. Little interest in doing things.	**0**	**1**	**2**	**3**
2. Feeling down, depressed, or hopeless.	**0**	**1**	**2**	**3**
3. Trouble falling or staying asleep.	**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.	**0**	**1**	**2**	**3**
8. Moving or speaking so slowly that other people could have noticed, or being so fidgety 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 hurting yourself.	**0**	**1**	**2**	**3**
Column Totals				

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SOCIAL INFORMATION

1. Do you usually spend leisure time: ☐ Alone ☐ With family ☐ With friends

2. Describe your strengths: _____ _____ _____ _____

3. List your hobbies: _____ _____ _____ _____

SUICIDAL ISSUES

1. Have you ever thought about suicide? ☐ No ☐ Yes

2. Do you have a history of suicide attempts? ☐ No ☐ Yes Date of most recent if yes: _____

How?: _____

3. Do you currently feel suicidal now? ☐ No ☐ Yes Explain: _____

EDUCATION

☐ Did not complete High School ☐ High School Diploma ☐ GED ☐ Vocational Training
☐ Associate's Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctorate / Psy D. ☐ MD/DO
School: _____ Major: _____ Final GPA: _____

1. Have you experienced academic difficulties? ☐ No ☐ Yes If, yes, When ?:_____
Explain:_____

2. Have you experienced behavior problems in school? ☐ No ☐ Yes _____

OCCUPATION

☐ Student ☐ Homemaker ☐ Retired ☐ Unemployed ☐ Employed

Name of Employer: _____ Job Title: _____

Primary Sources of support: ☐ Self-support ☐ Full/Part Time Job ☐ Parents
☐ Spouse ☐ Retirement ☐ Disability

Have you ever been in the military? ☐ No
☐ Yes: ☐ Army ☐ Air Force ☐ Coast Guard ☐ Navy Marines

Enlistment Date: _____ (Circle): Honorable / Dishonorable Discharge Date: _____

Are you having issues at work? Circle: No Yes: If yes, please explain:

FAMILY INFORMATION

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widow(er)

Children: ☐ I do not have children

Name	Age	Dates of Marriage &/or Divorce	Lives with you?
Spouse(s):			☐ No ☐ Yes
			☐ No ☐ Yes
			☐ No ☐ Yes
Children:		**Biological/Step/Adopted**	☐ No ☐ Yes
			☐ No ☐ Yes
			☐ No ☐ Yes

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			☐ No ☐ Yes
Siblings:			☐ No ☐ Yes
			☐ No ☐ Yes
			☐ No ☐ Yes
			☐ No ☐ Yes
			☐ No ☐ Yes
			☐ No ☐ Yes

Describe your relationships with family members:

At Childhood: ☐ Poor ☐ Strained ☐ Good ☐ Excellent
At Adulthood: ☐ Poor ☐ Strained ☐ Good ☐ Excellent
At Present: ☐ Poor ☐ Strained ☐ Good ☐ Excellent

Were you raised in a home that practiced a religion? ☐ No ☐ Yes
Do you currently practice a religion? ☐ No ☐ Yes
☐ Catholic ☐ Christian ☐ Hindu ☐ Jewish ☐ Protestant ☐ Muslim ☐ Other: _____

Ethnic Group:
☐ African-American/Black ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American
☐ Other: _____

LEGAL HISTORY

(Circle) Are you <u>currently</u> and/ or have been <u>in the past</u> involved in a:

☐ Custody Suit, Date: _____ ☐ On Probation, Date(s): _____

☐ DUI/OWI Conviction(s), Date(s): _____ ☐ Divorce(s), Date(s): _____

☐ Other Legalities: _____

MEDICAL HISTORY

Describe Your current health:	**Are you experiencing physical pains at this time?**
☐ Poor ☐ Fair ☐ Good ☐ Very good	☐ No ☐ Yes: Where?_____

Medical Problem Experienced:	**About <u>Myself</u> - Use <u>Dates</u>**		**About Family Members / Dates**
	Current/ Recent	**Past**	☐ Mother ☐Father ☐Sibling
Abuse: Emotional/Physical/Sexual			☐ Mother ☐Father ☐Sibling
Alcohol Abuse…&/or Inpatient hospitalization…			☐ Mother ☐Father ☐Sibling ☐ Mother ☐Father ☐Sibling
ADD/ADHD			☐ Mother ☐Father ☐Sibling
Anxiety			☐ Mother ☐Father ☐Sibling
Asthma			☐ Mother ☐Father ☐Sibling
Appendicitis			☐ Mother ☐Father ☐Sibling
Bed wetting			☐ Mother ☐Father ☐Sibling
Birth defects			☐ Mother ☐Father ☐Sibling
Bulimia			☐ Mother ☐Father ☐Sibling

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Cancer			☐ Mother ☐Father ☐Sibling
Chest pain			☐ Mother ☐Father ☐Sibling
Constipation			☐ Mother ☐Father ☐Sibling
Chicken Pox			☐ Mother ☐Father ☐Sibling
Diabetes			☐ Mother ☐Father ☐Sibling
Diarrhea			☐ Mother ☐Father ☐Sibling
Fainting			☐ Mother ☐Father ☐Sibling
Hearing			☐ Mother ☐Father ☐Sibling
High blood pressure			☐ Mother ☐Father ☐Sibling
Migraines			☐ Mother ☐Father ☐Sibling
Nausea			☐ Mother ☐Father ☐Sibling
Psychiatric hospitalization			☐ Mother ☐Father ☐Sibling
Stroke			☐ Mother ☐Father ☐Sibling
Other hospitalization(s)			☐ Mother ☐Father ☐Sibling
Other Issues:			☐ Mother ☐Father ☐Sibling

MEDICATION LOG

List Prescribed or over-the-counter medication(s) or herbal supplements you currently take: Add additional sheets of paper if needed.

Medication	Daily Dosage	Reason for Use	Use Dates: mm/yyyy
			From: To:
			From: To:
			From: To:

Allergies/Side Effects:

_____ _____ _____ _____

MEDICAL HISTORY CONTINUED

List any major accidents or surgeries: ☐ Not applicable

Surgeries(s): Type: _____ Reason: _____ Date: _____

Type: _____ Reason: _____ Date: _____

Accidents(s): Type: _____ Reason: _____ Date: _____

Type: _____ Reason: _____ Date: _____

Do you have any diet or nutritional concerns: ☐ No ☐ Yes: Your Height:_____

Have you gained weight in the last 60 days: ☐ No ☐ Yes: How much?_____

Have you lost weight in the last 60 days: ☐ No ☐ Yes: Lbs: _____Height: _____

Do you ever: ☐ overeat ☐ induce vomiting ☐ Use laxatives ☐ Exercise to get rid of calories ☐ Skip meals

SUBSTANCE USE

ALCOHOL USE:

Do you currently drink? ☐No ☐ Yes What is your consumption weekly?

_____

Have you ever been told to cut down on your drinking? ☐ No ☐ Yes

Have you ever felt bad about your drinking habits? ☐ No ☐ Yes

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Have you ever attended an AA group? ☐No ☐ Yes: When: _____

Have you ever been convicted of an: ☐MPI ☐DWI ☐ OWI? When? _____ _____ _____

Have you been treated as an *outpatient* for alcohol use: ☐ No ☐Yes - Dates:_____
Therapist: _____

Have you been treated as an *inpatient* for alcohol use? ☐ No ☐Yes - Dates: _____
Facility?_____

DRUG USE

Do you / have you use/(d) illegal drugs, or non-prescription medication now or in the past? ☐ No ☐ Yes

Circle Drugs Used: ☐ Amphetamines ☐ Crack/Cocaine Heroine Opiates Fentanyl Marijuana Vaping/
Substance of Choice:_____ How often do you use/amount?_____

Have you ever attended an NA meeting? ☐ No ☐ Yes Date(s):_____

Have you ever been treated as an *outpatient* for drug use? ☐No ☐Yes Date(s): _____

Have you ever been treated as an *inpatient* for drug use? ☐ No ☐Yes Date(s):

CAFFEINE USE: ☐ Not applicable
Coffee: Cups per day ☐ 1 ☐2 ☐3 ☐4+
Tea: Cups per day: ☐1 ☐2 ☐3 ☐4+
Energy Drinks: ☐1 ☐2 ☐3 ☐4+

SMOKING: Check the response that best summarizes your cigarette smoking status:

☐ Never smoked ☐ Former smoker / Vape: Month/Year Quit: _____

☐ Current Smoker: Average number of cigarettes/vape smoked per day: _____

THERAPY GOALS

Please list what you hope to accomplish during therapy

1.

2.

3.

X_____ **Date:** _____
Patient/Guardian Signature