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Client Information

Client:

Last name	First name	Middle name	Gender	Birthdate	Age

Home address	City	State	Zip

Cell phone	Other type of phone	Employer/School	Occupation

Emergency contact (parent/guardian if minor)	Relationship to person	Person's phone

These questions must be listed, but answers are not required:

Preferred language	Race	Hispanic/Non-Hispanic

Insurance:

Insurance name	Plan name	Policy/Subscriber number	Deductible

Copays (specialist & regular)	Policy holder, if not client	Relationship to person	Person's birthdate

Member services/mental health phone number on card	Other important insurance information, if any

Billing Address: (If this section is blank, bills will be sent to the home address.)

Billing address, if different from home address	City	State	Zip

Person receiving bill, if not client or parent/guardian	Relationship to person	Person's phone

Privacy: Protected health information (PHI) may be released for treatment, payment, or healthcare operations and other purposes. Providing insurance and/or address information indicates consent for the provider/biller to file claims and send bills, including releasing PHI. Physical and electronic PHI is kept in locked, confidential environments. At times, this office requests PHI from other providers including pharmacies.
The privacy policy is printable on the website. For clients who want a copy but do not wish to print it themselves, paper copies are available in the office.

_____ _____ I have read, understand, and consent to all of the above. If I wanted a paper copy of the privacy policy, that has now been given to me.
Initial Date

_____ _____ Optional: I understand that regular (non-encrypted) email messages and attachments can be misaddressed, intercepted, or wrongly accessed. I consent to receive non-encrypted emails containing PHI.
Initial Date

_____ _____ Optional: I understand that text messages can be misaddressed or wrongly accessed and may be able to be intercepted. I consent to receive text messages containing PHI.
Initial Date

Consent/Payment: I consent to receive health care services from the provider at this and subsequent visits, knowing that health care is inexact, with no guaranteed outcomes. I will pay for services at the time of service, be it in full or a copay. A fee will be charged if I cancel a visit with less than 24 hours notice or if I do not attend a visit. I am solely responsible for knowing the details of my insurance coverage and I am responsible for any part of my bill unpaid by insurance. The provider/biller may contact my insurer to verify eligibility/benefits as a courtesy. Accounts are expected to remain in good standing: accounts considered "in default" may incur additional administrative/attorney fees and may be sent to a collection agency. Finance charges may accrue (current policy is a 12% annual interest rate) on balances unpaid over 90 days, even if insurance benefit is expected. Bills may be mailed to me at the above address(es) or an address on file with the provider, biller, or collections agency.

I understand and agree to the above. Any questions have been answered to my satisfaction.

Printed name	Signature	Date

___ Signed by the client ___ Signed on client's behalf by: _____
Relationship to patient (e.g. mother, guardian, etc.)

These forms will help give a picture of how you are doing and how therapy and/or medication may be able to help you. They also screen for some specific psychiatric problems. Some of these questions may not apply to your situation. If you need to leave something blank, please write "prefer not to answer" or "N/A," whichever is more accurate.

Overview

Please briefly describe the main concerns that led you to seek treatment:

Please list the two biggest concerns, when they started, and how severe they are from 0-10 (10 means it can't get worse):

1) _____ Started:_____ Severity: 0 1 2 3 4 5 6 7 8 9 10

2) _____ Started:_____ Severity: 0 1 2 3 4 5 6 7 8 9 10

Who referred you here? Why?

Please list all past and current mental health care providers, psychiatric hospitals, residential/day programs, groups (including support or addiction groups), etc. List when they treated you, and the location, phone ,and fax.

Have you ever been diagnosed with any of the following, even if you disagreed with the diagnosis?

__Depression __Bipolar __Mood disorder __Anxiety __PTSD __OCD __Eating disorder __ADD/ADHD

__Schizophrenia __Psychosis __Addiction __Other psych diagnosis: _____ __None of the above.

Have you ever attempted suicide, or harmed your body on purpose? If so, when and why?

Have you ever heavily restricted your eating, or used laxatives or vomiting to lose weight, or had overeating episodes that you felt like you couldn't control? If so, when?

Have you been a victim of sexual or physical assault or abuse, or domestic violence? If so, please list the type of abuse/violence, your relationship to that person, and when it happened.

Have you ever had any contact with child protective services, or had legal problems (arrest, probation, jail, charges, etc.)?

Please check any of the following that are a problem at times: __Remembering appointments/obligations

__Wrapping up details of a project once the hard part is done __Getting organized for tasks __None of these

How often are these a problem? _____

Number of close friends: _____

Has anyone close to you passed away recently? If so, who and when? _____

Do you have a religious preference? If so, how involved are you currently?_____

Medication List

Please circle the meds and supplements you've tried for mental health, sleep, or related problems.

Celexa/citalopram
Lexapro/escitalopram
Luvox/fluvoxamine
Paxil/paroxetine
Prozac/fluoxetine
Zoloft/sertraline
Viibryd/vilazodone
Cymbalta/duloxetine
Effexor/venlafaxine
Pristiq/desvenlafaxine
Savella/minalcipran

Concerta/Daytrana/Focalin/Metadate/Methylin/
Ritalin/methylphenidate
Adderall/Vyvanse/Dexedrine/amphetamine
Provigil/modafinil/Nuvigil/armodafinil
Strattera/atomoxetine

Anafranil/clomipramine
Aventyl/nortriptyline
Elavil/amitriptyline
Tofranil/imipramine
Norpramin/desipramine
Adapin/Sinequan/doxepin
Vivactil/protriptyline
Surmontil/trimipramine
Ludiomil/maprotiline
Asendin/amoxapine
Dutonin/nefazodone
Remeron/mirtazapine
Emsam/Eldepryl/selegiline
Wellbutrin/Zyban/buproprion
Buspar/buspirone

Neurontin/gabapentin
Tegretol/carbamazepine
Dilantin/phenytoin
Trileptal/oxcarbazepine
Topamax/topiramate
Lamictal/lamotrigine
Depakote/divalproex/valproate/valproic acid
Lyrica/pregabalin
Eskalith/lithium
Zonegran/zonisamide

Deplin/l-methylfolate
NAC/N-acetyl Cysteine
Sun-theanine/l-theanine
Lavender oil pills
Melatonin

Ativan/lorazepam
Klonopin/clonazepam
Valium/diazepam
Xanax/alprazolam
Tranxene/clorazepate
Librium/chlordiazepoxide
Serax/oxazepam
ProSom/estazolam
Dalmane/flurazepam
Versed/midazolam
Restoril/temazepam
Halcion/triazolam

Saphris/asenapine
Clozaril/clozapine
Fanapt/iloperidone
Latuda/lurasidone
Zypreza/olanzapine
Risperdal/risperidone
Invega/paliperidone
Seroquel/quetiapine
Geodon/ziprasidone
Abilify/aripiprazole
Rexulti/brexpiprazole

Vivalan/viloxazine
Ambien/zolpidem
Sonata/zalplon
Lunesta/eszopiclone
Rozerem/ramelteon
Benadryl/diphenhydramine
Vistaril/Atarax/hydroxyzine
Desyrel/trazodone

Haldol/haloperidol
Thorazine/chlorpromazine
Trilafon/perphenazine
Prolixin/fluphenazine
Loxitane/loxapine
Moban/molindone
Orap/pimozide
Navane/thiothixene
Stelazine/trifluoperazine

Intuniv/Tenex/guanfacine
Inderal/propranolol
Catapress/Kapvay/clonidine
Minipress/Prazosin

Other: _____ ___None

Medication History

Please list each medication you have tried (see the list on the prior page). Then fill out the boxes for each medication.

- Your pharmacy may be able to help you remember your past doses and the dates you first filled and last filled prescriptions.
- If you run out of room on this page, please print another copy of the page so you can make a complete list.

Medication	Dose	AM/ PM	Date started	What it helped with	How much it helped	Side effects	Date stopped	Why stopped	Any other info

 Name:_____ Date of Birth: _____ Date: _____

Social

Sexual orientation: __Straight __Bisexual __Gay/Lesbian __Other: _____

Please list your parents, siblings, current and former spouses/partners, children, and anyone currently living with you.

Name	Age	Relationship	Lives with you, Yes/No

Please describe any problems you are having with the people listed above: __No problems with these people at all.

Please describe child custody and visitation: __N/A

Have there been recent, major changes to your family structure or routine?

Are you currently in a romantic relationship? If so, how do you feel about it?

Are your parents married to each other? If not, please list the years they married, divorced, remarried, etc.

How did your parents enforce the rules at home?

Please circle the problems you had in school: Classroom behavior Focus/attention Depression Hyperactivity Truancy Organization Friendships Fidgeting Anxiety Interrupting __None of these problems

Highest level of education completed: ____ Have you ever been suspended or expelled from school? __Yes __No

Were you ever in resource classes or receiving special services at school? __No __Yes (please explain)_____

What is your career or current job? _____ Hours worked per week:____

How do you feel about your performance at work/school?_____

Please check each substance you have ever tried, even if you only tried it once. List how old you were the first time you tried that substance, and when you most recently used it, even if your first try or recent use was minor.

__ Alcohol _____
__ Tobacco _____
__ Marijuana _____
__ Heroin _____
__ Methamphetamine _____
__ LSD _____
__ Cocaine _____
__ Ecstasy _____
__ Prescription drug misuse _____
__ Over-the-counter drug/supplement misuse _____
__ Other _____
__ None of the above

Developmental and Medical

Please circle any of the following that you started to do later than average: Smile Babble Sit Stand Walk Speak Play pretend Toilet training Sentences Tricycle Cooperate with other kids Write name __None of these

During pregnancy with you, did your mother struggle with: __drugs/alcohol/nicotine __domestic violence __medical problems __severe problems with delivery __Delivery before 39 weeks __None of these

Please explain anything you marked above: _____

_____

Have you ever had problems with: __Muscles __Bones __Bladder __Kidneys __Heart __Lungs __Ears/Hearing __Eyes/Vision __Thyroid __Stomach/Digestion __Problems at birth (needed oxygen, etc.) __Height/growing __Seizures __Concussions __Loss of consciousness __Hospitalization __Surgery __Genetic mutation diagnosis such as MTHFR __I've never had any of these problems

Please explain anything you marked above, and when it happened: _____

_____

_____

_____

_____

_____

_____

_____

Please list all current physical health problems: __None

_____

_____

Has your weight changed over 5 pounds in the last 6 weeks? __No __Yes: I (lost) (gained) ____ pounds.

Please mark any of the following that you have had *recently*:

Cardio/respiratory: __Chest pain/tightness __Palpitations __Shortness of breath __Dizziness __Passing out

Genitourinary: __Difficulty urinating __Having accidents __Missed period or pregnancy __Sexual/libido issue

General/Psych: __Psych problems got much worse __Severe side effects __Blood test or EKG, or I need one soon

Constitutional: __Fever __Chills __Headache __Pain __Weakness __Night sweats

ENT/mouth: __Runny nose __Sore throat/hoarseness __Vision trouble __Eye pain __Light sensitivity

Musculoskeletal: __Stiffness __Bone/muscle pain __Twitches/spasms/uncontrolled motion __Restricted motion

Skin: __Rash/itching __Cuts/burns/wounds __Not healing properly __Dryness __Hair/nail changes

Gastrointestinal: __Belly pain __Heartburn __Nausea/vomiting __Constipation/diarrhea __Appetite change

Endocrine: __Heat/cold intolerance __Too much thirst/urination __Too much sweating

Neurological: __Seizures __Head injury __Sensation loss/change __Balance/coordination trouble __Tremor

Immune: __New food/drug allergy __Recurrent infection __Seasonal/environmental allergies

Other important problems in the above areas: _____

__None of the above

Who is your regular doctor (or nurse practitioner, etc)? Please include phone and fax numbers. __I don't have one

_____

_____

Current Medications and Family History

Please list all current medications, including as-needed and over-the counter medications, supplements, inhalers, etc.

Medication	Dose	When it's taken	Prescribed by

Do you have any concerns about your medications or supplements? __No __Yes (please explain)

_____.

Please list all food and medication allergies, including your reaction: __None

_____.

Please list biological parents, grandparents, aunts, uncles, siblings, nephews, and nieces who have struggled with:

__*Attempted/completed suicide _____
__*Psychiatric hospitalization _____
__*Drug or alcohol abuse/addiction _____
__*Schizophrenia _____
__*Diagnosed depression _____
__*Diagnosed bipolar _____
__*Diagnosed ADD/ADHD _____
__*Diagnosed anxiety _____
__*Diagnosed autism, Asperger's, or PDD-NOS _____
__*Other mental health problems _____
__MTHFR or other genetic mutations _____
__High blood pressure _____
__High cholesterol or triglycerides _____
__Heart attack or bypass _____
__Other heart problems _____
__Sudden unexpected death other than suicide, overdose, or heart attack _____
__Thyroid problems _____
__Diabetes _____
__None of the above: __I was adopted. I do not know my biological family's medical history.
__None of my biological family members have ever had any of the above.

For conditions with an asterisk (*), please list all medications your family members tried for this, and what the medications did (helped, caused nausea, etc.). Please be as detailed as possible.

Screener

***In the last 7 days*, I:** (1-Never 2-Rarely 3-Sometimes 4-Mostly 5-Always)

1 2 3 4 5 1. Avoided activities I used to enjoy.
1 2 3 4 5 2. Felt more afraid than other people.
1 2 3 4 5 3. Did my work carelessly, or didn't finish it.
1 2 3 4 5 4. Threatened someone else with physical harm, or physically hurt someone else.
1 2 3 4 5 5. Had trouble getting my worries off my mind.
1 2 3 4 5 6. Thought that things would be better if I were dead.
1 2 3 4 5 7. Felt nervous, anxious, or tense.
1 2 3 4 5 8. Saw or heard things that other people think aren't real.
1 2 3 4 5 9. Purposely cut or burned myself, or hurt my body.
1 2 3 4 5 10. Had over two drinks in a day, took a controlled substance prescription, or used any illegal substance.
1 2 3 4 5 11. Couldn't get organized.
1 2 3 4 5 12. Felt unhappy most of the day.
1 2 3 4 5 13. Heard other people's thoughts, or they could hear mine.
1 2 3 4 5 14. Did sexual things that my friends wouldn't approve of.
1 2 3 4 5 15. Couldn't wait my turn in conversations or activities.
1 2 3 4 5 16. Thought about killing myself.
1 2 3 4 5 17. Couldn't fall asleep when I tried to, or couldn't stay asleep, or had nightmares.
1 2 3 4 5 18. Felt much better about myself than I did a few weeks ago, or felt like I could do anything.
1 2 3 4 5 19. Was much more energetic or happy than I was a few weeks ago.
1 2 3 4 5 20. Talked a lot more than I did a few weeks ago, or my thoughts were faster than they used to be.
1 2 3 4 5 21. Had problems concentrating on my work, or couldn't think clearly.
1 2 3 4 5 22. Thought everything was my fault, or couldn't forgive myself for past mistakes.
1 2 3 4 5 23. Didn't stop to think before making choices.
1 2 3 4 5 24. Got a lot more done than I did a few weeks ago, or started several big projects.
1 2 3 4 5 25. Didn't have much energy.

Who is filling out this packet?

__The client __This person is (helping the client fill it out) (filling it out for the client): _____

Reminder about the additional form required for clients under 18:

__The client is over 18 so no other forms need to be attached to this packet.
__The client is age 17 . A parent/guardian must complete and attach the "Partial Vanderbilt" form.
__The client is age 16 or younger. A parent/guardian must complete and attach the "Standard Vanderbilt" form.