Bartlett Regional Hospital
Bartlett Outpatient Psychiatric Services
3240 Hospital Drive
Juneau, AK 99801
Phone: (907) 796-8498
Fax: (907) 796-8497

Date: _____

Patient Information

Patient: _____
Last Name First Name Middle Initial

Preferred Name: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: _____

Social Security #: _____-_____-_____ Primary Care Physician: _____

Employer: _____Occupation: _____

Veteran Status: ☐ Active Duty ☐ Non Veteran ☐ Veteran ☐ N/A

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Provide

Race: ☐Alaska Native or Native American ☐Black or African American ☐Caucasian
☐ Hispanic ☐ Decline to Provide ☐ Other_____

Organ Donor: ☐Yes ☐No

Contact Information

Mailing Address: _____

Phone: _____ Email: _____

Parent or Legal Guardian Name (if applicable): _____

Preferred method of contact for appointment ***reminder calls***: ☐ Call ☐ Text ☐ Email

Emergency Contact Name: _____ Phone: _____

Relationship: _____

Insurance Information

Please provide all insurance policies.

Primary Policy: _____Policy #: _____Group #:_____
Subscriber: _____ Subscriber Date of Birth: _____
Subscriber Social Security #: _____-_____-_____

Secondary Policy: _____Policy #: _____ Group #:_____
Subscriber: _____ Subscriber Date of Birth: _____
Subscriber Social Security #:_____-_____-_____

Tertiary Policy: _____Policy #:_____Group #:_____
Subscriber: _____ Subscriber Date of Birth: _____
Subscriber Social Security #:_____-_____-_____

Please present insurance cards to front office staff.

Bartlett Outpatient Services
Patient's Rights and Responsibilities

Policy: It is the intent of Bartlett Outpatient Psychiatry that all patients shall be informed of their legal rights pertaining to services rendered as follows:

Rights:

1. Each patient is entitled to participate in the development and evaluation of his/her treatment plan/goals.
2. Each patient may expect reasonable continuity of care and to be informed of his/her present progress and prognosis.
3. Each patient shall be informed of the name, purpose, and possible side effects of any medication that is prescribed for him/her by a licensed physician under this program as part of the treatment plan.
4. Each patient is entitled to examine and receive explanation of his/her billing regardless of the source of payment.
5. All records and information about patients and former patient shall be safeguarded and kept confidential with the exception that this information be disclosed to the following:
   a) A person authorized by court order;
   b) A designated hospital to which a patient is involuntarily committed;
   c) Insurance, medical assistance, or other program only to the extent necessary for a patient to make a claim, or for a claim to be made on behalf of a patient.
   d) Other persons to whom disclosure is required by law, an individual to whom the patient, patient's parent (if patient is a minor), legal guardian, or other legal designated representative has been given written consent for disclosure; and
   e) Public Safety personnel in the case of medical or psychological emergency.

Responsibilities:

1. To actively participate in your treatment.
2. To inform your psychiatrist of events, emotions, plans and commitments which may affect your treatment.
3. To maintain the confidentiality of other patients you may encounter during the course of your treatment.
4. To fulfill commitments made with your psychiatrist, including mutually agreed upon homework assignments.
5. To arrive on time for appointments, informing us a minimum of 24 hours in advance if the session must be canceled (you may be charged up to the full cost of the scheduled service if missed, but not canceled).

6. To pay for each appointment prior to the appointment unless other arrangements are made.
7. To update our office of any changes to your insurance policy.

Bartlett Outpatient Services personnel are required by State Law to report to Alaska Division of Family and Youth Services (DYFS), any known or suspected incident of neglect, abuse and/or sexual molestation of child or other vulnerable person.

I hereby certify that I have read and have been fully informed of the Patient's Rights and Responsibilities and hereby agree:

1. To accept the treatment goals negotiated with the clinical staff and to actively participate in my treatment program.
2. To accept full responsibility for the payment of all charges incurred at Bartlett Outpatient Services.

_____

Signature of Patient or Legal Guardian Date

_____

Signature of Spouse or Parent Date

_____

Signature of BRH Employee Date

BARTLETT REGIONAL HOSPITAL

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received a copy of the Bartlett Regional Hospital (BRH) Privacy Notice that describes how my health information is used and shared. I understand that BRH has the right to change this notice at any time. I may obtain a current copy by contacting the BRH Patient Access Services office or by visiting the BRH website at www.bartletthospital.org.

My signature below constitutes my acknowledgement that I have received a copy of the notice of privacy practices.

_____ _____

Signature Date

If signed by legal representative, relationship to patient:_____

If signature not obtained, reason why_____
(e.g.: patient refused, etc.)

_____ _____

Signature of BRH Employee Date

Bartlett Regional Hospital

3260 Hospital Drive, Juneau, Alaska 99801 907.796.8900 www.bartletthospital.org

NOTICE OF PRIVACY PRACTICES

Revised Date: October 15, 2019

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Pledge Regarding Medical Information We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at Bartlett Regional Hospital (BRH). We need this record to provide you with quality care and to comply with legal requirements. This notice applies to all of the records of your care generated by the hospital. Your personal doctor may have different policies regarding the use and disclosure of your medical information created in the doctor's office or clinic. Bartlett Regional Hospital is providing you this notice in order to explain the impacts of federal laws detailing exactly how your medical information may be used and disclosed. BRH is required by law to abide by the terms of this notice. If you have any questions, please contact the Bartlett Regional Hospital Compliance Officer at (907) 796-8578.

To Report A Problem Bartlett Regional Hospital is mandated by federal and State of Alaska law to maintain the privacy of your confidential information. It is a mandate that we at BRH take very seriously. If you believe your privacy rights have been violated, you can file a complaint with BRH, by contacting the Compliance Officer at (907) 796-8578 or with the Secretary of Health and Human Services. **You will not be penalized for filing a complaint**.

How BRH May Use And Disclose Medical Information About You The following describes different ways that we use and disclose medical information. For each use or disclosure we will explain what we mean and try to give some examples, although these examples are not the only type of use.

For Treatment BRH may use your medical information to provide you with medical treatment or services. For example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will record instructions for other members of your healthcare team, who in turn will then record their actions and their observations. We will also provide your physician or a subsequent healthcare provider with copies of various reports that will assist in treating you once you leave this hospital.

For Payment As permitted by law, we will use and disclose your health information for payment activities. Payment activities generally include billing, collections, and obtaining prior approval from your insurance plan for the care that we provide. Billing may be conducted by BRH or third-party companies on behalf of BRH, who may contact you by phone, text, email, or direct mail. Public and private insurance plans may require us to disclose your health information for the purposes of audits, inspections, and investigation.

<u>Some examples:</u> We may send a bill to your insurance plan. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used so we can get paid for the treatment we provide. We may disclose certain information to consumer reporting bureaus for collection of payment.

<u>For HealthCare Operations</u> We may use your health information for regular health operations. "Healthcare operations" are certain administrative, legal, and quality improvement activities necessary to run BRH and ensure that patients receive the highest quality of care. For example, we may use your medical information to evaluate the quality of care you received from us, or to evaluate the performance of those involved with your care. This may include BRH, or its business associate, contacting you to request survey feedback regarding your level of satisfaction for the care you received at BRH. Patient satisfaction surveys requests may be sent to you via text, phone, email or direct mail.

<u>Reminders</u> We may also use and disclose your PHI to contact you as a reminder that you have an appointment for treatment at our facility, to tell you about or recommend possible treatment options, or about health-related benefits or services that may interest you. We may communicate by phone or in electronic form, to include but not limited to, text messaging, short message service (SMS) and email. For instance, we may email you these appointment reminders. As part of our appointment reminders, we may email information regarding your procedure to you. The email may contain a link to an informational video that describes your procedure and the pre-procedure and post-procedure instructions. However, because the emailed link is not encrypted, there may be some risk that information about you and the procedure that you will receive is not secure. You have the option of not having this information emailed to you

<u>Hospital Directory</u> Unless you notify us that you object, at the time of admission, we will use your name and location in the facility for directory purposes while you are a patient. The directory information may also be released to people who ask for you by name. We may also provide your religious affiliation to members of the clergy. In an emergency, we are permitted to use such information in your best interest as determined by our professional judgment.

<u>Individuals Involved in Your Care or Payment for Your Care</u> BRH may release medical information about you to a family member or personal representative who is involved in your medical care or who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

<u>As Required by Law</u> BRH will disclose medical information about you when required to do so by federal, state or local law. For example: To the FDA, health information relative to adverse events with a medication.

<u>To Avert a Serious Threat to Health or Safety</u> BRH 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 would be to someone able to help prevent the threat.

<u>Business Associates</u> There are some services provided by BRH through contracts with other agencies or organizations. BRH may disclose your health information to these business associates so that they can perform services for BRH; for example, outside auditors or BRH retained attorneys. We require the business associates to appropriately safeguard your information.

Health Information Exchanges

We participate in health information exchanges with local hospitals, physicians, insurance plans, and other healthcare organizations. These information exchanges allow healthcare organizations to send and receive your health information when there is a need for this information for treatment, payment, or in limited circumstance, healthcare operations.

> *Some examples:* We disclose basic information regarding any emergency department visits you make to a health information exchange. The purpose of this exchange is to enable local emergency departments to coordinate patient care and reduce unnecessary services.

Patient Portal B.E.H.R. Care (Bartlett Electronic Health Record)

We provide you, or individuals authorized by you, with limited access to your electronic health information through BEHR CARE, a patient portal. Certain limitations apply to its use by minors and their parents/guardians

Special Situations

Research BRH may disclose information to researchers only after receiving a signed authorization from you. Alaska law places restrictions on the type of information that may be released in research related to substance abuse.

Photography, Videotaping and Audio Taping To document patient care, a number of visual or audio methods (photography, videotaping and digital imaging) may be used. A separate consent from you is required should BRH wish to photograph, record or tape.

Organ and Tissue Donation If you are an organ donor, BRH may release medical information to organizations that handle procurement or transplantation or to an organ donation bank.

Military and Veterans If you are a member of the armed forces, BRH may release medical information about you as required by military command authorities (i.e., to the VA).

Workers' Compensation BRH may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks As required by federal and State of Alaska law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability, to report births and deaths, to report child, elder, and vulnerable adult abuse or neglect, to report reactions to medications or problems with products, to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease. State of Alaska Law requires reporting of the birth defects registry, cancer registry, communicable diseases; firearm injuries; and blood lead test results.

Health Oversight Activities BRH may disclose medical information to a health oversight agency for activities authorized by law. These activities include audits, investigations, and medical licensure activities. They also include uses and disclosures of medical information to protect patient safety, safeguard public health, and ensure that BRH and our practitioners comply with government and accreditation standards.

Lawsuits and Disputes If you are involved in a lawsuit or a dispute, BRH may disclose medical information about you in response to a court order, subpoena, or administrative order in accordance with applicable law. We may also disclose your records if you provide a notarized release to the other party in the dispute.

Law Enforcement We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena, court order, or warrant.

Coroners, Medical Examiners and Funeral Directors BRH may release medical information to a coroner or medical examiner. We may disclose health information to funeral directors so to carry out their duties.

Inmates If you are an inmate of a correctional institution or under the custody of a law enforcement official, BRH may release medical information about you to the correctional institution or law enforcement official.

Marketing and Prohibited Sale of Your Information BRH may use and disclose your medical information to tell you about or recommend possible treatment options or alternatives that may be of use to you, or health-related products or services that may be of interest to you. BRH is prohibited from selling your protected health information (for example to another company for marketing processes) without a written authorization from you.

Your Rights Regarding Medical Information About You

The Duty of BRH to Notify You of a Breach In the unlikely event of a breach of your medical information, BRH will notify you of the circumstances of the breach and the efforts taken by the hospital to correct the incident.

Right to Inspect and Copy You have the right to inspect and copy medical information that may be used to make decisions about your care. You also have the right to receive your medical information in an electronic format. To do so, you must submit your request in writing to the BRH Health Information Management Department (Medical Records Department). We may charge a fee for our costs.

BRH may deny your request to inspect and copy in certain limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by BRH will review your request and the denial. We will comply with the outcome of the review.

Right to Amend If you feel that medical information we have about you is incorrect or incomplete, you have the right to request an amendment. That right exists as long as the information is kept by BRH.

Your request for an amendment must be in writing and submitted to the BRH Health Information Management Department. 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, BRH may deny your request if you ask us to amend information that:

- Was not created by us;
- Is not part of the medical information kept by or for BRH; or
- Is not accurate and complete, in the opinion of your physician.

Right to an Accounting of Disclosures An "Accounting of Disclosures" is a list of the disclosures BRH made of your medical information. To request this accounting, you must submit your request in writing to BRH Health Information Management Department. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. In some cases, we may be delayed in providing you a list of certain disclosures if we are required by law or court order to not disclose.

Right to Request Restrictions You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not disclose information about a surgery you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment for you. To request restrictions, you must make your request in writing to BRH Health Information Management Department. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Finally, you have the right to restrict disclosures of specific medical information to a health plan where you have paid the full amount of the bill out of pocket and submitted such a request in writing as stated above. Unlike the restriction request mentioned above, BRH cannot deny this specific type of request.

Right to Request Confidential Communications and the Right to have Information Communicated to you by Alternative Means and / or Location You may request that confidential information about you be communicated alternative means or at alternate locations. As example, test results mailed vs. a phone call. To make such a request, you must submit, in writing to BRH Health Information Management Department. BRH will accommodate all reasonable requests. Your request must specify how and /or where you wish to be contacted.

Discrimination is Against the Law

Bartlett Regional Hospital complies with applicable Federal, State, and local civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, religion, familial status, sexual orientation, gender identity, or gender expression. Bartlett Regional Hospital does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, religion, familial status, sexual orientation, gender identity, or gender expression. Bartlett Regional Hospital provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters; and
- Written information in other formats (large print, audio, accessible electronic formats and other formats).

Bartlett Regional Hospital provides free language services to people whose primary language is not English, such as:

- Qualified interpreters; and
- Information written in other languages.

If you need these services, contact Case Management: (907)796-8580

If you believe that Bartlett Regional Hospital has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

BRH Compliance Officer
3260 Hospital Drive Juneau, AK 99801
Telephone (907) 796-8578 or TTY 1-800-770-8973
Fax (907) 796-8221
Email noverson@bartletthospital.org

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the BRH Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
1–800–368–1019, 800–537–7697 (TDD)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Right to a Paper Copy of This Notice You have the right to a paper copy of this notice. You may ask BRH to give you a copy at any time. You may obtain a copy of this notice at our website, www.bartletthospital.org or by contacting the BRH Patient Access Services Dept. at (907) 796-8900.

CHANGES TO THIS NOTICE BRH reserves the right to change this notice. Copies of the current notice will be available at the hospital and on the BRH website, www.bartletthospital.org.

OTHER USES OF MEDICAL INFORMATION Other uses and disclosures of medical information not covered by this notice or the laws that apply to BRH will be made only with your written permission. If you provide BRH permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. Once you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. However, we are unable to take back any disclosures we have already made with your permission.

Attention: Language assistance services, free of charge, are available to you.
Call 1-907-796-8580 (TTY: 1-800-770-8973).

A daat iyasatáḵ! Gwál i tuwatee Lingít yoo x̱’atángi tin i éede gax̱dushée yáax’, yéi kgwatée. Hél a eetéenáx̱ yití wé dáanaa. Ḵaa jeet x̱’anidatán 1-907-796-8580 (TTY: 1-800-770-8973)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-907-796-8580 (TTY: 1-800-770-8973).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-907-796-8580 (TTY: 1-800-770-8973).

This is for instruction only. Please use this example as a guide to fill out the ROI on the following page. Thank you!

Bartlett Outpatient Psychiatric Services
3260 Hospital Drive, Juneau, Alaska 99801
Telephone (907) 796-8498 Fax: (907) 796-8497

Please DO NOT WRITE ON THIS FORM

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT INFORMATION

Patient Name: **Your information** _____ Birth Date:_____ Medical Record # (if known)_____

Address: _____ City / State/ Zip: _____

I Hereby Authorize Bartlett Outpatient Psychiatric Services to Release Information TO:

Name of Facility/ Organization / Individual: **Please add your primary care physician office** _____

Address: _____

City / State / Zip: _____ Phone Number: _____ FAX: _____

I Hereby Authorize Bartlett Outpatient Psychiatric Services to REQUEST Information FROM:

Name of Facility/ Organization / Individual: **Please add your primary care physician office** _____

Address: _____

City / State / Zip: _____ Phone Number: _____ FAX: _____

Please INITIAL on each selection! (no check marks or X marks)

❑ Dates of treatment: From_____To_____

❑ Purpose or need for information being requested: **Please Initial**
Further Treatment _____ Legal Proceedings _____ Insurance Claim _____ Other (specify): _____

❑ Type of Information to be used or disclosed: **Please Initial**
_____ Consultation _____ History & Physical _____ Progress Notes _____ Verbal Exchange
_____ Discharge Summary _____ Psychiatric Emergency Evaluation _____ Fax

I authorize the release of information relating to: Please Initial
_____ Substance Use Disorder Information _____ Psychiatric Evaluation / Treatment

This Authorization expires on the following date, event or condition: **you can leave this blank** _____
If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the date of signing.

** I understand that I have the right to revoke this authorization at any time. In order to revoke this authorization, I must submit a written revocation to the BOPS HIM Department. I understand that the revocation will not apply to information that has already been released in response to this authorization.
** I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment at BOPS.
** I consider a photocopy of this authorization to be as valid as the original. I understand that I may upon request inspect the information to be disclosed.
** I do not authorize further release to any third party. I understand that once information is released as specified in this authorization, BOPS their employees and physician(s) cannot prevent re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.
** I understand that my alcohol and / or drug treatment records are protected under 42 CFR, Part 2 and 45 CFR, parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Your signature _____ **(self)** _____ _____

Signature of Patient or Legally Responsible Party | Relationship to Patient | Date

FOR OFFICE USE ONLY

ID Verified & Medical Records Released By: _____ Date: _____
MR #: _____ Date Records Mailed/ Faxed/ Picked Up: _____ Therapist Initials: _____

Bartlett Outpatient Psychiatric Services

3260 Hospital Drive, Juneau, Alaska 99801
Telephone (907) 796-8498 Fax: (907) 796-8497

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT INFORMATION

Patient Name: _____ Birth Date:_____ Medical Record # (if known)_____

Address: _____ City / State/ Zip: _____

I Hereby Authorize Bartlett Outpatient Psychiatric Services to Release Information TO:

Name of Facility/ Organization / Individual: _____

Address: _____

City / State / Zip: _____ Phone Number: _____ FAX: _____

I Hereby Authorize Bartlett Outpatient Psychiatric Services to REQUEST Information FROM:

Name of Facility/ Organization / Individual: _____

Address: _____

City / State / Zip: _____ Phone Number: _____ FAX: _____

- ❑ Dates of treatment: From_____To_____
- ❑ Purpose or need for information being requested: **Please Initial**
  Further Treatment _____ Legal Proceedings _____ Insurance Claim _____ Other (specify): _____

- ❑ Type of Information to be used or disclosed: **Please Initial**
  _____ Consultation _____ History & Physical _____ Progress Notes _____ Verbal Exchange

  _____ Discharge Summary _____ Psychiatric Emergency Evaluation _____ Fax

I authorize the release of information relating to: Please Initial
_____Substance Use Disorder Information _____Psychiatric Evaluation / Treatment

This Authorization expires on the following date, event or condition: _____
If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the date of signing.

** I understand that I have the right to revoke this authorization at any time. In order to revoke this authorization, I must submit a written revocation to the BOPS HIM Department. I understand that the revocation will not apply to information that has already been released in response to this authorization.
** I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment at BOPS.
** I consider a photocopy of this authorization to be as valid as the original. I understand that I may upon request inspect the information to be disclosed.
** I do not authorize further release to any third party. I understand that once information is released as specified in this authorization, BOPS their employees and physician(s) cannot prevent re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.
** I understand that my alcohol and / or drug treatment records are protected under 42 CFR, Part 2 and 45 CFR, parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

_____ _____ _____
Signature of Patient or Legally Responsible Party Relationship to Patient Date

FOR OFFICE USE ONLY

ID Verified & Medical Records Released By: _____ Date: _____
MR #: _____ Date Records Mailed/ Faxed/ Picked Up: _____ Therapist Initials: _____

Date: _____/_____/_____

NAME: _____ Birthdate: _____/_____/_____

Last First M. I.

Age:_____ Sex: ❑M ❑F Address:_____

Phone (Home):_____ Phone (Cell):_____

Emergency Contact:_____ Emergency Phone:_____

Insurance Carrier:_____ Policy Number:_____

Are you mandated to participate in mental health services? ❑Yes ❑No

What is your main reason for coming here?_____

_____

Please list the names of other practitioners you have seen for this problem:_____

_____

Psychiatric Hospitalizations (include where, when, & for what reason):_____

PSYCHIATRIC HISTORY

Do you now or have you ever had any of the following:

❑Depression	❑Schizophrenia	❑Borderline personality disorder
❑Bipolar disorder	❑Schizoaffective disorder	❑Substance use disorder
❑Anxiety disorder	❑Posttraumatic stress disorder	❑Other:_____

Have you ever done anything to physically hurt yourself on purpose such as cutting, burning or attempts of suicide?
❑Yes ❑No If yes, please explain:_____

MEDICAL HISTORY

Do you now or have you ever had any of the following:

❑Diabetes	❑Heart murmur	❑Crohn's disease
❑High blood pressure	❑Pneumonia	❑Colitis
❑High cholesterol	❑Pulmonary embolism	❑Anemia
❑Hypothyroidism	❑Asthma	❑Jaundice
❑Goiter	❑Emphysema	❑Hepatitis
❑Cancer (type)_____	❑Stroke	❑Stomach or peptic ulcer
❑Leukemia	❑Epilepsy (seizures)	❑Rheumatic fever
❑Psoriasis	❑Cataracts	❑Tuberculosis
❑Angina	❑Kidney disease	❑HIV/AIDS
❑Heart problems	❑Kidney stones	

Have you ever had a seizure? ❑Yes ❑No

Have you ever had an accident or injury that caused you to lose consciousness for more than five minutes? ❑Yes ❑No

Have you ever had surgery? ❑Yes ❑No

If yes, what and when? _____

Other medical conditions (please list):_____

_____

CURRENT MEDICATIONS

Pharmacy:_____

Drug allergies: ❑No ❑Yes If yes, to what?_____

Please list any medications that you are now taking. Include non-prescription medications, vitamins & supplements.

Name of drug	Dose (include strength & number of pills per day)	How long have you been taking this?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

SOCIAL HISTORY

Where were you born and raised?_____

What is your highest education? ❑High school ❑Some college ❑College graduate ❑Advanced degree

Marital status:❑ Never married ❑Married ❑Divorced ❑Separated ❑Widowed ❑Partnered/significant other

What is your current or past occupation?_____

Are you currently working? ❑Yes❑No Hours/week_____ If no, are you: ❑Retired ❑Disabled ❑Sick leave?

Do you receive disability or SSI? ❑Yes ❑No If yes, for what & how long?_____

If no, do you have a pending disability claim? ❑Yes ❑No

Have you ever had legal problems? (specify)_____

Have you ever physically harmed another person on purpose? ❑Yes ❑No

Are there any firearms in your home or vehicle? _____

Religion:

FAMILY HISTORY

	IF LIVING							IF DECEASED
	Age(s)	Health & Psychiatric	Diabetes	High Blood Pressure	High Cholesterol	Heart Disease	Completed Suicide	Cause
Father								
Mother								
Siblings								
Children								

EXTENDED FAMILY PSYCHIATRIC PROMBLEMS PAST & PRESENT:

Maternal Relatives:

Paternal Relatives:

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

Women Only:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

OTHER PROBLEMS:
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____

WOMENS REPRODUCTIVE HISTORY:

Are you pregnant? ❑Yes ❑No

Have you reached menopause? ❑Yes ❑No At what age?_____

Do you have regular periods? ❑Yes ❑No

SUBSTANCE USE					
DRUG CATEGORY (circle each substance used)	Age when you first used this:	How much & how often did you use this?	How many years did you use this?	When did you last use this?	Do you currently use this?
ALCOHOL					❑Yes ❑No
CANNABIS: Marijuana, hashish, hash oil					❑Yes ❑No
STIMULANTS: Cocaine, crack					❑Yes ❑No
STIMULANTS: Methamphetamine—speed, ice, crank					❑Yes ❑No
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine					❑Yes ❑No
BENZODIAZEPINES/TRANQUILIZERS: Valium, Librium, Halcion, Xanax, Diazepam, "Roofies"					❑Yes ❑No
SEDATIVES/HYPNOTICS/BARBITURATES: Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					❑Yes ❑No
HEROIN					❑Yes ❑No
STREET OR ILLICIT METHADONE					❑Yes ❑No
OTHER OPIOIDS: Tylenol #2 & #3, 282'S, 292'S, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid					❑Yes ❑No
HALLUCINOGENS: LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), nitrous oxide					❑Yes ❑No
INHALANTS: Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room					❑Yes ❑No
OTHER: specify)_____					❑Yes ❑No