GHALY
HEALING & WELLNESS CENTER

Patient Name:_____ DOB:_____

SS#_____ Sex:____M____F

Street Address:_____

City:_____ State:_____ Zip:_____

Primary Phone:_____ Secondary Phone:_____

Therapist Name:_____ Location:_____

***PLEASE PROVIDE US WITH YOUR HEALTH INSURANCE CARD AND PERSCRIPTION CARD TO BE SCANNED INTO OUR FILES.**

SUBSCRIBER INFORMATION:

Name:_____ DOB:_____ Sex____M____F

Relationship to Patient:_____

Address:_____

Employer:_____ Work Phone:_____

Employers Address:_____

PRIMARY INSURANCE INFORMATION:

Insurance Company: _____

Policy Number: _____

Group # (If applicable):_____Insurance Phone: _____

SECONDARY INSURANCE INFORMATION:

Insurance Company: _____

Policy Number: _____

Group # (If applicable):_____Insurance Phone: _____

PRESCRIPTION COVEREAGE INFORMATION:

Insurance Company: _____

Policy Number: _____

Group # (If applicable):_____Insurance Phone: _____

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ADULT PATIENT MEDICAL HISTORY

Patient Name: _____ **Sex:** M F **Date of Birth:** ___/___/___ SS#_____

Past Medical History:

Condition	Y	N	*Condition*	Y	N	*Condition*	Y	N	*Condition*	Y	N
Chicken Pox			Anxiety			Heart Murmur			Shingles		
Diptheria			Arthritis			Hemorrhoids			Stroke		
Measles			Alzheimer's			Hernia			Thyroid Disease		
Meningitis			Bleeding Disorder			High Blood Pressure			Tuberculosis		
Mononucleosis			Blood Clots			High Cholesterol			**List others below**:		
Mumps			Bronchitis			HIV/AIDS					
Pertussis			Cancer			Intestinal Disorder					
Polio			Cataracts			Kidney Disease					
Rheumatic Fever			COPD/Emphysema			Liver Disease					
Scarlet Fever			Depression			Mental Illness					
Shingles			Diabetes			Migraines					
Strep Throat			Eczema			Motor Vehicle Accident					
Abnormal PAP			Fracture			Multiple Sclerosis					
Acne			Glaucoma			Parkinson's					
ADHD			Heartburn (Reflux)			Pneumonia					
Allergies			Heart Attack			Seizure Disorder					
Anemia			Heart Failure			Sexually Transmitted Disease					

Please provide any additional details regarding those condition(s) where you marked yes above:

_____

_____

_____

Allergies (Include reaction):

_____

Medications (Includes birth control, over the counter, vitamins, supplements, and herbal remedies):

Name:	**Dose**	**Frequency**	**Reason for use**

Pharmacy Name & Address:_____ **Phone:**_____

Surgeries:	**Year**	**Procedure**	**Facility**

Hospitalizations:	**Year**	**Reason**	**Facility**

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FAMILY HISTORY

Please list below any pertinent medical illnesses in your family.

Father _____ Mother _____

Brother(s) _____ Sister(s) _____

Additional family members (not listed above) _____

PERSONAL BACKGROUND

Education level completed (please circle 1): Grade School High School College Graduate Degree

Marital status (please circle 1): Single Married Divorced Widowed Separated

Occupation _____ Employer _____
Or circle one below:
Unemployed Retired Disabled/ Cause of disability _____

Tobacco Use: Yes____ No____ Former____ Type_____ #Years_____ #Packs/day____ #Years quit_____
Alcohol Use: Yes_____ No_____ Former_____ Type_____ Amt_____ Frequency_____ Abuse Y/N
Drug Use: Yes_____ No_____ Former_____ Type_____ IV Drugs Y/N Rehab Y/N

OBSTETRIC/ GYNECOLOGIC HISTORY (FOR WOMEN ONLY)

Age of first menstrual period _____ Last menstrual period _____ Age of menopause _____
Total number of pregnancies _____ Number of living children _____

I have completed this intake form to the best of my ability. I agree to allow the Ghaly Healing & Wellness Center to send a bill for treatment(s) to my insurance carrier and bill me for any balances that may incur.

Patient Name (Please print)_____

Patient Signature _____ **Date** _____

PATIENT NAME:_____ DATE:_____

BECK DEPRESSION SCALE- ON THIS QUESTIONNAIRE ARE GROUPS OF STATEMENTS. PLEASE READ EACH ONE CAREFULLY, AND CIRCLE THE ANSWER(S) THAT BEST DESCRIBE THE WAY YOU HAVE BEEN FEELING THE PAST WEEK, INCLUDING TODAY. IF SEVERAL IN THE GROUP SEEM TO APPLY EQUALLY, CIRCLE EACH ONE.

0	I AM NO MORE TIRED THAN USUAL	0	I DON'T FEEL DISAPPOINTED IN MYSELF	0	I GET AS MUCH SATISFACTION OUT OF THINGS AS I USED TO
1	I GET TIRED MORE EASILY THAN I USED TO	1	I AM DISAPPOINTED IN MYSELF	1	I DON'T ENJOY THINGS THE WAY I USED TO
2	I GET TIRED FROM DOING ALMOST ANYTHING	2	I AM DISGUSTED WITH MYSELF	2	I DON'T GET SATISFACTION OUT OF ANYTHING ANYMORE
3	I AM TOO TIRED TO DO ANYTHING	3	I HATE MYSELF	3	I AM DISSATISFIED OR BORED WITH EVERYTHING
0	I DON'T FEEL I AM BEING PUNISHED	0	I DO NOT FEEL SAD	0	MY APPETITE IS NO WORSE THAN USUAL
1	I FEEL I MAY BE PUNISHED	1	I FEEL SAD	1	MY APPETITE IS NOT AS GOOD AS IT USED TO BE
2	I EXPECT TO BE PUNISHED	2	I'M SAD ALL THE TIME. I CAN'T SNAP OUT OF IT	2	MY APPETITE IS MUCH WORSE NOW
3	I FEEL I AM BEING PUNISHED	3	I AM SO SAD OR UNHAPPY, I CAN'T STAND IT	3	I HAVE NO APPETITE AT ALL ANYMORE
0	I DO NOT FEEL LIKE A FAILURE	0	I AM NO MORE IRRITATED BY THINGS THAN I EVER WAS	0	I CAN SLEEP AS WELL AS I USED TO
1	I FEEL I HAVE FAILED MORE THAN THE AVERAGE PERSON	1	I GET ANNOYED OR IRRITATE MORE EASILY THAN I USED TO	1	I DON'T SLEEP AS WELL AS I USED TO
2	AS I LOOK BACK ON MY LIFE, ALL I CAN SEE IS A LOT OF FAILURES	2	I FEEL IRRITATED ALL THE TIME NOW	2	I WAKE UP 1-2 HOURS EARLIER THAN USUAL AND FIND IT HARD TO GET BACK TO SLEEP
3	I FEEL I AM A COMPLETE FAILURE AS A PERSON	3	I DON'T GET IRRITATED AT ALL BY THE THINGS THAT USED TO IRRITATE ME	3	I WAKE UP SEVERAL HOURS EARLIER THAN I USED TO AND CANNOT GET BACK TO SLEEP
0	I DON'T FEEL I AM ANY WORSE THAN ANYBODY ELSE	0	I DON'T HAVE THOUGHTS OF KILLING MYSELF	0	I AM NO MORE WORRIED ABOUT MY HEALTH THAN USUAL
1	I AM CRITICAL OF MY WEAKNESSES OR MISTAKES	1	I HAVE THOUGHTS OF KILLING MYSELF BUT WOULD NOT CARRY THEM OUT	1	I AM WORRIED ABOUT PHYSICAL PROBLEMS SUCH AS ACHES AND PAINS, UPSET STOMACH, ETC
2	I BLAME MYSELF ALL THE TIME FOR MY FAULTS	2	I WOULD LIKE TO KILL MYSELF	2	I AM VERY WORRIED, ITS HARD TO THINK OF MUCH ELSE
3	I BLAME MYSELF FOR EVERYTHING BAD THAT HAPPENS	3	I WOULD KILL MYSELF IF I HAD THE CHANCE	3	I AM SO WORRIED I CANNOT THINK OF ANYTHING ELSE
0	I HAVN'T LOST MUCH WEIGHT IF ANY LATELY	0	I AM NOT PARTICULARLY DISCOURAGED ABOUT THE FUTURE	0	I DON'T FEEL I LOOK ANY WORSE THAN I USED TO
1	I HAVE LOST MORE THAN 5 LBS	1	I FEEL DISCOURAGED ABOUT THE FUTURE	1	I AM WORRIED THAT I AM LOOKING OLD AND UNATTRACTIVE
2	I HAVE LOST MORE THAN 10 LBS	2	I FEEL I HAVE NOTHING TO LOOK FORWARD TO	2	I FEEL THAT THERE ARE PERMANENT CHANGES IN MY APPEARANCE THAT MAKE ME LOOK UNATTRACTIVE
3	I HAVE LOST MORE THAN 15 LBS	3	I FEEL THAT THE FUTURE IS HOPELESS AND THAT THINGS CANNOT IMPROVE	3	I BELIEVE THAT I LOOK UGLY
0	I DON'T CRY ANY MORE THAN USUAL	0	I DON'T FEEL PARTICULARLY GUILTY	0	I CAN WORK ABOUT AS WELL AS BEFORE
1	I CRY MORE THAN USUAL	1	I FEEL GUILTY A GOOD PART OF THE TIME	1	IT TAKES EXTRA EFFORT TO GET STARTED AT SOMETHING
2	I CRY ALL THE TIME NOW	2	I FEEL QUITE GUILTY MOST OF THE TIME	2	I HAVE TO PUSH MYSELF VERY HARD TO DO ANYTHING
3	I USED TO BE ABLE TO CRY, BUT NOW I CANT EVEN THOUGH I WANT TO	3	I FEEL GUILTY ALL OF THE TIME	3	I CAN'T DO ANY WORK AT ALL
0	I HAVE LOST INTEREST IN OTHER PEOPLE	0	I MAKE DECISIONS ABOUT AS WELL AS I EVER COULD	0	I HAVE NOT NOTICED ANY CHANGES IN MY INTEREST IN SEX
1	I AM LESS INTERESTED IN OTHER PEOPLE THAN I USED TO BE	1	I PUT OFF MAKING DECISIONS MORE THAN I USED TO	1	I AM LESS INTERESTED IN SEX THAN I USED TO BE
2	I HAVE LOST MOST OF MY INTEREST IN OTHER PEOPLE	2	I HAVE A GREATER DIFFICULTY IN MAKING DECISIONS THAN BEFORE	2	I AM MUCH LESS INTERESTED IN SEX NOW
3	I HAVE LOST ALL OF MY INTEREST IN OTHER PEOPLE	3	I CAN'T MAKE DECISIONS AT ALL ANYMORE	3	I HAVE LOST INTEREST IN SEX COMPLETELY

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otal Score:_____

Hamilton Rating Scale for Depression

Name:_____ **Date:**_____

Please circle ONE number that best describes you:

Depressed Mood
(sadness, hopeless, helpless, worthless)
0 None
1 Yes but I will only admit it if you ask me directly
2 Yes, I specifically feel depressed
3 Yes but also communicated through facial expression, posture, voice and tendency to weep (people notice you look depressed)
4 Yes, I have VIRTUALLY ONLY these feelings

Feelings of Guilt
0 None
1 Self-blame, feels like you have let people down
2 Ideas of guilt or obsessing over past errors or sinful deeds
3 Present illness is a punishment. Delusions of guilt
4 Hears abusive or criticizing voices and/or experiences threatening visual hallucinations

Suicide
0 None
1 Feels life is not worth living
2 Wishing you were dead or any thoughts of possible death to self
3 Suicide ideas or gestures
4 Attempts at suicide (any serious attempt rates 4)

Insomnia - Early
0 No difficulty falling asleep
1 Complains of occasional difficulty falling asleep
2 Complains of nightly difficulty falling asleep

Insomnia - Middle
0 No difficulty
1 Complains of being restless and disturbed during the night
2 Waking during the night – any getting out of bed rates 2 (except for purposes of voiding)

Insomnia - Late
0 No difficulty
1 Waking in early hours of the morning but goes back to sleep
2 Unable to fall asleep again if gets out of bed

Work and Activities
0 No difficulty
1 Thoughts and feelings of incapacity, fatigue or weakness related to activities; work or hobbies
2 Loss of interest in activity; hobbies or work – (feels like you have to push self to work or do activities)
3 Decrease in actual time spent in activities or decrease in productivity.
4 Stopped working because of present illness.

Psychomotor Retardation:
(slowness of thought and speech; impaired ability to concentrate; decreased motor activity)
0 Normal speech and thought
1 Slight slowness of thought, movement
2 Obvious slowness of thought, movement
3 Difficulty communicating at all
4 Complete stupor

Agitation
0 None
1 Fidgetiness
2 Playing with hands, hair etc
3 Moving about – can't sit still
4 Hand Wringing, nail biting, hair pulling, biting of lips

Anxiety - Psychological
0 No difficulty
1 Tension and irritability
2 Worrying about minor matters
3 Apprehensive attitude, apparent to those around you
4 Fears expressed openly

Anxiety - Somatic
0 None *Physiological symptoms of anxiety such as:*
1 Mild *dry mouth, indigestion, diarrhea, cramps*
2 Moderate *belching, palpitations, headaches, sighing*
3 Severe *hyperventilation, urinary frequency, sweating*
4 Incapacitating

Somatic Symptoms - Gastrointestinal
0 None
1 Loss of appetite but eating without encouragement.
2 Difficulty eating without urging. Takes laxatives or medications for bowels or for GI symptoms

Somatic Symptoms - General
0 None
1 Heaviness in limbs, back or head, backaches, headache, muscle aches, loss of energy and fatigability
2 Any clear-cut symptoms

Genital Symptoms
0 None
1 Mild Symptoms such as: loss of libido,
2 Severe menstrual disturbances

Hypochondriasis (Health phobias)
0 None
1 Self-absorbed about specific bodily parts
2 Preoccupation with over-all health
3 Frequent complaints, requests for help, etc.
4 Delusions regarding being sick

Loss of Weight
0 No weight loss
1 Probable weight loss associated with present illness
2 Definite weight loss

Insight
0 Acknowledges being depressed and ill
1 Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.
2 Denies being ill at all

Daily Variation
A. Are symptoms worse in the morning or evening.
  0 No difference
  1 Worse in the AM
  2 Worse in the P
B: If symptoms are present, note how severe:
  0 None
  1 Mild
  2 Severe

Depersonalization and Derealization (Feelings of unreality)
0 None
1 Mild
2 Moderate
3 Severe
4 Incapacitating

Paranoid Symptoms
0 None
1 Suspicious
2 Ideas of reference (I think people are after me, people are talking about me, ect)
3 Delusions of reference or of persecution (I know people are after me, etc)

Obsessional & Compulsive Symptoms
0 None
1 Mild
2 Severe

TOTAL SCORE:_____

PATIENT NAME: _____ **DATE:** _____

Epworth Sleepiness Scale (ESS)

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would doze off or fall asleep during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3, with 0 meaning you would never doze or fall asleep in a given situation, and 3 meaning that there is a very high chance that you would doze off or fall asleep in that situation. Even if you haven't done some of these activities recently, thing about how they would affect you.

Use this scale to choose the most appropriate number for each situation
0 = would never doze 2 = moderate chance of dozing
1 = slight chance of dozing 3 = high chance of dozing
It is important that you circle a number (0-3) on each of the questions.

Situation	Chance of dozing (0-3)
Sitting and reading	0 1 2 3
Watching television	0 1 2 3
Sitting inactive in a public place- for example, a theater or meeting	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch (when you've had no alcohol)	0 1 2 3
In a car, while stopped in traffic	0 1 2 3
	Total Score:

Fatigue Severity Scale (FSS)

The Fatigue Severity Scale (FSS) is a method of evaluating the impact of fatigue on you. The FSS is a short questionnaire that requires you to rate your level of fatigue. The FSS questionnaire contains nine statements that rate the severity of your fatigue symptoms. Read each statement and circle a number from 1 to 7, based on how accurately it reflects your condition during the past week and the extent to which you agree or disagree that the statement applies to you.

- A low value (e.g., 1) indicates strong disagreement with the statement, whereas a high value (e.g., 7) indicates strong agreement.
- It is important that you circle a number 1 to 7 for every question.

During the past week, I have found that:	Disagree - Agree
1. My motivation is lower when I am fatigued.	1 2 3 4 5 6 7
2. Exercise brings on more fatigue.	1 2 3 4 5 6 7
3. I am easily fatigued.	1 2 3 4 5 6 7
4. Fatigue interferes with my physical functioning.	1 2 3 4 5 6 7
5. Fatigue causes frequent problems for me.	1 2 3 4 5 6 7
6. My fatigue prevents sustained physical functioning.	1 2 3 4 5 6 7
7. Fatigue interferes with marrying out certain duties and responsibilities.	1 2 3 4 5 6 7
8. Fatigue is among my three most disabling symptoms.	1 2 3 4 5 6 7
9. Fatigue interferes with my work, family, or social life.	1 2 3 4 5 6 7
	Total Score:

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Patient Financial Responsibility Agreement

The providers and staff of the Ghaly Healing & Wellness Center appreciate the confidence you have shown in choosing them to provide for your medical needs. We are committed to providing you with the highest quality healthcare. Please read and sign this form to acknowledge your understanding of our financial policies.

Patient Financial Responsibilities

- The patient is responsible for the payment for his/her treatment and care.
- Patients are responsible for the payment of copays, coinsurance, deductibles and all other procedures or treatments not covered by their insurance plan.
- Patients may incur and are responsible for the payment of the following additional charges:
  - A $25.00 fee for all returned checks.
  - A $50 fee will be applied towards all no-show office visits.
  - $100 fee for all no-show first-time evaluations.

*If you do not have insurance benefits, please contact the Billing Department at (315) 463-0421 option 4 to set up self-pay payment arrangements.

The following are the patient's responsibility:

- Patients must bring their insurance card and photo ID to each visit.
- Notify our office of any changes to insurance, address, or phone numbers.
- Know their copays, benefits, and coverage.
- Determine if provider(s) are in or out network providers prior to first visit.
- Pay for any allowed amounts not covered by their insurance.
- Keeping their coordination of benefits up to date if patient is covered by secondary insurance.

*Please note we are currently unable to accept new patients with coverage through Worker's Compensation or NYS No Fault.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form. In the event of nonpayment or default, I am responsible for all costs and reasonable collection and/or attorney fees. The Ghaly Healing & Wellness Center reserves the right to change this statement at any time and at its discretion.

Print Name **Signature** **Date**

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INFORMED CONSENT FORM

PATIENT NAME:_____ DOB: _____

The behavioral services offered at Ghaly Healing & Wellness Center begin with an evaluation to determine the level of care you may need. This evaluation does not indicate that you are a patient of Ghaly Healing & Wellness Center until recommendations are made by the evaluating practitioner. Our out-patient services are not designed to address severe mental health needs or primary care issues, therefore every attempt will be made for you to receive the appropriate services.

The purpose of this document is to give authorization regarding services and treatments I receive by Dr. Nasri Ghaly and such providers, assistants, and associates employed by Ghaly Healing & Wellness Center. I understand that behavioral health services at the Ghaly Healing & Wellness Center are designed to complement my healthcare through development skills and strategies to help improve my lifestyle and habits.

I understand it may be recommended that I take medication for treatment of my illness. While medications may provide significant benefits, they may also pose risks. I have been informed of possible side effects. I acknowledge that I have received no warranties or guarantees, and I am aware of possible outcomes of the treatment or medication I am prescribed.

If I feel compelled to stop taking any prescribed medications, I agree to speak to my treating provider to discuss the appropriate protocol. I have informed the licensed health care provider of all known allergies to substances, drugs, and medications.

In all circumstances, consent to release information is given through written authorization. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

· When there is risk or imminent danger to myself or to another person, the clinician is ethically bound to take the necessary steps to prevent such danger.

· When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

· When there is suspicion that a child or elder is being abused or is at risk of such abuse, the clinician is legally required to inform the proper authorities.

We understand the importance of the completion of disability forms. Observations regarding mental health symptoms, diagnosis past and present prognosis and treatments cannot be summarized in an initial evaluation. Therefore, we require the patient to be seen a minimum of 6 months before we can fully analyze a patient in order to accurately submit disability paperwork.

The Ghaly Healing & Wellness Center ***DOES NOT*** provide emergency services. For non-emergency issues after normal office hours, please contact our answering service at: 1-877-551-4509. In a mental health emergency you should contact the Comprehensive Psychiatric Emergency Program at St. Joseph's Hospital: (315)448-6555. Located at 201 Prospect Ave. Syracuse, NY 13203. For immediate clinical care, call 911 or go to your nearest emergency room.

I have read and fully understand this document and have had to opportunity to have any questions I may have, answered by my healthcare provider.

PATIENT SIGNATURE:_____ DATE: _____

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Patient Treatment Contract
All Patients MUST sign this contract to receive treatment from our office.

As a patient of Ghaly Healing and Wellness Center I voluntarily agree to accept this treatment contract as follows:

- I agree that it is my responsibility to keep and be on time for all scheduled appointments.
- I acknowledge that if I am late for my appointment I may not be seen by my provider and asked to reschedule.
- I agree to pay all copays and balances at the time of my appointments.
- I agree that a missed appointment may result in me not being able to get my medication/prescription until my next scheduled appointment
- I understand that it is my responsibility to update the office of any changes to my address, phone number and insurance information.
- I agree to conduct myself in a courteous manner while at Ghaly Healing and Wellness Center.
- I agree that any illegal or disruptive activities observed by any provider may result in immediate discharge from the practice without any recourse for appeal.
- I understand that I may be required to do a drug screen via urine or oral fluid at every appointment or randomly as seen fit by my provider.
- I agree that my medication/prescription can only be given to me at regular office visits unless approved by my provider.
- I acknowledge that I must allow up to three business days for all medication prior authorizations.
- I understand that samples of medications are given as a courtesy
- I agree that any lost medication and/or written prescriptions will **NOT** be replaced and will be reported to the DEA.
- I agree not to obtain any medications from any providers, pharmacies or any other sources without my treating provider at Ghaly Healing and Wellness Center having knowledge of it.
- I agree to take my medications as prescribed by my treating provider at Ghaly Healing and Wellness Center.
- I acknowledge that I may be asked to bring my medications in for a random pill count.
- I agree not to sell, share or give any of my medications to another person.
- I understand that any mishandling of my medication is a serious violation of this agreement and will result in the immediate discharge from Ghaly Healing and Wellness Center without any recourse for appeal.
- I agree to abstain from all illicit drugs and/or mood altering substances.
- I acknowledge that it is medically advised by all providers of Ghaly Healing and Wellness Center to abstain from alcohol consumption.
- I agree that any unusual or suspicious behavior witnessed by the employees of my pharmacy will be reported to my provider at Ghaly Healing and Wellness Center.

By signing this contract, I agree that any violation to the above may be grounds for immediate termination of treatment.

Print Name:_____

Patient Signature_____ **Date:**_____