THE ARIZONA SCHWARTZ GROUP, PC

DR. ANDREA MONTOYA, PH.D., PLLC LICENSED PSYCHOLOGIST

1490 SOUTH PRICE ROAD, SUITE 316
CHANDLER, AZ 85286
T 480.899.4077 F 480.718.7737
www.azschwartzgroup.com

NEW PATIENT CHECKLIST

Please review the following items and bring completed and signed forms to your first appointment.

☐	Read the *Psychological Services Agreement* (6 pages; save for your personal records)
	This document details Dr. Montoya's office policies, as well as important information related to confidentiality, maintenance of medical records, and patient rights *(Notice of Privacy Practices/HIPPA)*.
☐	Review, PRINT & SIGN the *Consent for Psychological Services* form (1 page)
	Your signature on this document acknowledges that you have read and understood the information presented in the *Psychological Services Agreement*. You may contact me at any time, before or after starting services, to ask questions about this important information.
☐	Complete the *Adult Intake* form (5 pages)
	Thank you in advance for taking the time to complete this form! Your thoughtful responses provide valuable background information related to medical, mental health, social, emotional, and behavioral functioning.
☐	Complete the *DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult* (1 page)
	This is a brief (23-item) symptom measure that was developed by the American Psychiatric Association for the purposes of initial assessment and treatment progress.
☐	Please bring copies of any relevant documentation (e.g., psychological or psychiatric evaluation reports, treatment summaries, etc.) to the first appointment

Thank you for taking the time to carefully read and complete these forms! Please call the office if you have any questions about these forms prior to the first appointment. I look forward to meeting you and discussing how we might work together to address your treatment goals.

Sincerely,

Andrea Montoya, PhD

DR. ANDREA MONTOYA, PH.D., PLLC LICENSED PSYCHOLOGIST

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PSYCHOLOGICAL SERVICES AGREEMENT

Welcome to my practice! As you consider working with me, it is important that we have a shared understanding of what we can expect from each other. This document contains important information about my professional services and business policies. Please read it carefully and discuss with me any questions you may have at our first meeting. When you sign this document, it will represent an agreement between us, which you may revoke in writing at any time. If you have any questions or concerns while completing the forms, please call the office and one of our helpful staff members will be happy to assist you. I am looking forward to meeting you and your family.

This document (the Agreement) contains important information about the professional services and business policies of Dr. Andrea Montoya, Ph.D., PLLC and The Arizona Schwartz Group, PC. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA). HIPAA is a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that Dr. Montoya obtain your signature acknowledging that she has provided you with this information prior to the end of your session.

Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss questions you have about the procedures at any time. When you sign the Psychological Services Consent Form, it will also represent an agreement between us. You may revoke your consent in writing at any time. That revocation will be binding unless we have taken action in reliance on it or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychotherapist and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. Psychotherapy has also shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. In addition, therapy may be experiential at times. Therefore, you may be requested to participate physically. Please notify me of any physical limitations and know that you have the right to refuse. Our first few sessions will involve an evaluation of your needs. By the end of the evaluation process, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about our procedures, you should discuss them whenever they arise. If your doubts persist, I encourage you to set up a meeting with another mental health professional for a second opinion.

TERMINATION

Termination of psychotherapy is a critical juncture of the psychologist-patient relationship, much like the initiation of the professional relationship. Termination may take place for a variety of reasons and may be initiated by the patient, the psychologist, or as a mutual agreement. Reasons for termination may include; the patient achieves their desired outcome from therapy and no longer feels the need for services, the patient or psychologist

experience a significant life change (e.g., moving out of state), or the psychologist feels that the patient would be better served by a different provider due to the patient's individual needs. At times, financial or time constraints may be an issue for the patient or the family. Due to the importance of processing the end of the therapeutic relationship, I will make adjustments and do my best to ensure that we are able to meet for a final session.

In order to provide you with the best care possible, I ask that you notify me if you are thinking about ending the therapeutic relationship so we can collaborate and determine the best options for you. Since attendance in regularly scheduled sessions is essential to therapeutic progress, I expect that you will discuss any questions or concerns with me as they come up. If you have missed or cancelled several sessions, I will contact you to check in regarding your well-being and your continued interest in services. If I do not receive a response within three weeks of this date, you will be sent a letter notifying you that I am assuming you are no longer interested in services and your case will be considered "closed." I must do this for legal and ethical reasons, however, please be aware that you may communicate your renewed interest in treatment at any time. Additionally, I reserve the right to terminate treatment services for any patient who violates treatment protocol, is generally non-compliant, or who willfully disregards other treatment objectives that could support positive outcomes in therapy.

PATIENT RESPONSIBILITIES
Each patient is responsible for providing accurate contact information as well as billing information. If telephone numbers and/or addresses change, patients must inform Dr. Montoya's business office. Furthermore, the patient understands that the evaluation and treatment provided by Dr. Montoya is limited to outpatient psychology services. This does not necessarily constitute total or definitive psychological care. Further evaluation and treatment may be required in some cases. It is the patient's responsibility to obtain follow up medical care for general health as needed, or when advised to do so by Dr. Montoya.

MEETINGS/SCHEDULING
The initial evaluation period may last from 1 to 3 sessions. During this time, you and Dr. Montoya can decide if she is the best person to provide the services that you need in order to meet your treatment goals. A "therapy hour" is defined as a 45-50 minute session. If you schedule psychological testing, there are specific guidelines that will be discussed upon scheduling these services. Psychological Evaluations typically require 4-6 hours of in office, face-to-face testing with the patient, with a comparable time spent by the psychologist outside the office completing related tasks such as scoring, interpretation, records review, and report writing. An initial consultation meeting will be scheduled prior to testing in order to discuss the referral question(s) and purpose of evaluation, and determine scheduling needs.

Once an appointment is scheduled, you will be responsible to pay for that session unless you provide 24 hours advance notice of cancellation (unless we both agree that you were unable to attend due to circumstances beyond your control). The business offices are closed on Memorial Day, July 4th, Labor Day, Thanksgiving Holiday (both Thursday and Friday), Christmas Day and New Year's Day. There may be times when we need to contact you by phone. Please inform us if you do not want us to leave a message at any of the phone numbers you provided. We do not accept cancellation or change notices received via email. You must speak to a scheduler to make, change, or cancel appointments.

If you need to cancel or change an appointment, please call 480-899-4077 during regular business office hours of 8:00 am to 5:00 pm Monday through Friday only. Please remember that you will be charged when you do not show for a scheduled appointment.

CONTACTING DR. MONTOYA
You may call and leave a confidential message with one of our receptionists or our office voicemail at any time. I do not return calls on evenings, weekends, and holidays. During business hours, I am often not immediately available by telephone. I typically check my messages several times a day and will return your call within 48 hours unless it is a weekend or holiday, in which case I will return your call on the first business day thereafter. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist [psychiatrist] on call. If I have not returned your call within a reasonable time period, please call again because it is likely that something went wrong and I did not receive your message. If you are requesting correspondence over phone that requires more than 10 minutes of my time, I may inform you that charges may apply before this service is provided.

EMERGENCIES
I do not provide 24-hour or emergency therapy services. Although I will make every effort to be available to you if crises arise, you cannot depend on me to be available in emergency situations. If I am out of town or unavailable for an extended period of time, I will provide you with contact information for a colleague so that you may have interim support, if necessary. If you anticipate needing more than very occasional crisis contact with me outside of our sessions, please talk with me about this prior to beginning our work together. In the event that you have an urgent need and cannot reach me, please go to the nearest emergency room or call 911. You may also call the EMPACT psychological crisis line (480)-784-1500 or the Maricopa County Crisis Line (602) 222-9444.

MINORS & PARENTS
For patients under 18 years of age, their parents must review and sign the *Consent for the Provision of Psychological Services to a Minor* form. Consent from both parents, regardless of the custodial arrangement, is the preferred practice of this office. I prefer to see parents and children together as much as possible, as I believe in taking a collaborative approach to therapy. As children enter the teenage years, I tend to spend more time with them individually in therapy. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, I strongly encourage teenage children to share treatment information directly with their parents. I will also provide you with general information about treatment status. I will not share specific details without his/her assent, however, if I believe that your child is at serious risk of harming him/herself or another, I will inform you. Examples of serious risk would include a plan to harm self or suicidal ideation which is intensifying.

If you are in a divorce or custody litigation, or involved in the court system in any other manner, you need to understand that my role as a therapist is not to make recommendations for the court concerning custody or parenting issues or to testify in court concerning opinions on issues involved in the litigation. By signing this disclosure statement, you agree not to call me as a witness in any such litigation. Experience has shown that testimony by therapists in domestic cases causes damage to the clinical relationship between a therapist and a patient. Only court-appointed experts, investigators, or evaluators can make recommendations to the court on disputed issues concerning parental responsibilities and parenting plans. I am always happy to write letters to jurisdictions regarding a person's attendance in psychotherapy when requested by the patient.

INDEPENDENT PRACTICE
As you know, I work with a group of independent mental health professionals, under the name The Arizona Schwartz Group, PC. This group is an association of independently practicing professionals which share certain expenses and administrative functions. While the members share a name and office space, I want you to know that I am completely independent in providing you with clinical services and I alone am fully responsible for those services. My professional records are separately maintained and no member of the group can have access to them without your specific, written permission.

BILLING AND PAYMENTS
Dr. Montoya is a fee-for-service provider. The office does not file insurance claims for you, however, we will provide you with all of the information that you should need to make a claim in the form of a "super bill" invoice. You may receive reimbursement from your insurance provider if you have "out of network" benefits. This has been successful for a number of patients. Of course, plans vary, particularly with regard to mental health coverage, and you will need to discuss reimbursement with your insurance provider if you would like to pursue this option.

Office staff collects full payment at the time of your visit and then your insurance company will reimburse you directly after you submit your claim. Also, if you plan on billing your insurance for reimbursement of your visit, you may need to obtain a prescription from your physician prior to your first appointment (depending on the type of insurance plan you have). If you do not plan on billing insurance, you do not need a prescription. You will be expected to pay for each session at the time it is held at the beginning of your session. When therapy is provided over the telephone during or after office hours, you will be responsible for paying for these therapy services prior to the telephone call. You may choose to have a credit card number kept on file for these appointments if this would be more convenient.

You should also be aware that most insurance companies require you to authorize us to provide them with a clinical diagnosis. Sometimes we have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance

company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it.

PROFESSIONAL FEES

The following are my fees for routine services. If our sessions or other services are shorter or longer than the defined payment schedule, fees will be prorated accordingly. I do not charge for emails or telephone calls to patients, family members, or other care providers that are under 10 minutes.

- Individual Therapy (In-office): $175/50-minute session

- Psychological Assessment: Variable, and dependent on age of child, referral question(s), case complexity, and other factors such as the child's ability level, attention, and motivation for assessment tasks. Please contact the office for more information.

- Other Services and Administrative tasks: $175/hour, prorated to 15-minute (.25 hour) increments – includes email, telephone conversations with you or professionals whom you have authorized me to speak with on your behalf, and/or any other tasks that you ask of me outside of our scheduled therapy sessions. Other services include report or letter writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. *Please note that services related to legal involvement (e.g. consultations with attorneys) will be billed at a higher rate.

Payment schedules for other professional services, such as psychotherapy performed out of office, will be discussed and agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. Please note that the above listed fees are subject to change.

PROFESSIONAL RECORDS

I maintain an electronic record keeping system. I will make progress notes in your chart after each session. These notes will be brief and will only convey general information that communicates the progress you are making. If another physician referred your case to me and you have provided written consent for care coordination, your progress will be communicated to the physician in writing or by phone. When written consent is obtained I can share information about you with whoever you wish. Otherwise, our communication will be confidential between us. Clinical data and psychotherapy notes, along with your financial records and all related information about your case, are stored on a server which is kept locked. This server is backed up and on line in a secured and encrypted server. By signing the consent for treatment, you hereby give me permission to destroy the original of any document that you provide to me, and to retain such documents only in an electronic imaged format. After termination of our professional relationship, I will likely only retain an electronic copy of your file for the minimum period required by law. The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your (or your child's) records, I recommend that you review them in my presence so that we can discuss the contents.

ELECTRONIC COMMUNICATION POLICY

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, I have prepared the following policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

EMAIL COMMUNICATIONS AND TEXT MESSAGING

I use email communication only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges with my office should be limited to things like questions regarding services, appointments, billing matters and other related issues. Please do not email me about clinical matters because email is not a secure way to contact me. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication. Because text messaging is a very unsecure and impersonal mode of communication, I do not text message to nor do I respond to text messages from anyone in treatment with me. Please do not text message me unless we have made other arrangements.

SOCIAL MEDIA

I do not communicate with, or contact, any of my patients through social media platforms like Twitter and Facebook. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you. I believe that any communications with patients online have a high potential to compromise the professional relationship. In addition, please do not try to contact me in this way. I will not respond and will terminate any online contact no matter how accidental.

WEBSITES AND WEB SEARCHES

I will not use web searches to gather information about you without your permission. I believe that this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. In this day and age there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about me through web searches, or in any other fashion for that matter, please discuss this with me during our time together so that we can deal with it and its potential impact on your treatment. Recently it has become fashionable for patients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews, please share it with me so we can discuss it and its potential impact on your therapy.

CONFIDENTIALITY POLICIES

The law protects the privacy of all communications between a client and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I am professionally and ethically required to consult with other psychologists regularly. Such consultations are bound by the same confidentiality as are individual sessions. Should I decide to consult about your case, I will omit identifying information from such consultations to protect your privacy. If you object to my consulting with colleagues about your situation, please inform me so that I can understand your concerns. I will note all consultations in your file to further protect the privacy of your information.
- If you use health insurance to pay for any portion of your treatment, I may be required to release some treatment details to your insurance company.

There are some situations where I am permitted or required to disclose information without either your consent or authorization:

- Generally, if you are involved in a court proceeding, I cannot disclose any information about you without your written consent or a court order. In the event that I am court ordered to disclose your information, I am legally obligated to do so.
- If a government agency requests information for health oversight activities, I may be required to comply.
- If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to respond to the complaint.
- If a client files a worker's compensation claim, I may be required to comply with legal requests. This may include disclosure of your record to parties involved in the claim.

Certain Federal and Arizona laws require that I take action that I believe is necessary to attempt to protect others from harm. These situations include:

- If I have cause to suspect that you or someone you know is or may be abusing or neglecting a child, an elderly person, or an otherwise impaired or disabled person, I am required by law to report this to the proper authorities.
- If I believe that you present an imminent danger to the health and safety of yourself or someone else, I may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim, if identifiable, and/or calling the police.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to only what is necessary.

NOTICE OF PRIVACY PRACTICES

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

In compliance with the federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), The Arizona Schwartz Group PC and Dr. Andrea Montoya, Ph.D. PLLC have established privacy policies and procedures relating to the protected health information of our patients. Protected health information is information related to your past, present, or future physical or mental health or condition, or payment for such, in which you personally could be identified. HIPPA requires that providers must maintain the privacy of protected health information, provide a notice of their legal duties and privacy practices, and abide by the terms of the privacy notice currently in effect.

If you have any questions about our privacy practices or any of the information contained in this Notice of Privacy Practices for Protected Health Information ("Notice"), or wish to register any complaints related to our privacy practices, you should contact:

DR. ANDREA MONTOYA, PH.D. PLLC.
1490 S PRICE ROAD, SUITE 316
CHANDLER, AZ 85286

We will supply a written copy of this Notice to any person requesting it, whether or not they are a current patient. All patients will be given a copy of this Notice at the time of the first service provided to them following the effective date listed above. This Notice will be posted prominently and copies will be made available in our office. We reserve the right to make changes to our Notice and have any new provisions become effective for all protected health information we maintain. If we make any material changes to the uses or disclosures of protected health information, the individual's rights, our legal duties, or other privacy practices stated in this Notice, this Notice will be revised. The revised Notice will be posted prominently in our office, and we will make the revised Notice available to anyone who requests a copy. The Notice is also available at www.AZSchwartzGroup.com.

The "Privacy Rule" protects all individual identifiable health information held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information 'protected health information (PHI).' Individual identifiable health information' is information, for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number, etc...)."

YOUR RIGHTS AS A PATIENT

With respect to your protected health information, you have the right to:

- Have full and complete knowledge of your therapist's qualifications, training, and licenses.
- Be fully informed regarding proposed evaluation and treatment.
- Discuss your therapy with anyone you choose, including another therapist or mental health provider.
- Refuse treatment entirely, or any component of any proposed treatment arrangement.
- Request that information from your treatment be shared with another therapist or organization, provided that appropriate consent forms have been signed.
- Question your therapist's competence. Should you become displeased with services, you are encouraged to talk to me to see if the matter can be resolved. If you feel unable to address these concerns with me, you may address these concerns with another therapist or pertinent or legal bodies.
- Request copies of ethical principles or other guidelines that govern my practice.

CONSENT FOR PSYCHOLOGICAL SERVICES

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ACKNOWLEDGMENT OF PATIENT RIGHTS, PRIVACY POLICY, LIMITS TO CONFIDENTIALITY, AND OFFICE POLICIES

Please initial to indicate your understanding of the following:

_____ / _____*	I understand that psychotherapy can have benefits and risks, and since therapy often involves discussing unpleasant aspects of my life, uncomfortable feelings may be experienced.
_____ / _____*	I understand that I can end treatment at any time I wish and that I can refuse any requests or suggestions made by my psychologist.
_____ / _____*	I understand that Federal and Arizona state laws require that psychologists report all cases in which there is a danger to self or others, as well as any information that might be related to child or elder abuse.
_____ / _____*	I understand that my medical records will be held or released in accordance with the state & federal laws (*HIPPA*) regarding confidentiality of such records, as outlined in the *Notice of Privacy Practices*.
_____ / _____*	I agree that I will be responsible for the payment of all professional fees associated with the services provided.
_____ / _____*	I understand the policy for missed appointments and that I may be responsible for my usual service fee if I do not provide 24 hour notice of cancellation.

*** (If patient is under age 18 and biological/adoptive parents are divorced, both parents must initial and sign this document)**

OPTIONAL AUTHORIZATION FOR CONSULTATION AND/OR COORDINATION OF CARE

Dr. Montoya is an independent contractor with the Arizona Schwartz Group, PC. In order to provide the highest level of care, psychologists often consult with other clinicians and physicians to discuss clinical impressions and treatment plans. You have the option of giving authorization for Dr. Montoya to consult and coordinate care with colleagues at the Arizona Schwartz Group, PC. This authorization is completely voluntary and can be revoked at any time by giving written notice.

By checking the below box(es), I hereby authorize Dr. Andrea Montoya, Ph.D., PLLC to discuss, send and/or receive medical information to/from:

☐	Dr. Marc Schwartz, DO and Board Certified Child, Adolescent, & Adult Psychiatrist for the purpose of care coordination and professional consultation.
☐	Kim Leight, RN, MSN, PSYNP for the purpose of care coordination and professional consultation.
☐	Dr. Allison Solomon, Psy.D., PLLC. for the purpose of care coordination and professional consultation.
☐	I *DO NOT* wish to authorize Dr. Montoya to consult with other providers at this time.

Your signature below indicates that you have read and understand the information detailed in Dr. Montoya's *Psychological Services Agreement*, agree to abide by its terms, and consent to participate in treatment. For parents/guardians of patients under 18 years of age, the *Consent for Provision of Psychological Services to a Minor* form must also be completed.

Patient Name		Patient Signature (age 18 yrs. and older)	Date
Parent/Guardian Signature (if patient is under age 18)	Date	Second Parent/Guardian Signature (if required)	Date

ADULT INTAKE FORM

1490 South Price Road, Suite 316
Chandler, AZ 85286
Tel: 480.899.4077
www.azschwartzgroup.com

Date	

Thank you for your time in completing this form.
All of the information will help us provide a thorough and comprehensive assessment.

Identifying Information

Patient Information

Name		Date of Birth		Age	
Ethnicity		Language		Gender	
Address		Email		Phone #	
				Work #	

Emergency Contact Information

Name		Phone #(s)	
Relationship			

Name		Phone #(s)	
Relationship			

Primary Care Doctor Information

Provider Name		Type	☐ Psychiatrist (MD, DO) ☐ Pediatrician ☐ Family Physician ☐ Nurse Practitioner
Phone #(s)		Dates Seen	________________ to ________________

How did you hear about the AZ Schwartz Group?	

Current Concerns

Please briefly describe your reason for seeking treatment at this time.

How long have you been experiencing the issues described above?	

How do the above issues impact your life in the areas of:	
Home Functioning	
Work/School Functioning	
Relationships	

Medical History

Typical Daily Functioning

How would you describe your:					
Overall physical health	☐ Poor	☐ Below Average	☐ Average	☐ Above Average	☐ Excellent
Appetite	☐ Poor	☐ Below Average	☐ Average	☐ Above Average	☐ Excellent
Energy/Activity Level	☐ Poor	☐ Below Average	☐ Average	☐ Above Average	☐ Excellent
Sleep	☐ Poor	☐ Below Average	☐ Average	☐ Above Average	☐ Excellent
Libido (interest in sex)	☐ Poor	☐ Below Average	☐ Average	☐ Above Average	☐ Excellent

Do you suffer from allergies? (Please list specific allergies & reactions below)				
☐ seasonal	☐ environmental	☐ food	☐ medication	☐ none

Please indicate if you have a history of any of the following:		
☐ migraine headaches	☐ tension headaches	☐ chronic pain
☐ seizures	☐ other neurological issues	☐ chronic fatigue syndrome
☐ thyroid problems	☐ hormonal problems	☐ TMJ dysfunction
☐ reproductive problems	☐ vision problems	☐ hearing problems
☐ exposure to toxins (e.g. lead)	☐ POTS Syndrome	☐ diabetes
☐ head injury	☐ speech problems	☐ infectious disease:
☐ other:		

Chronic Health Condition(s)/Significant Illnesses/Surgical Procedures	Date Diagnosed	Treating Physician

Current Medication(s) (non-psychiatric)	Dose	Start Date	Reason	Side Effects

Mental Health History

Have you received outpatient mental health treatment? If so, please indicate the treatment provider, what their training background was (if known), reason for treatment (e.g., anxiety, depression, substance use), approximate treatment dates, type of treatment (e.g., CBT, exposure, talk therapy, parent training, EMDR, family therapy, "I don't know," etc.), and how you feel it went.

Copies of existing evaluations (educational or psychiatric) or treatment summaries are greatly appreciated

Psychotherapy Information

Provider Name		Provider Background	☐ Psychologist (PhD, PsyD) ☐ Counselor (MA, MS, MFT)	☐ Psychiatrist (MD, DO) ☐ Social Worker
Reason for Treatment		Dates Seen	_______ to _______	☐ Currently Seeing
Type of Treatment		Outcome	☐ Satisfactory	☐ Unsatisfactory

Provider Name		Provider Background	☐ Psychologist (PhD, PsyD) ☐ Counselor (MA, MS, MFT)	☐ Psychiatrist (MD, DO) ☐ Social Worker
Reason for Treatment		Dates Seen	_______ to _______	☐ Currently Seeing
Type of Treatment		Outcome	☐ Satisfactory	☐ Unsatisfactory

Psychiatric Hospitalization

Have you ever been hospitalized for a mental health condition?	☐ No	☐ Yes, _____ times

Date	Hospital	Reason

Prescriber Information

Provider Name		Provider Background	☐ Psychiatrist (MD, DO) ☐ Primary Care (MD, DO)	☐ Nurse Practitioner ☐ Other:
Reason for Treatment		Dates Seen	_______ to _______	☐ Currently Seeing

Provider Name		Provider Background	☐ Psychiatrist (MD, DO) ☐ Primary Care (MD, DO)	☐ Nurse Practitioner ☐ Other:
Reason for Treatment		Dates Seen	_______ to _______	☐ Currently Seeing

Psychiatric Medication History

Current Medication(s)	Dose	Start Date	Side Effects

Previous Medication(s)	Dose	Dates	Reason For Stopping
		_____ to _____	
		_____ to _____	
		_____ to _____	
		_____ to _____	

Family History of Mental Health Issues

Please indicate if any of the following mental health conditions are present or suspected in your immediate or extended family history. (Please include individual's relationship to you)

Condition	Family Member(s)
☐ Alcohol Abuse/Dependence/Heavy Drinking	
☐ Anger Problems	
☐ Anxiety (includes worry, panic, & nervous conditions)	
☐ Attention Deficit Hyperactivity Disorder (ADHD)	
☐ Autism Spectrum Disorder/Asperger's/ Developmental Delays	
☐ Behavior/Conduct Problems	
☐ Bipolar Disorder/Mood Disorder	
☐ Depression	
☐ Eating Disorders	
☐ Intellectual Disability	
☐ Learning Disorders (e.g., dyslexia, or reading/math/writing problems)	
☐ Obsessive Compulsive Disorder (OCD)	
☐ Schizophrenia	
☐ Suicide - Attempts	
☐ Suicide - Completed	
☐ Substance Abuse	
☐ Tourette's/Tic Disorder	
☐ PTSD or Trauma History	
☐ Other:	

Educational History

Are you currently attending school?	☐ No	☐ Yes*	*School		Area of Study	

If not currently in school, what is the highest level of education achieved?	

Please indicate if you experienced any of the following in school:		
☐ special education services	☐ learning difficulties	☐ behavioral problems
☐ lack of opportunity	☐ lack of interest	☐ bullying

Employment History

Current Employment (if applicable)

Employer		Position	
Time in Position		Job Duties	
Stress Level	☐ Low ☐ Medium ☐ High	Job Satisfaction	☐ Low ☐ Medium ☐ High

Military Service (if applicable)

Are you currently an active member of the armed forces?				☐ No	☐ Yes
Branch		Rank		Years of Service	_______ to _______
Were you ever in combat?				☐ No	☐ Yes

Social, Emotional, & Behavioral Functioning

What is your current relationship status?		
☐ married	☐ unmarried but in a relationship	☐ unmarried
☐ divorced/separated*	☐ widowed	☐ other:

Please describe your current living situation. Include the names, ages, of family members and/or any other individuals residing in the home.			
Name	Age	Name	Age

Are you satisfied with how your family functions?		☐ No (Please indicate)	☐ Yes
☐ lack of structure/rules	☐ no family "together times"	☐ poor communication	
☐ lack of breathing space	☐ marital problems	☐ poor division of chores	
☐ other:			

Are you currently involved in any divorce or child custody proceedings?	☐ No	☐ Yes*

Have you or your family ever been involved in a case with Child Protective Services (CPS)?	☐ No	☐ Yes*

* Please explain "Yes" responses

Please identify your social support network by indicating which of the following describe you:		
☐ family	☐ neighbors	☐ friends
☐ co-workers	☐ support group	☐ community group
☐ religious/spiritual center	☐ other:	☐ none

Please indicate whether you experienced any of the following stressors over the past year:		
☐ parental separation/divorce	☐ loss of loved one	☐ severe illness
☐ move to a new home	☐ change of school	☐ pregnancy/birth of child
☐ financial stress	☐ loss of job	☐ out of town for work
☐ other:		☐ none

What are some of your interests/hobbies?

How would you describe your typical mood?

What do you do when you are feeling upset?

Critical Items

Past

Have you ever experienced any traumatic events? (e.g., physical or sexual abuse, neglect, victimization by peers, major losses, the witnessing of violence done to others, accidents, injuries, natural disasters, etc.)	☐ No	☐ Yes*
Have you ever intentionally harmed yourself, or thought about doing this?	☐ No	☐ Yes*
Have you ever felt like you could see or hear things that others could not?	☐ No	☐ Yes*
Have you ever been hospitalized due to an inability to be safe with yourself or others?	☐ No	☐ Yes*
Have you ever been in trouble because of your temper/violence?	☐ No	☐ Yes*
Have you ever used illegal substances?	☐ No	☐ Yes*
Have you ever been convicted of a misdemeanor or felony?	☐ No	☐ Yes*
* Please explain "Yes" responses:		

Current Risk Assessment

Do you have thoughts of harming yourself?	☐ No	☐ Yes
Do you have a plan for how you would harm yourself?	☐ No	☐ Yes
Have any relatives committed suicide?	☐ No	☐ Yes
Do you have thoughts of harming someone else?	☐ No	☐ Yes
Have you assaulted or threatened anyone in the past 6 months?	☐ No	☐ Yes
Do you own a gun or a lethal weapon?	☐ No	☐ Yes

Please feel free to provide any additional information not covered in this form that you think is important.

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: ___________________________ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**________

If this questionnaire is completed by an informant, **what is your relationship with the individual?** ___________________
In a typical week, approximately how much time do you spend with the individual? ____________________ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

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