DR #_____

CHART #_____

HOPE SPEAKS, PLLC
PATIENT INFORMATION

Please print and provide complete information.

LAST NAME:_____ FIRST NAME:_____ MI:_____

SSN:_____ DOB:_____ AGE:_____ SEX:_____

MARITAL STATUS:_____ EMPLOYER:_____

MAILING ADDRESS: _____

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ CELL PHONE:_____ WORK PHONE: _____

EMAIL ADDRESS:_____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE: _____

INSURANCE

IS MEDICARE PRIMARY? YES:_____ NO:_____

INSURANCE CO NAME:_____ PHONE NO:_____

SUBSCRIBER NAME:_____ DOB:_____ SSN: _____

POLICY NO:_____ GROUP NO:_____

RELATIONSHIP:_____ EMPLOYER:_____

IS THE SUBSCRIBER'S ADDRESS DIFFERENT THEN THE PATIENT'S ADDRESS: YES NO

IF YES - SUBSCRIBER'S ADDRESS: _____

_____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize HOPE SPEAKS, PLLC to release any medical information concerning my care for the purpose of claims to federal, state, city, or town governmental agencies, third party payors of all categories, doctors, hospitals, and pharmacies.

DISABILITY: I understand that all providers of HOPE SPEAKS, PLLC DO NOT do any type of disability paperwork or any paperwork associated with disability.

CONSENT FOR MEDICAL/PSYCHIATRIC TREATMENT: I am authorizing my physician(s) and/or therapist(s) to perform and/or direct another person to perform all tests, exams, evaluations, and any other care deemed necessary or advisable for the diagnosis, evaluation, and treatment of my medical/psychiatric condition. I understand that my provider(s) at HOPE SPEAKS, PLLC is not responsible for the care by any other health care professional.

ACKNOWLEDGEMENT FOR THE TREATMENT BY OTHER PROVIDERS: Dr. Shoaf and his team of providers are dedicated to providing quality healthcare to our patients. Please be aware that there will be times that you will be treated by one of the other qualified providers for your follow-up appointments.

HIPAA NOTICE OF PRIVACY PRACTICES: I acknowledge that I have been given a copy of the HIPAA Notice of Privacy Practices for HOPE SPEAKS, PLLC.

PATIENT/GUARDIAN SIGNATURE:_____ DATE:_____

HOPE SPEAKS, PLLC
Prescription Insurance

If you have prescription insurance either through your medical policy or a separate policy, please complete the following information.

Please be aware that these answers need to be for the most up-to-date information with the insurance company.
(For example – if you've moved but the policy is still under the old address, we will need the old address.)

POLICY HOLDER INFORMATION

PATIENT'S NAME AS IT APPEARS ON THE CARD: _____

PATIENT'S D.O.B.:_____ ***POLICY HOLDER'S*** PHONE NUMBER:_____

ADDRESS OF ***POLICY HOLDER***: _____

CITY:_____ STATE:_____ ZIP:_____

PRESCRIPTION POLICY INFORMATION

INSURANCE COMPANY NAME: _____

PRESCRIPTION BENEFITS COMPANY NAME: _____

INSURANCE'S PROVIDER HELPDESK PHONE NUMBER: _____

INSURANCE'S PHARMACY HELPDESK PHONE NUMBER: _____

RX BIN NUMBER: _____

RX PCN NUMBER: _____

RX GROUP NUMBER: _____

ID NUMBER: _____

This information is to be used for the completion of medication prior authorization(s) (if needed) and any pharmacy issues that may arise.

HOPE SPEAKS, PLLC
HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this notice, please contact THE PRIVACY OFFICER.

Your medical information is personal. We are committed to protecting your medical information. We create a record of the care and services you receive at this office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this office whether made by your personal physician or one of the office's employees. This notice will tell you about the ways in which we may use and disclose your medical information. This notice will also describe your rights and certain obligations we have regarding the use and disclosure of your medical information.

This office is required by law to:

1. Make sure that medical information that identifies you is kept private,
2. Give you this notice of our legal duties and privacy practices with respect to medical information about you, and
3. Follow the terms of the notice that is currently in effect.

How this office may use and disclose your medical information

The following describes the different ways that your medical information may be used or disclosed by this office. For clarification we have included some examples. Not every possible use or disclosure is specifically mentioned. However, all of the ways we are permitted to use and disclose your medical information will fit within one of the general categories:

For Treatment: We will use medical information about you to provide you with medical treatment and services. We may disclose medical information about you to doctors, nurses, technicians and other office personnel who are involved in providing you medical treatment.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about treatment you received here so your health plan will pay us or reimburse you for the treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations: We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run our office and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also disclose information to doctors, nurses, technicians, and other personnel for review and learning purposes.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at this office.

Treatment Alternatives and Other Health Related Benefits and Services: We may use and disclose medical information to tell you about or recommend possible treatment options, alternatives, or other health related benefits and services that may be of interest to you.

Release of Information to Family/Friends: Our practice may release your medical information to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter or family member take their child for an appointment.

As Required By Law: We will disclose medical information about you when required to do so by federal, state or local law. For example, disclosure may be required by Workers' Compensation statutes and various public health statutes in connection with required reporting of certain diseases, child abuse and neglect, domestic violence, adverse drug reactions, etc.

To Avert a Serious Threat to Health or Safety: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be made to someone able to help prevent the threat.

Health Oversight Activities: We may disclose medical information to a governmental or other oversight agency for activities authorized by law. For example, disclosures of your medical information may be made in connection with audits, investigations, inspections and licensure renewals, etc.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may use your medical information to defend the office or to respond to a court order.

Law Enforcement: We may release medical information about you if required by law when asked to do so by a law enforcement agency.

Coroners and Medical Examiners: We may release medical information to a coroner or medical examiner to identify a deceased person or determine the cause of death.

National Security: Our practice may disclose medical information to federal officials for intelligence and national security activities authorized by law. We also may disclose your medical information to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

PATIENT/GUARDIAN INITIALS: _____

Inmates: Our practice may disclose your medical information to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: A) for the institution to provide health care services to you, B) for the safety and security of the institution, and/or C) to protect your health and safety of other individuals.

Workers' Compensation: Our practice may release your medical information for workers' compensation and similar programs.

Your Rights Regarding Your Medical Information

You have the following rights regarding the medical information this office maintains about you.

Right to Inspect or Obtain a Copy: You have the right to inspect or obtain a copy of your medical information with the exemption of any psychotherapy notes. **To inspect or obtain a copy of your medical information you must submit your request in writing.** If you request a copy of the information we may charge a fee for the cost of copying, mailing or for other supplies associated with your request. We may deny your request to inspect or obtain a copy of your information in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed. For information regarding such a review contact THE PRIVACY OFFICER.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by this office. To request an amendment, your request must be made in writing and submitted to THE PRIVACY OFFICER. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request.

In addition, we may deny your request if you ask us to amend information that:

a) Was not created by us,
b) Is not part of the medical information kept by this office,
c) Is not part of the information which you would be permitted to inspect or obtain a copy of, or
d) Is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures this office has made of your medical information. To request this accounting of disclosures you must submit your request in writing to THE PRIVACY OFFICER. Your request must state a time period which may not be longer than five years and may not include dates before January 1, 2013.

Right to Request Restrictions: You have the right to request a restriction or limitation on the use or disclosure we make of your medical information. **We are not required to agree to your request for a restriction.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to THE PRIVACY OFFICER.

Right to Request Confidential Information: You have the right to request that we communicate with you only in certain manners. For example, you can ask that we only contact you at specific numbers or by mail. To request confidential communications, you must make your request in writing to THE PRIVACY OFFICER. We will accommodate all reasonable requests.

Right to a Paper Copy of this Notice: You have the right to a paper copy of this notice. To obtain a paper copy of this notice, contact THE PRIVACY OFFICER.

Right to Provide an Authorization for Other Uses and Disclosures: Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your medical information may be revoked at any time **in writing**. After you revoke your authorization, we will no longer use or disclose your medical information for the reasons described in the authorization. Please note, we are required to retain records of your care.

Revisions to This Notice

We reserve the right to revise this notice. Any revised notice will be effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of any revised notice in this office. Any revised notice will contain the effective date of the revisions.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with this office or with the Secretary of the Department of Health and Human Services. To file a complaint with this office, contact THE PRIVACY OFFICER, Hope Speaks, PLLC, 1200 E. Collins Blvd., Suite 300, Richardson, TX 75081, (972) 669-1733. All complaints must be submitted in writing. THIS OFFICE WILL NOT PENALIZE YOU IN ANY WAY FOR FILING A COMPLAINT.

Other Uses of Medical Information

Other uses and disclosures of your medical information not covered by this Notice of Privacy Practices will be made only with your written authorization. If you provided us an authorization in writing to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact THE PRIVACY OFFICER, Hope Speaks, PLLC, 1200 E. Collins Blvd., Suite 300, Richardson, TX 75081, (972) 669-1733.

PATIENT/GUARDIAN SIGNATURE: _____

HOPE SPEAKS, PLLC
Patients' Bill of Rights

Texas Administrative Code Title 25, Part 1, Chapter 448, Subchapter G, Rule §448.701

1. ***Information Disclosure***
   You have the right to receive accurate and easily understood information about your health plan, health care professionals, and health care facilities. If you speak another language, have a physical or mental disability, or just do not understand something, assistance will be provided so you can make informed health care decisions.

2. ***Choice of Providers and Plans***
   You have the right to a choice of health care providers that is sufficient to provide you with access to appropriate high-quality care.

3. ***Access to Emergency Services***
   If you have severe pain, an injury, or sudden illness that convinces you that your health is in serious jeopardy, you have the right to receive screening and stabilization emergency services whenever and wherever needed, without prior authorization or financial penalty.

4. ***Respect and Nondiscrimination***
   a) You have the right to a humane environment that provides reasonable protection from harm and appropriate privacy for your personal needs.
   b) You have the right to be free from abuse, neglect, and exploitation.
   c) You have the right to be treated with dignity and respect.
   d) You have the right to appropriate treatment in the least restrictive setting available that meets your needs.

5. ***Participation in Treatment Decisions***
   a) You have the right to be told before your first appointment:
      i) The condition to be treated,
      ii) The proposed treatment,
      iii) The risks, benefits, and side effects of all proposed treatment and medication(s),
      iv) The probable health and mental health consequences of refusing treatment, and
      v) Other treatments that are available and which ones, if any, might be appropriate for you.
   b) You have the right to a treatment plan designed to meet your needs, and you have the right to take part in developing that plan.
   c) You have the right to meet with staff to review and update the plan on a regular basis.
   d) You have the right not to receive unnecessary or excessive medication(s).
   e) You have the right to refuse to take part in research studies without affecting your regular care.

6. ***Treatment Queries***
   a) You have the right to be told in advance of all estimated charges and any limitations on the length of services of which the facility is aware.
   b) You have the right to receive an explanation of your treatment or your rights if you have questions while you are being treated.

7. ***Confidentiality of Health Information***
   a) You have the right to have information about you kept private and to be told about the times when the information can be released without your permission.
   b) You have the right to review and copy your own medical record and request that your physician amend your record if it is not accurate, relevant, or complete.

8. ***Complaints and Appeals***
   a) You have the right to make a complaint (HIPAA or otherwise) and receive a fair response from the facility within a reasonable amount of time.
   b) You have the right to complain directly to the Texas Commission on Alcohol and Drug Abuse at any reasonable time.
   c) You have the right to get a copy of these rights before your first visit, including the address and phone number of the Texas Commission on Alcohol and Drug Abuse:
      i) customer.service@dshs.texas.gov
      ii) Phone: (888) 963-7111, ext. 2150 or (512) 776-2150
      iii) Department of State Health Services
      Attn: Customer Service Coordinator
      P.O. Box 149347, MC-1913
      Austin, TX 78714-9347

9. ***Explanation of Rights***
   You have the right to have your rights explained to you in simple terms, in a way you can understand, within 24 hours of your first appointment.

PATIENT/GUARDIAN SIGNATURE: _____

HOPE SPEAKS, PLLC
PATIENT FINANCIAL RESPONSIBILITY

Recognizing the need for patients to understand what is expected regarding payment of medical/mental services we have established our financial policy. Some of these items are required by law. It is our goal to remain sensitive to our patients' needs while providing quality medical care, and we encourage you to contact our office if a problem should rise regarding your account.

1. **All co-pays and co-insurance required by your insurance company must be paid at the time services are rendered.** We accept cash, checks, and Visa, MasterCard, Discover and American Express cards. There is a $40.00 service charge on all returned checks. After receiving a returned check, HOPE SPEAKS, PLLC will only accept cash, money order, or credit card as a form of payment.

2. **It is the patient's responsibility to be aware of the contract benefits of his/her insurance carrier or any co-payment or deductible obligation.** If your insurance requires referrals for full benefits to be paid, it is your responsibility to verify that the referrals are in place prior to your visit.

3. **Our facility will file primary insurance claims for medical services rendered.** Claims for a secondary and third insurance will not be filed unless required by our contract. We cannot file claims correctly without accurate information from you. Proof of insurance must be presented at each visit.

4. **If you do not have insurance,** payment in full is expected at the time of service unless financial arrangements have been made in advance with our billing department.

5. **You will be responsible for any outstanding balance after your insurance company processes your claim.** If you are dissatisfied with the amount paid by your insurance company, please contact your insurance carrier.

6. **We are participating providers for Medicare.** This means that we must accept Medicare's allowed charge for the services rendered. Medicare will pay 80% of the approved amount. The patient is responsible for the remaining 20%, plus any out-of-pocket deductible. We will write off the difference between what we charge and what Medicare approves. If you have secondary insurance, we will submit the claim for the remaining balance after Medicare has paid. Please remember that although we accept assignment for Medicare, the patient, by federal law, is responsible for any portion of the approved amount not paid by Medicare or a secondary insurance.

7. **Responsibility for payment for services rendered to the child/children of divorced or separated parents** rests with the parent who seeks treatment at the time of service. Any court ordered judgement must be between the individuals involved, without including our facility.

8. **There will be a charge for all missed appointments without a 24-hour notice.** We reserve resources for your visit and would like to be available to others if you have a schedule change. If such scheduling problems arise, please contact us promptly.

It is our hope that you will find this information helpful. If you have any questions, please speak with our billing staff at (972) 669-1733.

_____ _____

Patient's/Guardian's Signature **Date**

_____ _____

Witness' Signature **Date**

HOPE SPEAKS, PLLC

1200 E. COLLINS BLVD. STE. 300 RICHARDSON, TX 75081 PHONE (972) 669-1733 SECURE FAX (972) 644-7056

MEDICATION CHECKLIST

Chart #:_____

Name:_____ Date:_____

Place a check mark next to any medication you are currently taking or that you may have taken in the past – even if it was for a short time. Then next to the medicine write a brief description based on your experience with the medication. Examples: good, helped, bad, side effects, made dizzy, gained weight, headaches, etc

Anti-Depressants

Anafranil (clomipramine)_____
Aplenzin_____
Auvelity_____
Celexa (citalopram)_____
Cymbalta (duloxetine)_____
Deplin (L-methylfolate)_____
Desyrel (tradozone)_____
Effexor (venlafaxine)_____
Elavil (amitriptyline)_____
Emsam (selegiline patch)_____
Fetzima (levomiluacipran)_____
Forfivo XL (bupropion)_____
Lexapro (escitalopram)_____
Ludiomil (maprotiline)_____
Luvox (fluvoxamine)_____
Marplan_____
Nardil (phenelzine)_____
Nuvigil (armodafinil)_____
Pamelor (nortriptyline)_____
Parnate (tranylcypromine)_____
Paxil (paroxetine)_____
Pristiq (desvenlafaxine)_____
Provigil (modafinil)_____
Prozac (fluoxetine)_____
Remeron (mirtazapine)_____
Rexulti (brexpiprazole)_____
Serzone (nefazodone)_____
Sinequan (doxepin)_____
Stavzor (valproic acid)_____
Symbyax
(olanzapine+fluoxetine)____
Tofranil (imipramine)_____
Trintellix (vortioxetine)_____
Viibryd (vilazodone)_____
Vivactil (protriptyline)_____
Wellbutrin (bupropion)_____
Zoloft (sertraline)_____

Anti-Anxiety

Ativan (lorazepam)_____
Buspar (buspirone)_____
Klonopin (clonazepam)_____
Librium (chloradiazipoxide)___
Loreev XR(lorazepam er)_____
Niravam (alprazolam ODT)____
Restoril (temazepam)_____
Serax (oxazepam)_____
Tranxene (clorazepate)_____
Valium (diazepam)_____
Vistaril (hydroxyzine pam.)____
Xanax (alprazolam)_____
Xanax XR (alprazolam er)_____

Mood Stabilizers

Carbatrol (carbamazepine)_____
Celontin (mesuximide)_____
Depakote (divalproic acid)____
Dilantin (phentoin Na)_____
Equetro (carbamazepine)_____
Felbatol (felbamate)_____
Gabitril (tiagabine)_____
Keppra (levetiracetam)_____
Lamictal (lamotrigine)_____
Latuda (luvasidone)_____
Lithium_____
Mysoline (primidone)_____
Neurontin (gabapentin)_____
Oxtellar XR (oxcarbazepine)___
Phenobarbital_____
Saphris (asenapine)_____
Stavzor (valproic acid)_____
Tegretol (carbamazepine)_____
Topamax (topiramate)_____
Trokendi XR (topiramate er)___
Trileptal (oxcarbazepine)_____
Vraylar (cariprazine)_____
Zarontin (ethosuximide)_____
Zonegran (zonisimide)_____

Early Cognitive Delay-Alzheimers/Dementia

Aricept (donepezil)_____
Cerefolin NAC_____
Cognex (tacrine)_____
Exelon (rivastigmine)_____
Lycroremine (galantamine)____
Metanx (B6-B9-B12)_____
Namenda (memantine)_____
Namzaric_____
Razadyne (galantamine)_____
Reminyl (galantamine)_____

Anti-Psychotics

Abilify (aripiprazole)_____
Caplyta_____
Clozaril (clozapine)_____
Cogentin (benzatropine)_____
FanApt (iloperidone)_____
Geodon (ziprasidone)_____
Haldol (haloperidol)_____
Invega (paliperidone)_____
Invega Sustenna/Trinza inj____
Latuda (lurasidone)_____
Loxitane (loxapine)_____
Lybalvi_____
Mellaril (thiondazine)_____
Moban (molindone)_____
Navane (thiothixene)_____
Prolixin (fluphenazine)_____
Risperdal (risperidone)_____
Secuado_____
Seroquel (quetiapine)_____
Stelazine (trifluoperazine)_____
Symbyax
(olanzapine+fluoxetine)____
Thorazine (chlorpromazine)___
Trilafon (perphenazine)_____
Zyprexa (olanzapine)_____

MEDICATION CHECKLIST CONTINUED

Attention Deficit Stimulants

Adderall (dextroamphetamine amphetamine salts)_____
Adderall XR (dextroamphetamine amphetamine er)_____
Adhansia_____
Adzenys XR ODT_____
Aptensio_____
Azstarys_____
Concerta (methylphenidate)_____
Cotempla XR ODT_____
Cylert_____
Daytrana (methylphenidate)_____
Dexedrine (dextroamphetamine er)_____
Evekeo (amphetamine sulfate)_____
Focalin (dexmethylphenidate)_____
Focalin XR (dexmethylphenidate er)_____
Jornay PM_____
Metadate (methylphenidate cd/er)_____
Methylin (methylphenidate)_____
Quillivant/Quillichew_____
Relexxii_____
Ritalin (methylphenidate)_____
Ritalin LA (methylphenidate la)_____
Vyvanse (lisdexamphetamine dimelylate)_____
Xelstrym_____
Zenzedi (dextroamphetamine sulfate)_____

Weight Loss

Mounjaro (tirzepatide)_____
Ozempic (semaglutide)_____
Saxenda (liraglutide)_____
Wegovy (semaglutide)_____
Zepbound (tirzepatide)_____

Attention Deficit Non-Stimulants

Clonidine _____
Guanfacine_____
Intuniv (guanfacine er)_____
Kapvay (clonidine er)_____
Strattera (atomoxetine)_____
Qelbree_____

Insomnia/Sleep

Ambien (zolpidem)_____
Ambien CR (zolpidem er)____
Belsomra_____
Dalmane (flurazepam)_____
Dayvigo_____
Doxepin_____
Edular (zolpidem)_____
Lunesta (eszopiclone)_____
Restoril (temazepam)_____
Rozerem (ramelteon)_____
Silenor (doxepin hcl)_____
Sonata (zaleplon)_____
Trazodone_____

Migraine Relief/Prevention

Amerge (natatriptan)_____
Axert_____
Frova (frovatriptan)_____
Imitrex (sumatriptan)_____
Keppra (levetiracetam)_____
Lamictal (lamotrigine)_____
Prinivil (lisinopril)_____
Midrin_____
Neurontin (gabapentin)_____
Nurtec_____
Qulipta_____
Relpax (eletriptan)_____
Topamax (topiramate)_____
Treximet (sumatriptan/naproxen na)___
Ubrelvy_____
Zomig (zolmitriptan)_____

Pain

Amrix_____
Anaprox_____
Butalbital_____
Butrans Patch_____
Codeine_____
Darvocet_____
Esgic_____
Fentanyl Patch_____
Fiorcet_____
Flexeril_____
Hydrocodone_____
Ketamine_____
Lorcet_____
Lortab_____
Lorzone_____
Lyrica_____
Morphine_____
Naprosyn_____
Norco_____
Opana_____
Oxycodone_____
Oxycontin_____
Percocet_____
Phrenilin_____
Soma_____
Stadol_____
Suboxone_____
Subutex_____
Ultracet_____
Ultram_____
Vicodin_____
Zanaflex_____
Zydone_____

HOPE SPEAKS, PLLC

1200 E. COLLINS BLVD. STE. 300 RICHARDSON, TX 75081 PHONE (972) 669-1733 SECURE FAX (972) 644-7056

HEALTH HISTORY QUESTIONNAIRE

Date:_____ ***MEDICATION ALLERGIES:**_____

Name:_____ M / F Age:_____ DOB:_____ Chart#:_____

Current Non-Psychiatric Medications and Dosages:

_____

_____

_____

Social History: Alcohol _____ Tobacco _____ Other Drugs (list) _____

Family Health History:_____

_____

Please check any symptoms or disorders that you have had either past or present.

Constitutional	Fever □Y □N; Weight Gain □Y □N; Weight Loss □Y □N; Night Sweats □Y □N; Insomnia □Y □N; Other □Y □N_____	Renal/Urological Gynecologic	Difficulty urinating □Y □N; History of urinary tract infection □Y □N; Sexual dysfunction □Y □N; Other □Y □N_____
Head and Neck	Visual changes □Y □N; Eye pain □Y □N; Nasal bleeds □Y □N; Sore throat □Y □N; Hoarseness □Y □N; Pain in gums □Y □N; Ear pain □Y □N; Hearing Loss □Y □N; Other □Y □N_____	Musculoskeletal	Joint pain □Y □N; Back pain □Y □N; Joint swelling □Y □N; Other □Y □N_____
Connective Tissue Disease	Lupus □Y □N; Scleroderma □Y □N; Rheumatoid/Osteo Arthritis □Y □N; Sjogren's □Y □N; Other □Y □N_____	Neurological	Headaches □Y □N; Seizure □Y □N; Weakness □Y □N; Difficulty speaking □Y □N; Other □Y □N_____
Respiratory	Difficulty Breathing □Y □N; Hemoptysis □Y □N; Cough □Y □N; Wheezing □Y □N; Other □Y □N_____	Endocrine	Frequent urination □Y □N; Fatigue □Y □N; Excessive thirst □Y □N; Other □Y □N_____
Cardiovascular	Chest pain □Y □N; Palpitations □Y □N; Feet/legs swelling □Y □N; Other □Y □N_____	Hematological	Anemia □Y □N; Easy bruising □Y □N; Other □Y □N_____
Gastrointestinal	Difficulty swallowing □Y □N; Vomiting □Y □N; Diarrhea □Y □N; Constipation □Y □N; Abdominal pain □Y □N; Indigestion/Heartburn □Y □N; Other □Y □N_____	Immunological	Hives □Y □N; Allergy to foods □Y □N; Other □Y □N_____

1. Have you ever been hospitalized overnight? □Y □N If yes, why?_____
2. Have you ever had surgery? □Y □N If yes, why?_____
3. Have you ever had racing of your heart or skipped heartbeats? □Y □N
4. Have you had high blood pressure or high cholesterol? □Y □N
5. Have you ever been told you have a heart murmur? □Y □N If yes, when was your last EKG?_____ Results?_____
6. Has any family member or relative died of heart problems or of sudden death before age 50? □Y □N
7. Has a physician ever denied or restricted your participation in sports for any heart problems? □Y □N
8. Have you ever had a head injury or concussion? □Y □N If yes, when?_____ CT or MRI? When?_____
9. Have you ever been knocked out, become unconscious, or lost your memory? □Y □N If yes, when?_____
10. Have you ever had a seizure? □Y □N If yes, when was your last EEG or MRI?_____ Results?_____
11. Do you have frequent or severe headaches? □Y □N
12. Have you ever had numbness or tingling in your arms, hands, legs, or feet? □Y □N
13. Have you ever had a stinger, burner, or pinched nerve? □Y □N
14. Have you had any problems with your eyes or vision? □Y □N
15. Do you wear glasses, contacts, or protective eyewear? □Y □N
16. Do you want to weigh more or less than you do now? □Y □N
17. Do you feel stressed out? □Y □N
18. Have you had respiratory, cardiovascular, or gastrointestinal disorders/issues? □Y □N If yes, what?_____
19. Have you ever had any renal, urological, musculoskeletal, neurological, or endocrine disorders/issues? □Y □N If yes, what?_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

_____ _____

Patient's/Guardian's Signature Date

Initial Information Form – Your Life in Review

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A ONE PAGE DIGEST ON EVERYTHING I WOULD WANT OTHERS TO KNOW ABOUT WHO I AM.

Please take a few moments to fill out this form as completely as possible. From this history, valuable information may be realized by examining areas such as the **PRESENTING PICTURE** (current symptoms and what precipitated them), the HISTORY of **PRESENT PROBLEMS** (current symptoms), the **PAST HISTORY** (past issues that may be important now), and the **DYNAMIC FORMULATION** (your own attempt to put all of this information together). In brief, this is what your life has been. You can work toward changing it to what you want it to be.

Name:_____ **Date:**_____ **Chart #:**_____

Briefly describe why you are here:

I. PRESENTING PICTURE (Current symptoms and what precipitated them):

I am a _____ year old □ (male) or □ (female) from _____ (city).

If I had to describe my one major symptom, it would be

□**Depression**	□**Anxiety**	□**Obsessive Worries**	□**Panic Attacks**
□**Times of Confusion**	□**Drug Abuse**,	□**Inattention/Hyperactivity**	□**Mood Swings**
□ **Loss of Memory**	□**Other**:_____.		

The major stressor(s) that precipitated my symptom is/are:

□**Marital Issues**	□**Parent/Child Issues**	□**Financial Issues**	□**Health Issues**
□**Relationship Issues**	□**Issues of Past** (□**Guilt**, □**Abuse**, □**Family or Origin** ((adoption issues))		
□**Job Issues**	□**Other**: (please specify)_____.		

My symptom(s) began:_____(date). My symptom(s) increased:_____(date).

My three biggest worries in life at the present time are:

1. _____
2. _____
3. _____

I am currently taking the following prescribed medications: (please list Psychiatric medications first)

Medicine & Doses	Date Began	Side Effects	Results (good, bad, etc.)	Doctor's Name
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

I am also currently taking the following over the counter medications or vitamin/mineral supplements:_____
_____.

II. HISTORY OF PRESENT PROBLEM: Current Symptoms (check all that apply) *If symptoms were present before medicine please specify.

Occ'l	Weekly	Daily	Depression & Anxiety
□	□	□	Increased Crying
□	□	□	Sad Mood
□	□	□	Lack of Motivation
□	□	□	Sleep Pattern (More) or (Less)
□	□	□	Appetite Changes ↑ or ↓
□	□	□	Weight Changes ↑ or ↓
□	□	□	Lack of Interest
□	□	□	Decreased Self Esteem
□	□	□	Sad Affect
□	□	□	Hopeless/Helpless Feeling
□	□	□	Energy Level ↑ or ↓
□	□	□	Chest Discomfort
□	□	□	Abdominal (Stomach) Distress
□	□	□	Feeling Dizzy
□	□	□	Fear of Going Crazy
□	□	□	Startled Response
□	□	□	Chills or Hot Flashes
□	□	□	Outburst of Anger
□	□	□	Anxiety in General
□	□	□	Restlessness, Keyed Up, Fatigued, Decreased Concentration, Irritability, Muscle Tension, Decreased Sleep
□	□	□	Hypervigilance – excessive attention & focus on all internal & external stimuli
□	□	□	Obsessions/Compulsions – constant checking, washing,or counting type behaviors unrelenting worries
□	□	□	Avoidance of stimuli associated with trauma
□	□	□	Agoraphobia – anxiety of places or inescapable situations
□	□	□	Specific Phobia – marked & persistent fear of social or Performance situations where embarrassment may occur
□	□	□	Post Traumatic Stress Experience

YES	NO	
□	□	SUICIDE IS A DEFINITE POSSIBILITY NOW

Occ'l	Weekly	Daily	Depression & Anxiety (cont'd)
□	□	□	Intense Fear
□	□	□	Rapid Heartbeat
□	□	□	Increased Sweating
□	□	□	Trembling
□	□	□	Shortness of Breath
□	□	□	Withdrawn
□	□	□	Nightmares
□	□	□	Other: _____

OTHER SYMPTOMS

□	□	□	Inattention
□	□	□	Hyperactivity
□	□	□	Delusions/Paranoia
□	□	□	Hallucinations (hearing voices/music and/or seeing things that no one else can)
□	□	□	High with racing thoughts, Increased Speech, Decreased Sleep, Increased Activity
□	□	□	Isolating self from all contact with others
□	□	□	Amnesia
□	□	□	Running Away
□	□	□	Truancy
□	□	□	Memory impaired with trouble organizing & sequencing
□	□	□	Somatization – undue health worries with adequate medical explanation
□	□	□	Agitated – irritable (easily annoyed provoked to anger)
□	□	□	Substance Abuse (including but not limited to drugs or alcohol)
□	□	□	Drugs you've used: _____
□	□	□	Behavioral Problems: _____
□	□	□	Developmental Problems: _____
□	□	□	Self-mutilation: _____
□	□	□	Legal Issue(s): _____
□	□	□	Sexual Issue(s): _____
□	□	□	Eating Issue(s): _____
□	□	□	Impulsive
□	□	□	Aphasia, Apraxia, Agnosia

III. PAST HISTORY

A. Have you had similar and signification symptom(s) in the past? □ YES □ NO If yes, when: _____
Did they recently increase? □ YES □ NO What caused the increase? _____

B. Name 3 past stressful events in your life that precipitated the original symptom(s): _____
_____

C. Prior Psychiatric Hospitalization? □ YES □ NO Where: _____
Reason hospitalized: _____ Date(s): _____
Prior Outpatient counseling: □ YES □ NO Therapist: _____ Date(s): _____

D. Substance Abuse History? □ YES □ NO When began? _____ Substances:_____Drug of Choice:_____
Any treatment □ YES □ NO Facility:_____ Date(s):_____

E. Birth and Early Development was □ Normal □ Abnormal If abnormal, explain: _____

F. My childhood was overall: □ Painful □Uneventful □Good

G. History of: □Abuse □School Problems □Abandonment □Relationship Problems □Disability □Job Problems □Legal □Other: _____

H. Family of Origin Issues:
1. Father – What was he like? _____
2. Mother – What was she like? _____
3. Brothers/Sisters – How many of each? _____
4. Where did you fit in the birth order? _____
5. What type of relationship did you have with your siblings? _____
6. School History – What type of grades did you get? _____ How many years? _____
College? (where/degrees): _____
7. Marriages – How many? _____ What types of stress were in the marriage(s)? _____
8. Children – How many do you have? _____ Ages and sex of each child? _____

I. Psychiatric History – Name of the past Psychiatrist and/or Therapist: _____

J. Name of referral source to the clinic: _____

K. Job History & Current Job: _____

L. Religious History: _____

M. **Past & Current History Summary**:

I grew up in _____(state). I grew up in the □country □a small town □a large city. Both parents (□were) (□were not) in the home. I was one of _____ children and was #_____in the birth order. My childhood was □good □difficult □very difficult in the sense of _____.

My teen years were □good □difficult □very difficult in the sense of _____.
In high school my life revolved around □sports, □work, □church, □social, □academics, □other:_____. After high school I (□did) (□ did not) attend college. After high school life has been □good □difficult □very difficult in the sense of_____.
I am currently □single □married for _____ years. I have been married _____ time(s). I (□do not have) (□do have) _____ children. I presently live □alone □with spouse □with parents □other (name)_____. My current support system is □good □fair □poor. I (□do not have) (□do have) health problems. (List any past or present problems: _____.)
Life now centers around □family □work □friends □other:_____. Recently life has been □good □difficult □very difficult in the sense of _____.

IV. DYNAMIC FORMULATION: (putting it all together)

Several factors may be involved in why I am in my current state of mind. First, a **[1] Current Stressful Life Event** of □relationship issue(s) □job/school issue(s) □health issue(s), □financial issue(s) □other:_____ has been present. Second, under stress I tend to turn to the **[2] DEFENSE MECHANISM** of □interjection of my emotions □denial of my emotions □suppression/repression of emotions □acting out rationalization □projection of my emotions onto others □undue health worries □withdrawal into my own world □passive behavior □other defenses of _____. Third, with my **[3] PERSONALITY** of being: □perfectionist □emotional □suspicious □idealizing then devaluating others □having few or no friends □living in my own world □low self-confidence □self-centered □eccentric □withdrawn and depressed □alternating moods from high to low □other personality issue(s):_____. Fourth, my **[4] EARLY LIFE** is an important factor in that it was □good □difficult □very difficult □abuse issue(s) of some kind (verbal, physical, sexual) □ abandonment issue(s) □ self-image issue(s) □other issue(s): _____. Fifth, **[5] GENETIC FACTORS** (□ do not) (□do) seem to contribute in that a relative(s) of mine (name):_____ had _____. Last, in spite of all of the above, my **[6] SPIRITUAL LIFE** (□has) (□has not) been a factor in the sense that _____. By putting all of the above together, insight into my life may emerge.

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM. This information will be utilized to assist in your treatment.

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Name: _____ Age: _____ Date: _____

Completed by: □ Patient □ Parent/Guardian: _____ □ Other: _____

ADHD QUESTIONNAIRE:

(Check all with either yes or no)

□ Yes □ No I have significant inattention.

□ Yes □ No My inattention is to the degree that I have trouble functioning at work, school, and home.

□ Yes □ No Although I have compensated, my inattention symptoms have been present before age 12.

□ Yes □ No I also have hyperactivity and/or impulsivity.

ABBREVIATED ADHD SYMPTOMS CHECKLIST

Directions: Indicate the degree to which each item below is a problem. Please respond to all items by circling a number.

	Never	At least once **MONTHLY** (Sometimes)	At least once **WEEKLY** (Often)	At least once **DAILY** (Very Often)
1. Doesn't pay attention to details; makes careless mistakes……	1	2	3	4
2. Difficulty paying attention……	1	2	3	4
3. Does not seem to listen……..	1	2	3	4
4. Difficulty following instructions; Does not finish things…….	1	2	3	4
5. Difficulty getting organized……..	1	2	3	4
6. Avoids doing things that require a lot of mental effort…….	1	2	3	4
7. Loses things……...	1	2	3	4
8. Easily distracted……	1	2	3	4
9. Forgetful……	1	2	3	4
10. Fidgets with hands or feet; squirms in seat……..	1	2	3	4
11. Difficulty remaining seated…….	1	2	3	4
12. Runs about or climbs on things……	1	2	3	4
13. Difficulty playing quietly……	1	2	3	4
14. "On the go", acts as if "driven by a motor"…..……	1	2	3	4
15. Talks excessively……	1	2	3	4
16. Blurts out answers to questions……	1	2	3	4
17. Difficulty awaiting turn……	1	2	3	4
18. Interrupts others or butts into their activities……	1	2	3	4

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Name: _____ Date: _____

Self-Rating Report of Symptoms

0----------1----------5----------10

Not significant most of the time.	Present a small amount of the time .	Present most of the time, to a significant degree.	As severe as possible.

1.	Upset	_____	Flustered, Distressed, Feel Bothered
2.	Depression	_____	Blue, Sad, Down Feeling
3.	Anxiety	_____	Nervous, Tense, Apprehensive
4.	Insomnia	_____	Difficulty Falling and Staying Asleep
5.	Low Energy	_____	Tired, Fatigued
6.	Anger	_____	Irritability, Anger, Frustrated
7.	Low Motivation	_____	Low Interests
8.	Manic	_____	Overly High, Energetic, Poor Judgement, Rapid Thinking
9.	Inattention	_____	Trouble Paying Attention, Distractible, Forgetful
10.	Behavior Problems	_____	(Specify) _____
11.	Hyperactivity	_____	Hyperactive, Fidget, Squirm
12.	OCD	_____	Repetitive, Irrational Worry or Actions
13.	Trouble Functioning	_____	At Work, Socially
14.	Dysthymia	_____	Sad Mood Most Days for Last 2 Years
15.	Stressor Severity	_____	Briefly List: _____ (Current Stressors, Changes, & Events)
16.	Worry	_____	
17.	Pain	_____	(Specify) _____
18.	Mood Swings	_____	Drastic Changes in Mood
19.	Decreased Cognition Information	_____	Difficulty thinking, Decreased ability to retain or learn
20.	Auditory Hallucinations	_____	Hearing things that are not there
21.	Visual Hallucinations	_____	Seeing things that are not there
22.	Paranoia	_____	Intense suspicion or exaggerated distrust of others

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
8. 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**
☐	☐	☐	☐