**Welcome**

Thank you for scheduling an appointment with our clinic. The purpose of this letter is to explain what you can expect from us during your first session. We also want to provide information about our practice and explain important issues that often arise during treatment. Please review this letter carefully.

The first session usually lasts 45-60 minutes. The focus will be on determining the specific nature of your problem, and outlining an initial treatment plan. This is primarily an information-gathering meeting and will not involve much “talk therapy.” At the conclusion of this session, you will be given specific recommendations in order to begin your treatment.

We will be reserving this time specifically for you. If you are going to be late, please call our office. Also, **please call our office 48 hours prior to your appointment and confirm your attendance**. **If we do not hear from you, we will assume** **you have canceled your appointment.** If it would make you feel more comfortable to be accompanied by a friend or relative, please feel free to invite them.

Prior to your appointment, please review and complete the enclosed SELF-ASSESSMENT FORM. This will save time and allow for more discussion during the session. After completing the form, please bring the original with you to the session.

Insurance plans have become more numerous and complex. It is in your best interest to contact your insurance company prior to the initial session. We would recommend asking the following questions:

 1. Are mental health services covered?

 2. Is there a mental health deductible in addition to a medical deductible?

 3. Is there a co-payment or other percentage that you are responsible for?

 4. Are our providers signed up with your plan?

As a service to you, our office will file your insurance claim. Co-payments and unmet deductibles will be due at the time of service. If you are unaware of your mental health benefit and we are unable to obtain the information from your insurance company, you will be asked to pay the entire fee at the time of service. Our office will reimburse you for the amount we collect from your insurance company.

A 24-hour notice is required for all cancellations or you may be billed for the session. If your insurance company requires treatment plans to be completed, this will be done in the follow-up visit with you. It is your responsibility to keep track of your authorized visits and bring the treatment plan to the office to be completed.

We hope this letter is helpful to you. If you have further questions, please feel free to contact our office. We look forward to our meeting. Remember to confirm your attendance 48 hours prior to your appointment.

Sincerely,

*Norman Psychiatry*

**Policy and Procedures**

**Office Hours:**

Office hours are Monday-Thursday from 8:00 am to 5:00 pm, excluding holidays. We are open on some Fridays by appointment only. We are closed for lunch between 12:00-1:00 pm. If you have an urgent problem requiring attention after-hours, you may contact the psychiatrist on call. This number changes on a monthly basis, so call our office at (405) 579-4111 and the phone number for the on-call psychiatrist will always be updated on our voicemail. Prescription refills are NOT considered an emergency.

**Telephone Calls:**

Our telephone is answered during regular office hours. You may leave a message on our answering machine after hours and your call will be returned the next business day. Calls received on weekends will be returned on Monday. After-hour telephone consultations with your provider will be reserved for emergency situations only. Providers answer phone messages by the end of the business day, after they are done seeing patients. Any voicemails left after 4:30 pm will be answered the next business day.

**Prescriptions and Refills:**

Allow at least 3 days to process prescription renewals and/or pick-up requests. Sometimes requests are filled sooner than this. You are responsible for knowing when your medication will run out and accounting for the time it takes for our providers to authorize your request. Have your pharmacy fax a request to (405)579-4223. Prescriptions require a scheduled follow-up appointment before we will refill. Count your pills and make sure you have enough to last until your next visit. No refills will be authorized if there is a history of missed appointments.

No controlled prescriptions will be replaced if lost, stolen, misplaced, or overused. No prescriptions will be refilled on Fridays, Saturdays, Sundays, or Holidays. Prescription phone in/pick up hours: Monday-Thursday 9:00-5:00 pm. Prescriptions will not be filled for unauthorized walk-in patients. New symptoms require an appointment. Providers will not diagnose via phone. Medications are for the prescribed individual’s use only. It is illegal to share or sell your medication. You must pick-up your prescription in person, unless pre-authorized by our staff. Please note: we will not refill SUBOXONE early under any circumstances.

A signed “Controlled-Substance Policy” is required for narcotic/controlled medications. Our practice takes the controlled substance policy very seriously. When physician-patient relationship is strained due to perceived drug-seeking behavior, providers may continue services but cease in prescribing any controlled substances. In other cases, a patient may be terminated from this office and given direction to locate another medical office for continued care. Patient termination is at the discretion of the provider. Common reasons for termination include, but are not limited to, chronic noncompliance with recommended treatment, drug-seeking behavior, and abusive behavior towards staff, physicians, visitors, or other patients.

**Controlled Substance(s) Policy**

Due to recent guidelines by standard health maintenance agencies, we reserve the right to conduct an initial urine drug test and every sixty days thereafter for patients prescribed a controlled substance for sleep, anxiety, or any other conditions.

I have read and agree to all of the policies and procedures listed above:

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tips For Future Visits**

1. It is expected that you will arrive 30 minutes early for your initial

evaluation. Please arrive 10 minutes early for all appointments thereafter to avoid last-minute rushes.

2. **To avoid being charged, give a 24 hour notice for cancellations.**

Otherwise, your provider will likely charge you the full price of the visit.

You will be responsible for the balance, and it must be paid off before

services will be rendered again. Missed appointment charges are not

covered by your insurance.

3. The physician on call is available 24 hours per day for emergencies. Do not

use this service if it is not an emergency. Prescription refills will not be considered an urgent matter.

4. Count your pills before your visit. Get a written prescription to ensure you have

enough medicine to last until your next visit.

5. Know your charge and write checks beforehand to make the best use of your

session time.

6. Do not change appointment times unless absolutely unavoidable.

7. For routine matters, call during office hours only.

8. Know your insurance benefits. Call your insurance company before receiving

services. Find out your exact copayment and/or deductible amount. Remember that if our provider is out-of-network, you will be responsible for the full charge.

9. Unless prior arrangements are made, payment is required at the time of service.

10. Please visit our website for additional information and services we provide:

[www.normanpsychiatry.com](http://www.normanpsychiatry.com/)

**Patient Information**

Please provide the information in the spaces provided. This and all other information relating to your association with Norman Psychiatry is regarded as strictly confidential and will not be shared without your signed consent.

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Referred by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_\_

Sex:\_\_\_\_Birth date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Insured or Responsible Party**

If Insurance does not pay your bill, who is financially responsible for the balance?

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Street Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

#1 Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mail Claims to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ph#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#2 Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mail Claims to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ph#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and address of policy holder’s employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy Holder’s work phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorizations and Agreements**

Payment Policy and Cancellation Agreement: I understand that the office files my primary insurance as a courtesy, but the bill is MY responsibility. I am aware that notice of cancellation must be given 24 hours in advance so that I will not be charged.

Release of Information and Assignment of Benefits Agreement: I authorize Norman Psychiatry to release any information acquired in the course of my treatment to my insurance company and assign the insurance payment due to me to Norman Psychiatry.

Patient’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Record of Disclosure**

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications on PHI be made by alternative means, such as sending correspondence to your office instead of your home.

**I WISH TO BE CONTACTED IN THE FOLLOWING MANNER**

**(Check all that apply):**

\_\_\_\_\_Home Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_OK to leave a message with detailed information

\_\_\_\_Leave message with call-back number only

 \_\_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_OK to leave message with detailed information

 \_\_\_\_Leave message with call back-number only

\_\_\_\_\_Work Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_OK to leave a message with detailed information

\_\_\_\_\_Leave message with call-back number only

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Print Name Birthdate

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian Date

(If patient is under 18 years old)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Relationship to Patient

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. The provisions do not apply to the uses or disclosures made pursuant to an authorization requested by the individual.

**NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.**

**ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES:** A complete description of how my medical information will be used and disclosed by Norman Psychiatry is in the “Notice of Privacy Practices.” A copy of the “Notice of Privacy Practices” is posted in the clinical site and is available if you would like a copy.

**I have accepted a copy of “Notice of Privacy Practices” \_\_\_\_\_yes \_\_\_\_\_no**

**Reason for the refusal, if No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Informed Consent, Confidentiality, Description of Services**

**Description of Services:** It is my understanding that Joseph M. Ripperger, M.D. is a licensed Psychiatrist, qualified in Oklahoma to practice medicine and provide psychotherapy. Counseling and psychotherapy involve discussing in detail my concerns, giving background information, and talking about areas that may cause me emotional pain, all for the purpose of trying to develop new and more effective methods of coping with problem areas in my or my child’s life. I understand that I am free to withdraw from therapeutic contact at any time if I so desire and will only be responsible to pay for the completed sessions.

**Confidentiality:** All services provided and all information obtained is kept confidential and cannot be released without your written permission. You need to know, however, that there are special situations under which confidential information could be revealed, such as:

1. A “duty to warn” ethic allows a psychiatrist to break confidentiality when

 danger exists to the patient or others.

 2. Under special circumstances, the court may subpoena patient records and may

 order a psychiatrist to give testimony during a court hearing.

3. Third party payers, such as insurance companies, have a right to review

 patient’s records prior to payment.

 4. Delinquent accounts may be turned over to a Collections Agency.

 5. Based on clinical judgment, consultation with another professional with

 respect to your treatment may be sought.

 6. Actual or suspected abuse to children or the elderly must be reported to

 authorities.

Your signature indicates that you have read and understood the above information concerning your confidentiality and that you have read and understood the description of possible services, and consent is given to provide services to you and/or your child (or children), \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, who is (are) not of legal age.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date Relationship, if pt is a minor

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Witness Date

**Advance Benificiary Notice (ABN)**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE: You need to make a choice about receiving these healthcare items or services.** Medicare/Private Insurance will not pay for all of your health care costs. They only pay for covered items and services when Medicare/Private Insurance rules are met. Some of the item(s) or service(s) they do not cover are described below. The fact that Medicare/Private Insurance will not pay for a particular item or service does not mean that you should not receive it. There may be good reason your doctor recommended it. Right now, in your case:

**MEDICARE/PRIVATE INSURANCE DOES NOT PAY FOR THESE SERVICES:**

* **Prior Authorization Request**
* **Letters/Forms Completed**
* **Patient Assistance for Medication**
* **Phone Sessions**

The purpose of this form is to help you make an informed choice about whether or not you want to receive these services and others like them that involve charge(s) to you, which are not covered by your insurance. If you need further explanation or do not understand why insurance does not cover these services, please ask us to explain. These items or services will be your responsibility. (Estimated Cost: $20.00)

\_\_\_\_\_**Option 1. YES. I WANT TO RECEIVE THESE ITEMS OR SERVICES**

I understand I will be responsible for payment of these services.

\_\_\_\_\_\_**Option 2. NO. I DO NOT WANT TO RECEIVE THESE ITEMS OR**

**SERVICES.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature of patient or legal guardian Date

Note: Your health information will be kept confidential. Any information that we collect on this form will be kept confidential in our office.

**Financial Policy and Missed Appointment Policy**

*Please read over our financial and missed appointment policy. If you have questions, feel free to ask our staff.*

**Financial Policy Information:** Fees vary depending on what provider you are seeing and for what service.

 Initial evaluation with Psychiatrist: $230-330

 Medication Appointments: $90-135 (more if therapy is added)

 Initial evaluation with Nurse Practitioner: $190-230

 Medication Appointments: $90-110 (more if therapy is added)

 Initial evaluation with Counselor: $150

 Therapy appointments: $135

**Insurance Patients.** If you have health insurance, our office is happy to call your insurance company and verify your insurance benefits. They will also file your insurance for you. If your insurance covers a portion of your therapy, we will wait for 90 days for them to pay their portion. However, you will be responsible for your deductible and co-pays. That portion of your care will be due at the time of your appointment.

 You will be responsible for all charges not covered by your insurance company. Any outstanding balance that has not been paid off in 90 days will be charged to your credit card on file. If for some reason this is not possible, you will be billed what you owe. If this is not paid within 30 days from that date, your account will be turned over to a collection agency.

**Self-Pay Patients.** Patients without insurance or with high deductibles are responsible for the cost of their care. Payment is expected at the time the service is rendered.

**Methods of Payment.** We accept cash, checks, and major credit cards.

**Missed Appointment Policy.** A full twenty-four hours is required for the cancellation of an appointment. Appointments canceled with less than 24 hours notice will be charged the full fee at rates shown above. Appointments missed due to inclement weather will not be charged. Your charge will be applied to your credit card on file.

**I have read and agree to the above conditions.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Date

**Credit Card Guarantee for Personal Balance**

The credit card guarantee ensures that your account stays up-to-date and current. Your card will be kept on file and only used when payment has not been made by mail or in person. You can make co-pays, pay for special services, or pay your bill with your credit card on file, if you so choose. We will charge the amount due if payment has not been made in a timely manner. No show and/or cancellations made without 24 hours notice will be charged to your credit card on file.

**( ) UNINSURED/SELF-PAY PATIENTS**

I understand that since I do not have insurance that I am personally responsible for payment. I understand that payment is due at the time of service.

**( ) INSURANCE ASSIGNMENT**

I understand that as a courtesy to me, Norman Psychiatry will bill my health insurance carrier, but that my bill is MY responsibility. I understand that this office will wait up to 90 days for payment from my insurance provider. I understand that any amount owed after 90 days, which has not been paid by my insurance provider, will be placed on my designated credit card below. Any insurance payments made on these claims thereafter will be placed on my account as a credit or will be refunded to me, if I so choose.

I understand that if my insurance does not cover the cost of mental health treatment, if my deductible is high, or there are other limitations in my coverage, that I will be responsible for my bill at the time of service.

I agree to the above terms and authorize you to charge any payment not paid by the date due.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 SIGNATURE DATE

CREDIT CARD: Circle One Visa Mastercard Discover

 CARD HOLDER’S NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 CARD HOLDER’S BILLING ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 CARD #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_EXP. DATE:\_\_\_\_\_\_\_\_THREE DIGIT CID NUMBER:\_\_\_\_\_\_\_\_\_\_

**SELF-ASSESSMENT FORM**

Please Print

Date:\_\_\_\_\_\_\_\_\_\_\_Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Place of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

With whom do you live (relationship, if any)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Religion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Education (Highest level completed)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Degree, if any:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital History:**

If you have been married, how many times?\_\_\_\_\_\_\_\_If you have been divorced, how many times?\_\_\_\_\_

**Current Marital Status:**

Never married:\_\_\_\_\_Married:\_\_\_\_Living cooperatively:\_\_\_\_\_Separated:\_\_\_\_\_Divorced:\_\_\_Widowed:\_\_

**Emergency Contact:**

Name of Person to call in an emergency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person filling out form, if not patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Care:**

Who is your Primary Care Physician?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently doing therapy with anyone else? If so, who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please State the Principal reason you are requesting a consultation or treatment:**

**Please describe your illness from the time of your first symptom to the present. Provide as many dates, names, and addresses of psychiatrists, psychologists, and/or social workers you have seen. Also, please provided the kinds of treatment you received:**

|  |
| --- |
|  |

**Please briefly describe any expectations you or your family members may have regarding treatment:**

|  |
| --- |
|  |

**Suicide and/or Hospitalizations:**

Have you ever thought about suicide? Yes\_\_\_No\_\_\_

If “yes,” when was the last time?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever attempted suicide? Yes\_\_\_\_No\_\_\_\_\_

Do you have thoughts about suicide now? Yes\_\_\_\_\_No\_\_\_\_

Have you ever been hospitalized for a psychiatric reason? Yes\_\_\_\_No\_\_\_\_How many times?\_\_\_\_\_

When was the last time and where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How long?\_\_\_\_\_\_\_

What were the circumstances?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Recent stressful life events:**

(Check any of the following that have occurred in the last year) Comments

|  |  |  |
| --- | --- | --- |
| Married |  |  |
| Engaged |  |  |
| Separated |  |  |
| Divorced |  |  |
| Breakup of important relationship |  |  |
| Child left home |  |  |
| Death of spouse or other loved one |  |  |
| Bad health (behavior) of family member |  |  |
| Personal Injury, illness |  |  |
| Changes at school, work |  |  |
| Retired, lost job |  |  |
| Changed residences |  |  |
| Legal difficulties, multiple traffic tickets |  |  |
| Owe money |  |  |
| Traumatic experiences |  |  |

**Alcohol Use:**

Do you drink alcohol? Yes\_\_\_\_No\_\_\_\_

If yes, how many drinks do you consume in an average day?\_\_\_\_\_\_\_Week?\_\_\_\_\_\_\_

In the past 12 months, have you had 3 or more alcoholic drinks within a 3-hour period on 3 or more occasions? Yes\_\_\_\_\_No\_\_\_\_ Was there ever a time when you felt you were or someone told you that you were drinking too much? Yes\_\_\_\_\_\_No\_\_\_\_\_If “yes,” under what circumstances?\_\_\_\_\_\_\_\_\_\_\_\_\_

**Drug Use:**

Check any drugs you have taken. List the circumstances and pattern of use, or any consequences to the use. Also, state the amount you used at its heaviest, and the last time you used.

|  |  |  |
| --- | --- | --- |
| None |  |  |
| Marijuana |  |  |
| Amphetamine/Speed |  |  |
| Heroin/Opiates |  |  |
| PCP |  |  |
| LSD/Hallucinogens |  |  |
| Cocaine/Crack |  |  |
| Barbituates/sedatives/downers/benzos |  |  |
| Purchased substances via the Internet |  |  |
| Other |  |  |

**Past History:**

|  |  |  |
| --- | --- | --- |
| **Check if during childhood you...** |  | **Comments** |
| Were afraid to go to school |  |  |
| Had difficulty with reading, writing, or math |  |  |
| Were truant |  |  |
| Failed or repeated a grade |  |  |
| Wet bed after age 5 |  |  |
| Had tics |  |  |
| Had stutter/stammer |  |  |
| Nightmares, disturbed sleep, fear of the dark |  |  |
| Ran away from home |  |  |
| Were cruel to animals |  |  |
| Frequently lied to family or others |  |  |
| Set fires |  |  |
| Moved Frequently |  |  |
| Worried excessively about your appearance |  |  |
| Were exposed to incest |  |  |

**Family History:**

Please list all psychiatric illnesses (include depression, bipolar, anxiety, substance abuse, suicide attempts,etc). Indicate their relationship to you and age at death if deceased

|  |  |  |  |
| --- | --- | --- | --- |
| **Relationship** | **Age** | **Age at death** | **Psychiatric Illness** |
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**Health History:**

**Weight**

 What is your current weight in pounds?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Height?\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Has your weight increased or decreased by more than 10 pounds in the last year: Yes\_\_\_\_No\_\_\_\_

 If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Do you have any history of an eating disorder? Yes\_\_\_\_No\_\_\_\_\_Do you have episodes of excessive

 overeating, in which you eat significantly more than what most people would eat in a similar period

 of time and then feel distressed about your episodes of excessive overeating? Yes\_\_\_\_No\_\_\_\_

**Sleep**

Do you:

 Have difficulty sleeping? Yes \_\_\_\_\_No\_\_\_\_\_

 Have difficulty staying asleep? Yes\_\_\_\_\_No\_\_\_\_\_

 Experience daytime sleepiness? Yes\_\_\_\_\_No\_\_\_\_\_

 Snore? Yes\_\_\_\_No\_\_\_\_Wake up short of breath? Yes\_\_\_\_\_No\_\_\_\_

 Wake up with a headache? Yes\_\_\_\_No\_\_\_\_\_

 Has anyone ever told you that you stop breathing? Yes\_\_\_\_No\_\_\_\_

 Jerk or have restless legs in your sleep? Yes\_\_\_\_No\_\_\_\_

**Smoking**

 Do you smoke? Yes\_\_\_\_No\_\_\_\_ If yes, do you want to quit? Yes\_\_\_\_No\_\_\_\_

**Caffeine**

 Do you drink caffeinated coffee, tea, or colas? Yes\_\_\_\_No\_\_\_\_

 Do you believe you are sensitive to caffeine? Yes\_\_\_\_No\_\_\_\_

**Sexual Functioning**

 Active? Yes\_\_\_\_No\_\_\_\_Satisfied with your libido or your level of desire? Yes\_\_\_\_No\_\_\_\_

 Satisfied with functioning? Yes\_\_\_No\_\_\_

**Allergies**

 **List all allergies. Be sure to include medication allergies.**

|  |
| --- |
| List all allergies here: |

**Medical Problems**

List all past and present medical problems, as well as any surgeries or accidents. Please list the age of onset or occurrence.

|  |
| --- |
| List all medical problems here: |

**Check if you have had:**

\_\_\_\_Head injury \_\_\_\_ CAT scan or MRI of the brain \_\_\_\_ Seizure \_\_\_\_\_ EEG\_\_\_\_

Neurological exam\_\_\_\_

Have you ever had a time lasting more than several days when you were feeling “up” or “high” or “hyper” or so full of energy OR persistently irritable that you got into trouble, or that other people thought you were not your usual self? (Do not consider times when you were under the influence of drugs or alcohol). Yes\_\_\_\_No\_\_\_\_

**Current Medications:**

Include prescriptive, herbal, and over-the-counter medications

|  |  |  |  |
| --- | --- | --- | --- |
| Medication name | Dosage and frequency | Prescribing Physician | How long? |
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**Preferred Pharmacy:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Psychiatric Medications:** This is a list of commonly prescribed psychotropics. Please indicate all that you have tried in the past. Both trade and generic names are provided. If you have taken any, please indicate those that were particularly helpful or unhelpful, and any negative side effects you experienced.

|  |  |
| --- | --- |
| **Check Medication Helpful? Did you have****If taken Name Yes/No Side Effects?** | **Check Medication Helpful? Did you have****If taken Name Yes/No Side Effects?** |
| Prozac/Fluoxetine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Paxil/Paroxetine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zoloft/Sertraline \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Celexa/Citalopram\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Lexapro/Escitalopram\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Luvox/Fluvoxamine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Viibryd/Vilazodone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Trintellix/Vortioxetine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Effexor XR/Venlafaxine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cymbalta/Duloxetine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fetzima/Levomilnacipran\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pristiq/Desvenlafaxine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Remeron/Mirtazepine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Wellbutrin/Bupropion\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Anafranil/Clomipramine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Elavil/Amitriptyline\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pamelor/Nortriptyline\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Tofranil/Imipramine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Desyrel/Trazodone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Serzone/Nefazodone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Risperdal/Risperidone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zyprexa/Olanzapine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Seroquel/Quetiapine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Symbyax/Olan-Fluoxetine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Geodon/Ziprasidone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Abilify/Aripiprazole\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Saphris/Asenapine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Invega/Paliperidone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Rexulti/Brexipiprazole\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Vraylar/Cariprazine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Latuda/Lurasidone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fanapt/Iloperidone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Clozaril/Clozapine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mellaril/Thioridazine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Prolixin/Fluphenazine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Navane/Thiothixene\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Trilafon/Perphenazine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Haldol/Haloperidol\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Provigil/Modafinil\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Nuvigil/Armodafinil\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Revia/Naltrexone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Campral/Acomprosate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  Antabuse/Disulfiram\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Eskalith/Lithobid/Lithium\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Depakote/Divalproex\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Tegretol/Carbamazepine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Trileptal/Oxcarbamazepine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Lamictal/Lamotrigene\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Topamax/Topiramate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Gabitril/Tiagabine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Neurontin/Gabapentin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Buspar/Buspirone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Inderal/Propranolol \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Catapres/Clonodine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Atarax/Vistaril/ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hydroxyzine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ambien/Zolpidem\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sonata/Zaleplon\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Lunesta/Eszopiclone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Somnote/Chloral Hydrate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Restoril/Temazepam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Halcion/Triazolam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Silenor/Doxepin\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dalmane/Flurazepam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Rozerem/Ramelteon\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Belsomra/Suvorexant\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Xanax/Alprazolam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Klonopin/Clonazepam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Valium/Diazepam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ativan/Lorazepam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Serax/Oxazepam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Tranxene/Clorazepate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Librium/Chlordiazepoxide\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ritalin/Concerta/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Methylphenidate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Adderall/D-amphetamine/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Amphetamine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Vyvanse/Lisdexamfetamine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Strattera/Atomoxetine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Evekeo/Amphetamine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Intuniv/Guanfacine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**List any other medications here:** |

**REVIEW OF SYSTEMS (General Health Questions)**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Constitutional** | **Yes** | **No** | **Respiratory** | **Yes** | **No** | **Hematology/Lymph** | **Yes** | **No** |
| Weight loss |  |  | Cough |  |  | Easy Bruising |  |  |
| Fatigue |  |  | Coughing Blood |  |  | Bleeding gums |  |  |
| Fever |  |  | Wheezing |  |  | Enlarged glands |  |  |
| **Eyes** |  |  | Chills |  |  | **Musculoskeletal** |  |  |
| Glasses/Contact |  |  | **Gastrointest.** |  |  | Joint Pain/Swelling |  |  |
| Eye Pain |  |  | Heartburn/Reflux |  |  | Stiffness |  |  |
| Double vision |  |  | Nausea/Vomitting |  |  | Muscle Pain |  |  |
| Cataracts |  |  | Constipation |  |  | Back Pain |  |  |
| **Ear, Nose,** **Throat** |  |  | Change in BMs |  |  | **Skin** |  |  |
| Difficulty hearing |  |  | Diarrhea |  |  | Rash/Sores |  |  |
| Ringing in the ears |  |  | Jaundice |  |  | Lesions |  |  |
| Vertigo |  |  | Abdominal Pain |  |  | Itching/Burning |  |  |
| Sinus trouble |  |  | Black or Bloody Stools |  |  | **Neurological** |  |  |
| Nasal stuffiness |  |  | **Genitourinary** |  |  | Loss of Strength |  |  |
| Frequent sore throat |  |  | Burning/Frequency |  |  | Numbness |  |  |
| **Cardiovasc** |  |  | NighttimeFrequency |  |  | Headaches |  |  |
| Murmur |  |  | Blood in Urine |  |  | Tremors |  |  |
| Chest Pain |  |  | Erectile Dysfunction |  |  | Memory Loss |  |  |
| Palpitations |  |  | AbnormalDischarge |  |  | **Addictive Behaviors** |  |  |
| Dizziness |  |  | Bladder Leakage |  |  | Gambling |  |  |
| Fainting Spells |  |  | **Allergic** |  |  | Shopping/Spending |  |  |
| Shortness of Breath |  |  | Hives/Eczema |  |  | Internet |  |  |
| Difficulty lying flat |  |  | Hay Fever |  |  | Pornography |  |  |
| Swelling ankles |  |  | **Psychiatric** |  |  | Sex |  |  |
| **Endocrine** |  |  | Anxiety |  |  | Gaming |  |  |
| Loss of hair |  |  | Depression |  |  | Food |  |  |
| Heat/cold Intolerant |  |  | Mood swings |  |  | Reviewed by: | **Date:** |