CONFIDENTIAL PATIENT INFORMATION

Today's Date: _____ Birthdate:_____ First Appt. Date: _____

Name: (First)_____(Middle) _____ (Last) _____

Telephone: (HM) _____ (WK) _____

(FAX) _____ (E-MAIL) _____

Address: _____ Soc Sec # _____

City, State, Zip: _____ Age: _____ Sex: _____

Specific Confidentiality Requests (e.g. "Don't leave messages on home phone recorder"):

_____

General Problem(s) you would like assistance with: _____

_____

_____

_____

_____

Your Occupation: _____ Employer: _____

Marital Status: __S __M __D __W __ Live w/Someone How Long? _____

Spouse/Partner Name: _____ Okay to Contact? Y N

Spouse's Occupation: _____ Phone (WK): _____

Children (Name/Ages): _____

_____

Parent/Guardian: _____ Phone: _____

How did you learn about us? (If Yellow Pages, what listing?)_____

Emergency Contact: _____ Phone: _____

General Physician (Name/City/Phone): _____

Other Physician (Name/City/Phone): _____

Other Contact: _____

Your signature below indicates that you have read all of the information in the attached **New Patient Information Guide** and understand ***the HIPAA privacy information*** that has been explained in this document and agree to abide by its terms during our professional relationship. I understand and agree that I am responsible for making payment for professional and other services at the time that they are rendered. I agree to read carefully all of the new patient and recipient rights information given to me and ask questions if necessary. I certify that I will notify you immediately if I am a Medicare or Medicaid recipient. I agree that I am responsible at all times for my own safety and welfare and that I am solely responsible for decisions I make based on the professional advice I receive.

SIGNATURE: _____ DATE: _____

CONFIDENTIAL MEDICAL INFORMATION

Describe any current medical problems: _____
_____
Any lab tests in the past 12 months? _____
Any medicine allergies/reactions or sensitivities? _____

Please list all medications, including herbs, you are now taking:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____
7._____ 8._____

Medical Conditions/Symptoms

Any abnormalities around the time of your birth? (prematurity, breathing difficulties, etc) _____
_____
Illnesses as a child? _____
_____
Have you taken frequent or repeated antibiotics? _____

Please mark ALL the following that apply to you. Put a "P" for past, and/or a "C" for current conditions:

_____ High blood pressure	_____ Anemia or blood disorder	_____ Low blood sugar
_____ Fainting/loss of consciousness	_____ Chronic cough or lung disease	_____ Diabetes
_____ Seizures (even in childhood)	_____ Snoring or other sleep disorder	_____ Rashes or itching
_____ Feeling chilly or warmish often	_____ Tingling or numbness	_____ Tumor, cancer
_____ "Brain fever" or meningitis	_____ Adrenal insufficiency	_____ Hearing problem
_____ Severe or unusual headaches	_____ Dizziness/lightheadedness	_____ Heart condition
_____ Sexually transmitted disease	_____ Eye or visual problems	_____ Severe head injury
_____ Worsening aches/pains	_____ Jaundice/liver trouble	_____ Thyroid condition
_____ Allergies (pollen, dust, etc)	_____ Stomach or bowel trouble	_____ Head injuries
_____ Disease of male/female organs	_____ Blood in urine or stools	_____ Low-DHEA levels
_____ Hormonal disregulation	_____ Pituitary abnormalities	_____ Walking trouble
_____ Rheumatoid arthritis	_____ Kidney, bladder, or prostate problems	

_____ Others: _____

Have any blood relatives had:
Diabetes? _____ Heart disease under 55 years? _____
Hereditary disease of any sort? _____ Suicide? _____
Depression, anxiety or other psychological conditions? _____ Alcoholism? _____
Thyroid condition? _____ Alzheimer's dementia? _____
Others: _____

Do you smoke? _____ In the past? _____ How much? _____ How long? _____
Do you take alcohol? _____ Average number of drinks per week? _____
Do you use "recreational" drugs? _____ Did you in the past? _____
Were you ever <u>told</u> you were taking too much alcohol or drugs? _____ Your height _____
Do you exercise regularly? _____ Take any vitamins? _____ Dressed weight _____
Any recent gain or loss of weight? _____ If yes, # of pounds gained/lost, _____, since _____
Are you on a special diet? _____
Is it possible you may have been exposed to the HIV/AIDS virus, thru needles, blood, or sexual contact? _____

<u>For Women Only</u>
Any menstrual problems? _____ Severe premenstrual symptoms? _____
Recurrent vaginal infections? _____ Last menses began _____ Are your cycles regular? _____
Number of pregnancies? _____ Number of living children? _____

OPTIONAL INITIAL ASSESSMENT INFORMATION

Instructions: To assist us in understanding your situation and being of assistance, please complete any of the sections below which seem important or of relevance to you. You do not need to fill out all of the sections – only as much as you choose to. This information is confidential and only released with your permission.

Name _____ Date _____

Current Symptoms: (check those that are problematic to you)

___Angry outbursts
___Anxious feelings
___Appetite change
___Concentration difficulties
___Crying spells
___Depressed mood
___Disorganized thoughts
___Energy level changes
___Excessive guilt
___Feel like hurting others
___Hallucinations
___Health worries
___Hopeless/helpless
___Impulsive behaviors
___Irritable
___Loneliness
___Money management
___Mood shifts
___Not enjoying things
___Panic attacks
___Recurring behaviors
___Recurring thoughts
___Self-harm
___Sexual problems
___Sleep problems
___Suicidal thoughts
___Unable to experience forgiveness
___Unable to pray
___Withdrawing
___Worrying excessively

Others (specify):
_____
_____

How do the symptoms you checked effect your daily functioning?
_____
_____
_____
_____
_____

Personal Information:

What are your greatest strengths?
_____
_____

What are your greatest weaknesses?
_____
_____

How <u>depressed</u> are you on average lately: None---Mild---Moderate---Very---Extremely

How <u>anxious</u> are you on average lately: None---Mild---Moderate---Very---Extremely

Persons currently living in your home:

Name	Age	Relationship	Quality of Relationship
_____	_____	_____	Good Fair Poor
_____	_____	_____	Good Fair Poor
_____	_____	_____	Good Fair Poor
_____	_____	_____	Good Fair Poor
_____	_____	_____	Good Fair Poor
_____	_____	_____	Good Fair Poor

Children living out of your home: (if applicable)

Name	Age	Relationship	Quality of Relationship
_____	_____	_____	Good Fair Poor
_____	_____	_____	Good Fair Poor
_____	_____	_____	Good Fair Poor

Significant Supportive Relationships:

Name	Age	Relationship	Quality of Relationship
_____	_____	_____	Good Fair Poor
_____	_____	_____	Good Fair Poor
_____	_____	_____	Good Fair Poor

Marital Status: (check all that apply)

___Never married

___Committed partnership
Length of time _____

___Legally married
Length of time ____

___Separated
Length of time ____

___Divorce in process
Length of time ___

___Divorced
Length of time ___

___Widowed
Length of time ___

Total number of marriages (if applicable) _____

Extended Family:

	Name	Age	Living?		Occupation	Quality of Relationship		
Father	_____	___	No	Yes	_____	Good	Fair	Poor
Mother	_____	___	No	Yes	_____	Good	Fair	Poor
Stepfather	_____	___	No	Yes	_____	Good	Fair	Poor
Stepmother	_____	___	No	Yes	_____	Good	Fair	Poor
Siblings	_____	___	No	Yes	_____	Good	Fair	Poor

Which of the following best describes the family in which you grew up? (Circle 1 number along the continuum below)

Warm & Accepting				Average					Hostile & Fighting
1	2	3	4	5	6	7	8	9	10

Trauma History:

Have you had a history of trauma or abuse? No Yes If yes, what type of abuse or trauma occurred?
___ Physical ___ Sexual ___ Emotional ___ Neglect Abuse was as: ___ Victim ___ Perpetrator

Social Relationships:

How do you usually get along with people?
___ Avoidant ___ Shy ___ Leader ___ Outgoing ___ Assertive ___ Follower ___ Irritable

Has there been a recent change in your attitude/relationships with others? No Yes If yes, circle the above words that describe that change.

What is your sexual orientation? ___ Heterosexual ___ Bisexual ___ Gay ___ Lesbian

Cultural/Ethnic Concerns:

Do you have concerns related to cultural or ethnic issues? No Yes If yes, explain:
_____

Spiritual/Religious History:

In your experience, how important are spiritual matters?
_____

What is your present religious affiliation?
_____

Do you have spiritual concerns that you would like to address in the therapy process? No Yes Not Sure Describe:
_____

Legal History: (if applicable)

Are you currently involved with the legal system? No Yes If yes, explain
_____
_____

Have you been involved with the legal system in the past? No Yes If yes, explain
_____
_____

Do you currently have a probation or parole officer? No Yes If yes, name
_____
_____

Educational History: (check all that apply)

___Currently in school No Yes
___Vocational
___Graduate School
___College

___High School Grad/GED No Yes
Graduated No Yes Major _____
Graduated No Yes Major _____
Graduated No Yes Major _____

Did you experience any of the following problems in school? __Learning __Emotional __Discipline __Social

Do you currently experience any of the following learning barriers?
___ Learning disability ___ Vision impairment ___ Hearing impairment ___ Language

I learn best through: (check all that apply) ___ Discussion ___ Written materials ___ Videos ___ Tapes

What is your primary language? ___ English ___ Spanish ___ Sign ___ Other

Employment History: (complete those that apply)

List job history beginning with most recent job

Employer	Dates	Job Title	Reason for Leaving

Current Status: ___ FT ___ PT ___ Disabled ___ Laid off ___ Retired ___ Student ___ Homemaker Other
_____

Please check any current work related concerns:

___ Attendance problems ___ Performance problems ___ Work load ___ Medical leave
___ Employer Concerns ___ Potential for lay off ___ Dislike job ___ Relationship problems with coworkers, employer, other

Military History:

Military experience No Yes If yes, specify branch and dates of service:

Branch _____ Date Enlisted _____ Date Discharged_____

Leisure/Recreational:

Hobbies/Interests	Recent change in frequency?
_____	__ No change __ Decreased frequency __ Increased frequency
_____	__ No change __ Decreased frequency __ Increased frequency
_____	__ No change __ Decreased frequency __ Increased frequency

Personal Counseling/Treatment History:

Please provide past and present information.

	No	Yes	When	Purpose	Result
Counseling/Psychiatric Treatment					
Drug/Alcohol Treatment					
Hospitalizations					
Self-help Groups					

Family/Significant Others Counseling/Treatment Information:

	No	Yes	When	Purpose	Result
Counseling/Psychiatric Treatment					
Drug/Alcohol Treatment					
Hospitalizations					
Self-help Groups					

Substance Use History:

Do you use alcohol or non-prescription drugs? No Yes If yes, what is your favorite?

_____

Do you see your use as a problem? No Yes If yes, how motivated are you to make changes?

___ Low ___ Moderate ___ High

Is your current living situation and/or family helpful in supporting your changes? (please explain)

_____

_____

Have you received inpatient or outpatient treatment or educational programs for alcohol or drug use?

Where & With Whom	Type of Treatment	Dates	Was it helpful?
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever tried to cut down on your alcohol or drug use or quit using? No Yes If yes, please explain

_____

_____

Has alcohol/drug use interfered with family or interpersonal life? No Yes If yes, please explain

_____

_____

Have you experience any of the following in relation to your alcohol or drug use?

___ Anxiety
___ Depression
___ Hallucinations
___ Inability to abstain
___ Increased tolerance
___ Loss of control
___ Memory loss
___ Overdoses
___ Preoccupied with substance
___ Stomach problems
___ Tremors
___ Withdrawal symptoms
___ Other adverse reactions (please explain)

_____

_____

Yale-Brown Obsessive Compulsive Scale

NAME: _____

DATE: _____

Obsession Rating Scale (circle appropriate score)

Rate the composite effect of all of your obsessive compulsive symptoms considering the whole picture of your day.
Rate the average occurrence of each item during the prior week up to and including the time of interview.

Item	Range of Severity				
1. Time Spent on Obsessions	0 h/day	0-1 h/day	1-3 h/day	3-8 h/day	>8 h/day
Score	0	1	2	3	4
2. Interference From Obsessions	None	Mild	Definite but manageable	Substantial Impairment	Incapacitating
Score	0	1	2	3	4
3. Distress From Obsessions	None	Little	Moderate but manageable	Severe	Near constant, disabling
Score	0	1	2	3	4
4. Resistance to Obsessions	-Always resists	Much resistance	Some resistance	Often Yields	Completely yields
Score	0	1	2	3	4
5. Control Over Obsessions	Complete control	Much control	Some control	Little Control	No control
Score	0	1	2	3	4

Obsession subtotal (add items 1-5) _____

Compulsion Rating Scale (circle appropriate score)

Item	Range of Severity				
6. Time Spent On Compulsions	0 h/day	0-1 h/day	1-3 h/day	3-8 h/day	>8 h/day
Score	0	1	2	3	4
7. Interference From Compulsions	None	Mild	Definite but manageable	Substantial Impairment	Incapacitating
Score	0	1	2	3	4
8. Distress From Compulsions	None	Mild	Moderate but manageable	Severe	Near constant, disabling
Score	0	1	2	3	4
9. Resistance to Compulsions	Always Resists	Much resistance	Some resistance	Often Yields	Completely Yields
Score	0	1	2	3	4
10. Control Over Compulsions	Complete control	Much control	Some control	Little Control	No control
Score	0	1	2	3	4

Total Obsessions _____+ Compulsions _____ = Total Score _____

Y-BOCS TOTAL SCORE (Range of severity for patients who have both obsessions and compulsions): 0-7 Subclinical; 8-15 Mild; 16-23 Moderate; 24-31 Severe; 32-40 Extreme

STOP HERE

Thank you for sharing this information with us. Please be assured that this information will be kept confidential and used only to provide you with optimal treatment.

PROCEDURE TRACKING FOR _____

Date Started	Procedure / Medication	Status Change