Osika & Scarano Psychological Services, P.C.

4-1/2 Woodruff Street
Elizabethtown, NY 12932

5 Pine Street
Glens Falls, NY 12801

125 Broad Street
One Broad Street Plaza
Glens Falls, NY 12801

432 Franklin Street
Schenectady, NY 12305

Telephone (518) 745-0079 Fax (518) 745-4291 www.OSPsychServices.com

Intake Form

(bring with you to scheduled appointment)

Patient Information:

Patient Name: Date of Birth: Age:
Marital Status: Sex: Address:
City: State: Zip Code:
Home Phone #: Cell Phone #: Work Phone #:
Social Security #: Occupation:
Employer: Address:

Referring Physician:
Primary Physician:
Referred to this office by:

Primary Insurance: Employer:
Subscriber Name:
Subscriber SS#: Subscriber DOB:
Subscriber ID#: Group #: Co-pay Amount:
Secondary Insurance: Employer:
Subscriber Name:
Subscriber SS#: Subscriber DOB:
Subscriber ID#: Group #: Co-pay Amount:

Psychologist Use Only: Diagnosis: (numerical codes only)

Signature of guarantor, insured party, or authorized person's signature certifies that:
I authorize payment of the medical benefits to Osika & Scarano Psychological Services, PC, and understand that I am responsible for all balances not covered by my insurance company, such as co-payments, co-insurance, deductibles, and non-coverage of benefits. I understand that my co-payment is due at the time of service, and if this account becomes delinquent, it may be turned over to a collection agency, and the fact that I received treatment in this office will become public record. I understand that there is a $50.00 no-show charge if I do not cancel appointments 24 hours in advance. If I do not pay my co-pay at the time of my service date, a $10.00 late fee will be charged. On any balance 6 months overdue, 18% APR and a $50.00 collection fee will be added.

Patient/Guardian Signature:_____ Date:_____

Print Name:

Please attach photos or scans of your insurance card: Front: Back:

I do not have and cannot acquire images of my insurance card at this time. (It is important that we have these images on file, so please do your best to provide them to us here.)

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Informed Consent to Individual and Group Psychotherapy

This form documents that I, , give my consent to Osika & Scarano Psychological services, P.C. (the "psychologist") to provide psychotherapeutic treatment to me.

While I expect benefits from this treatment, I fully understand that no particular outcome can be guaranteed. I understand that I am free to discontinue treatment at any time, but that it would be best to discuss with the psychologist any plans to end therapy before doing so.

I have fully discussed with the psychologist what is involved in psychotherapy, and I understand and agree to the policies about scheduling, fees, and missed appointments.

- I understand that I am fully financially responsible for treatment, which, if I have health insurance, includes any portion of the psychologist's fee that are not reimbursed by our insurance.
- I understand that the frequency of our sessions will be ***1-4x PER MONTH***, and that I am fully responsible for payment of all deductibles and co-payments.
- I understand that payment will be due at the time services are rendered.
- I understand that I will be charged $50.00 for any canceled sessions if I do not give the psychologist at least ***24 BUSINESS HOURS*** notice. For example, if I call at 2pm on Sunday to cancel a Monday appointment, I will be billed $50.00. (Insurers don't pay for canceled sessions.)
- I understand that there will be a $10.00 charge if I do not pay my co-pay at the time services are rendered.
- I understand that if my bill is not paid in full within 6 months of the unpaid date of service, in addition to an 18% APR, a $50.00 collection fee will be added.

Our discussion about therapy has included the psychologist's evaluation and diagnostic formulation of my problems, method of treatment, goals, and length of treatment, and information about record-keeping. I have been informed about and understand the extent of treatment, its foreseeable benefits and risks, and possible alternative methods of treatment. I understand that therapy can sometimes cause upsetting feelings to emerge, that I may feel worse temporarily before feeling better, and that I may experience distress caused by changes I may decide to make in my life as a result of therapy.

Many providers at Osika & Scarano receive supervision by Dr. Tom and Dr. Gina (the supervisors). I understand that during supervision the patient's name, diagnosis, and treatment plan are shared with the supervisors. I also understand that during the course of treatment, pertinent information is shared with the supervisors. As always, all providers abide by privacy policies and HIPAA.

I understand that the psychologist cannot provide emergency service. If an emergency arises I will call the beeper numbers as follows: Drs. Scarano and Osika, 518-744-7978. In any case, I understand that in any emergency I may call 911 or go to the nearest hospital emergency room. I understand that Glens Falls Hospital has an Emergency Mental Health Staff, and they can be reached at 518-761-5325.

I have received a HIPAA Notice of Privacy Practices from the psychologist. I understand that information about psychotherapy is almost always kept confidential by the psychologist and not revealed to others unless I give

my consent. There are a few exceptions as noted in the HIPAA Notice of Privacy Practices. Details about certain of those exceptions follow:

1. The psychologist is required by law to report suspected child abuse or neglect to the authorities.

2. If I tell the psychologist that I intend to harm another person, the psychologist must try to protect that person, including by telling the police or the person or other health care providers. Similarly, if I threaten to harm myself, or my life or health is in any immediate danger, the psychologist will try to protect me, including by telling others, such as my relatives, or the police,+69- or other health care providers, who can assist in protecting or assisting me.

3. As per Section 9.46 of the Mental Health Hygiene Law, the psychologist is mandated to report (at https://nvsafe.omh.nv.gov) patients who are at imminent risk of harming themselves or others. Such a report could have direct implications as to whether or not I could possess a firearm.

4. If I am involved in certain court proceedings, the psychologist may be required by law to reveal information about my treatment. These situations include child custody disputes, cases where a therapy patient's psychological condition is an issue, lawsuits or formal complaints against the psychologist, civil commitment hearings, and court-related treatment.

5. If my health insurance or managed care plan will be reimbursing me, or paying the psychologist directly, they will require that I waive confidentiality, and that the psychologist give them information about my treatment.

6. The psychologist may consult with other psychotherapists about my treatment, but in doing so will not reveal my name, or other information that might identify me. Further, when the psychologist is away or unavailable, another psychotherapist might answer calls and so will need to have some information about my treatment.

7. If my account with the psychologist becomes overdue, and I do not pay the amount due or work out a payment plan, the psychologist will reveal a limited amount of information about my treatment in taking legal measures to be paid. This information will include my name, social security number, address, dates and type of treatment, and the amount due.

In all of the situations described above, I understand that the psychologist will try to discuss the situation with me, or notify me, before any confidential information is revealed, and will reveal only the least amount of information that is necessary.

I have the right to be notified of a data breach. I have the right to ask for an electronic copy of my medical record. I have the right to opt out of fundraising communications from us. Uses and disclosures of your medical information cannot be sold or used for marketing purposes without your authorization. All patients who pay in full out of pocket for services (i.e. do not bill their insurance) can instruct us to not share information about your treatment with your health plan.

If I am participating in a managed care plan, I have discussed with the psychologist my financial responsibility for any co-payments and the plan's limits, if any, on the number of therapy sessions. I have discussed with the psychologist my options for continuation of treatment when my managed care benefits end. If I am not participating in a managed care program, I understand that I am fully financially responsible for treatment.

I understand that I have a right to ask the psychologist about the psychologist's training and qualifications, and about where to file complaints about the psychologist's professional conduct.

I understand that under HIPAA, I have the right to request that communications with the psychologists' office be confidential, and by means of my selection. I understand that the psychologists' office will approve my request if it is reasonable and made in writing. Once agreed upon, the psychologists' office is obligated to honor it, except if an emergency arises.

I allow the administrative and professional staff at Osika & Scarano Psychological Services to contact me by telephone at my home and at my work, and in writing at my home, unless I instruct them otherwise. Phone messages will be left with minimal information: the provider's name and call back number. Any requests I have for alternative means of, or limits to my communication with, your staff (e.g., specific times of day to call) will be made in writing.

I understand that I have a right to ask the psychologist about the psychologist's training and qualifications. If I ever desire to file a complaint about the psychologist's professional conduct, I understand that I can call the NYS Psychology Licensing Board within the Department of Education at 518-474-3817. Complaints to the licensing board can also be made if you feel your provider or any staff member of Osika & Scarano violates your patient rights, or discriminates against you based on gender, race, sexual orientation, national origin or color. If the licensing board finds that an employee of Osika and Scarano has violated this non-discrimination policy, appropriate disciplinary action, ranging from counseling to termination, will be taken against the employee who violated the policy.

I look forward to our initial meeting on .

By signing below, I indicate that I have read and understand this form, and that I give my consent to treatment.

Patient/Guardian Signature:_____ Date:_____

Print Name:

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Telemedicine Informed Consent Form

I, (patient) hereby consent to engaging in telemedicine with (psychotherapist) as part of my psychotherapy. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, and treatment using interactive audio-video communications. I also understand that, with my signed consent, telemedicine may involve the electronic communication of my medical/mental healthcare information to other health care practitioners. The rights stated supplement those rights I have generally as a patient of the psychotherapist.

I understand that I have the following rights with respect to telemedicine:

I have the right to withhold or withdraw consent to telemedicine treatment at any time.

The laws that protect the confidentiality of my medical/healthcare information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are mandatory exceptions to confidentiality, including reporting child abuse and the imminent risk of danger to self or others. If I put my mental state at issue in certain legal proceedings, then the psychotherapist may be compelled to release otherwise confidential information about my evaluation and treatment.

I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that the transmission of my medical information could be disrupted or distorted by technical failures or unauthorized persons, and that the electronic communication of my medical information could be accessed by unauthorized persons.

I understand that telemedicine based services and care may not be as complete or effective as face-to-face services. I also understand that if my psychotherapist believes I would be better served by in-person psychotherapeutic services, I will be referred to a psychotherapist who can provide such services in my area. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve, and in some cases may even get worse. I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

As with all medical records, I understand that I have a right to access my medical information and copies of medical records of telemedicine treatment in accordance with New York State law.

(Optional: If I am temporarily to be outside of New York State at any time during my telemedicine treatment, then I also hereby represent that I am a permanent resident of New York State. I understand that the psychotherapist is licensed in New York State, and that I have recourse to the professional licensing board and courts of New York State should I have any grievance against the psychotherapist.)

I have read and understand the information provided above. I have discussed it with the psychotherapist, and all of my questions have been answered to my satisfaction. My signature below indicates my informed consent to treatment.

Patient/Guardian Signature:_____ Date:_____

Print Name:

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Fees

For **routine outpatient visits** to our office, we bill your insurance. You are responsible for your co-pay and deductible (which varies with each plan).

If you **do not have insurance**, please complete the Sliding Fee Scale Packet. In addition, we work closely with a specialist from Fidelis Care and an enrollment specialist from Adirondack Health Institute. Both can help you find a health insurance plan that is affordable for you. We will be more than happy to make a referral for you.

If your insurance does not cover **evaluations for court, probation, etc.**, it will be billed at $300. This includes fees for your sessions and writing of the report.

If your insurance does not cover achievement testing required to make a diagnosis of a Learning Disability, you have 3 options:

1. Call your insurance company and ask if they would agree to pay for 2 hours of achievement testing
2. Ask your child's school to complete the achievement testing
3. Have our office complete the testing and agree to pay over a six-month period of time.
    a. If you choose our office to complete the testing, we will administer the Wechsler Individual Achievement Scale. Administration of the WIAT will take about 2 hours and the charge is $60 per hour. A six-month payment plan can be agreed upon in writing at this time.

Unfortunately, most insurance plans do not allow providers to bill for **report writing**. Scoring and writing psychological reports is a daunting task and typically takes 1-3 hours of work. This, again, is billed at a rate of $60 per hour. A six- month payment plan can be agreed upon if needed. Medicaid does allow clinicians to bill for report writing.

Unless you have a specific insurance, there will be a $50 **No Show or Late Cancellation Fee**. We respectfully ask that you give us at least a 24-hour notice prior to cancelling your appointment. However, we understand life happens: you are sick, your car breaks down, or you got called into work. Please keep in mind that No Shows (unless you have a specific insurance) will always be billed, and frequent late cancellations will be billed.

By signing below, you state that you understand and agree to our fee policy.

Patient/Guardian Signature:_____ Date:_____

Print Name:

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Release of Information / Authorization Form

(If you decline to authorize the release of your information at this time, please continue to the following page.)

1. I authorize my healthcare practitioner, at Osika & Scarano Psychological Services, P.C., and/or administrative and clinical staff to disclose my protected health information, as specified below, to the persons indicated below who will receive the information:

   Primary Care Physician:

   Other (specify):

2. I am hereby authorizing the disclosure of the following protected health information:
   Diagnostic Examination and Treatment Plan

3. This protected health information is being used or disclosed for the following purposes:
   To collaborate regarding the treatment plan and diagnosis.

4. This authorization shall be in force and affect until one (1) year after the date below, at which time this authorization to disclose protected health information shall expire.

5. I understand that I have the right to revoke this authorization, in writing, at any time, by sending such written notification to my healthcare practitioner at: Osika & Scarano Psychological Services, P.C., 5 Pine Street, Glens Falls, NY 12801. I understand that a revocation is not effective to the extent that my healthcare practitioner has relief on my authorization, or if my authorization was obtained as a condition of obtaining insurance coverage, and the insurer has a legal right to contest a claim.

6. I understand that information disclosed pursuant to this authorization may be disclosed by the recipient, and may no longer be protected by HIPAA or any other federal or state law.

7. My healthcare practitioner will not condition my treatment on whether I provide an authorization for disclosure, except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Patient/Guardian Signature:_____ Date:_____

Print Name:

Date of Birth:

(Provide a copy of this form to the patient.)

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Refusal to Sign ROI for PCP

ONLY SIGN THIS FORM IF YOU REFUSED TO SIGN THE PREVIOUS PAGE

According to HIPAA, you have the right to refuse to give consent for your provider at Osika & Scarano (O&S) to coordinate care with your Primary Care Physician (PCP). Your insurance company, however, requires documentation of this refusal, and an explanation of the reason.

Please check any of the following reasons why you feel that coordination of care with your PCP is not necessary at this time.

I need to discuss very personal issues that I do not want shared with my PCP.

I may consider signing a release at a later date as I gain trust in my provider at O&S.

I may consider signing a release at a later date as I discuss the things I do and don't want released to my PCP.

I just don't feel it is necessary at this time.

Other (specify):

Patient/Guardian Signature:_____ Date:_____

Print Name:

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Patient Request for Confidential Communications

We, Osika & Scarano Psychological Services, P.C., assume that we may contact you by telephone at your home and at your work, and in writing at your home, unless you instruct us otherwise.

Under HIPAA, you have the right to request that communications with you be confidential, and by means of your selection. We will approve your request if, in our opinion, it is reasonable. Once we agree to your request, we are obligated to honor it, except if an emergency arises.

I wish to be contacted as follows (check all that apply):

At my home telephone number:

You can leave messages with detailed information.

Leave message with a call-back number only.

Call only at specified times of day:

At my work telephone number:

You can leave messages with detailed information.

Leave message with a call-back number only.

Call only at specified times of day:

At my cell phone number:

You can leave messages with detailed information.

Leave message with a call-back number only.

Call only at specified times of day:

In writing at:

My home address:

My work address:

My fax number(s):

My email address:

Other (specify):

If any means of contacting you will place you in danger, please specify:

Patient/Guardian Signature:_____ Date:_____

Print Name:

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Authorization for the Transmission of ePHI

(Electronic Private Health Information)

I have requested that my PHI be transmitted electronically (via email or texting), which I understand is **not** HIPAA Compliant. Since transmitting ePHI is **not** standard procedure at Osika and Scarano, you need to authorize us to send and receive such information electronically. By signing below, you authorize us to send and receive your PHI electronically.

I understand that although the electronic devices and e-mail at Osika and Scarano are password-protected, the privacy of my PHI may be breeched by forces beyond our control (e.g., hacking, stolen devices, et al.). I understand I should delete any correspondence with our office from my e-mail and phone as soon as possible, which is a standard and customary procedure by all staff at Osika and Scarano. Once signed, this waiver will be in effect until the office is notified in writing.

Patient/Guardian Signature:_____ Date:_____

Print Name:

Check here if you decline to authorize the transmission of your ePHI at this time.

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Contact Us / Notice of Privacy

Our contact information:

Privacy Officers: Dr. Thomas Osika and Dr. Gina Scarano-Osika

Mailing Address: 5 Pine Street, Glens Falls, NY 12801

Telephone: 518-745-0079

Fax: 518-745-4291

Acknowledgement of Receipt

I hereby acknowledge that I have received, read, and understood this Notice of Privacy, effective April 4, 2003, and that any questions I have about it have been answered.

Patient/Guardian Signature:_____ Date:_____

Print Name:

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Important Notice

In order to minimize my out-of-pocket expenses, I understand that I am fully responsible for updating this form on a yearly basis, and when my insurance changes. Failure to give immediate notice of any change in insurance can result in large out-of-pocket expenses, which I will be fully liable to pay in full.

1. Name of insurance company as it appears on the card:

   Name of insurance representative from whom you got this information:

   Date you called:
2. Co-pay amount:
3. Is there a deductible? Yes No
4. Referral from Primary Care Physician needed? Yes No
5. Outpatient Treatment Report (OTR) needed? Yes No

   After how many sessions?

By signing below, I am agreeing to pay in full any outstanding balance that results from incomplete or inaccurate information.

Patient/Guardian Signature:_____ Date:_____

Print Name:

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Informed Consent for In-Person Services During COVID-19 Public Health Crisis

Our office is strongly encouraging telehealth visits during the COVID-19 pandemic. If, for some reason you need a face-to-face session, you and your provider will have a discussion as to why.

We are requiring all patients to read, initial and sign this document, regardless of whether we have planned a face-to-face session. This document contains important information about how to safely have a face-to-face session in light of the COVID-19 public health crisis. Please read this carefully and let your provider know if you have any questions. When you sign this document, it will be an official agreement between you and our practice.

Refusal to Meet Face-to-Face
If there is a resurgence of the pandemic or if other health concerns arise, your provider may refuse your request for a face-to-face session. If you have concerns about meeting through telehealth, you will talk to your provider about it first and try to address any issues. You understand that, if your provider believes it is necessary, they may determine that you return to telehealth for everyone's well-being. If you insist on face-to-face sessions, you may request a change in provider if your provider continues to refuse. Risks of Opting for In-Person Services
You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by pubslic transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure
To obtain services in person, you agree to take certain precautions which will help keep everyone (e.g., you, me, our families, my staff, and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our termination of the option for face-to-face sessions.

Initial each item below to indicate that you understand.

I agree to these actions if I ever have a face-to-face session:

- You will only have your in-person appointment if you are symptom free.
- You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, we won't charge you our normal cancellation fee. Ask your provider if you'd like to use our point and shoot thermometer at the office.
- You will wait in your car or outside until no earlier than 5 minutes before our appointment time.
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building.
- You will adhere to the safe distancing precautions we have set up in the waiting room and service rooms. For example, you won't move chairs or sit where seating is prohibited.
- You will wear a mask in all areas of the office. (I and my staff will too.)
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with any member of our staff.
- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands.
- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols.
- You will take steps between appointments to minimize your exposure to COVID-19.

- If you have a job that exposes you to other people who are infected, you will immediately let me and my staff know.
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me and my staff know.
- If a resident of your home tests positive for the infection, you will immediately let us know and we will then begin or resume treatment via telehealth.

We may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure
My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick
You understand that we are committed to keeping you, me, my staff, and all of our families safe from the spread of this virus. If you show up for an appointment and we believe you have a fever or other symptoms, or believe you have been exposed, we will have to require you to leave the office immediately. Our providers reserve the right to take your temperature. If you are asked to leave the office, we can follow up with services by telehealth as appropriate. If your provider tests positive for the coronavirus, we will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection
If you have tested positive for the coronavirus, we may be required to notify local health authorities that you have been in the office. If we have to report this, we will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that we may do so without an additional signed release.

Informed Consent
This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below indicates that you agree to these terms and conditions.

Patient/Guardian Signature:_____ Date:_____

Print Name:

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Office Safety Precautions in Effect During the Pandemic

My office is taking the following precautions to protect our patients and help slow the spread of the coronavirus.

- Office seating in the waiting room and in therapy/testing rooms has been arranged for appropriate physical distancing.
- My staff and I wear masks.
- My staff maintains safe distancing.
- Restroom soap dispensers are maintained and everyone is encouraged to wash their hands.
- Hand sanitizer that contains at least 60% alcohol is available in the therapy/testing rooms, the waiting room and at the reception counter.
- We schedule very few face-to-face appointments in order to minimize the number of people in the waiting room.
- We ask all patients to wait in their cars or outside until no earlier than 5 minutes before their appointment times.
- Credit card pads, pens and other areas that are commonly touched are thoroughly sanitized after each use.
- Physical contact is not permitted.
- Tissues and trash bins are easily accessed. Trash is disposed of on a frequent basis.
- Common areas are thoroughly disinfected at the end of each day.
- Providers have to attest daily that they are symptom free, do not have a temperature, have not traveled outside of the state within the past 2 weeks, and have had no known exposure to COVID-19.

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Psychosocial History

Patient Name: Date of Birth:

Date of First Session:

Who referred you to this office?

Why?

Primary Care Physician:

In order to better meet your needs during sessions, it is beneficial for the leaders to know some general social history. Please answer the following questions. The more truthful you are, the more beneficial treatment can be for you.

Directions: Check any of the following statements that are true for you.

When I was born, my birth mother was a teen or unmarried.

I was conceived from a sexual assault.

My birth parents remain(ed) married as of my 18th birthday.

My birth parents separated when I was years of age.

One or both of my birth parents remarried prior to my 18th birthday.

My birth parents never married.

I was adopted.

Directions: Fill in the blanks.

I have birth siblings (same parents), of whom I am the born.

I have half-siblings (share only one birth parent).

I have step-siblings (children of a step-parent).

Directions: Check any of the following statements that are true for you, and fill in the blanks.

At least one of my childhood mentors (e.g., birth parents, step-parents, grandparents, foster parents) were addicted to or overused ALCOHOL.

Who?

At least one of my childhood mentors (e.g., birth parents, step-parents, grandparents, foster parents) used ILLEGAL DRUGS.

Who?

At least one of my childhood mentors (e.g., birth parents, step-parents, grandparents, foster parents) were PHYSICALLY VIOLENT with each other.

Who?

At least one of my childhood mentors (e.g., birth parents, step-parents, grandparents, foster parents) were VERBALLY ABUSIVE with each other.

Who?

What were their abusive statements / names?

I have been a victim of CHILDHOOD PHYSICAL ABUSE (e.g., at least red marks or bruising).

Who?

I have been a victim of CHILDHOOD SEXUAL ABUSE (e.g., at least red marks or bruising).

Who?

I have been the victim of stranger or date rape.

Directions: Check any of the following statements that are true for you, and fill in the blanks.

I received my GED.

I dropped out of high school in the grade.

I graduated from high school.

I graduated from college.

Directions: Fill in the blanks.

I currently work at on a basis.

Directions: Check any of the following statements that are true for you, and fill in the blanks.

I currently live with:

I have children, ages .

I have been in physically abusive relationships as an adult.

I have been in verbally abusive relationships as an adult.

Medical illnesses that I currently have:

I have had periods of unconsciousness in my lifetime.

Prescription medications that I take daily:

I am allergic to these medications:

I weigh approximately pounds.

I am feet inches tall.

Number of cigarettes I smoke daily:

Amount of caffeine I drink daily (e.g., coffee, tea, cola): 8 oz. servings.

Number of alcoholic "drinks" I consume weekly:

(Note: One "drink" is considered 12 oz. of regular beer, 5 oz. of wine, or 1.5 oz. of liquor.)

Prescription pain meds I have used in the past 6 months:

Illegal drugs I have used in my lifetime:

Illegal drugs I have used in the past 6 months:

I have been arrested times since the age of 18. Offenses include:

I have firearms in my home.

Are the firearms locked in a secure location? Yes No

Directions: Check any of the following statements that are true for you in the past six months, and fill in the blanks.

I have visual memories of abusive childhood events.

I have nightmares of previous abuse/assaults.

I feel depressed most days.

I feel irritable most days.

I feel anxious most days.

I have explosive bouts of anger.

My family would say that I get way too angry over little things.

I worry about things I don't think will ever happen.

My appetite has decreased.

I feel tired most days.

I have difficulty falling asleep.

I get too little sleep.

I have had periods of time when I get no sleep for multiple nights in a row.

I have trouble staying asleep.

I require more than 10 hours of sleep.

I have a difficult time concentrating.

I've had thoughts of killing myself in the past.

First time was when I was years old.

I recently thought of killing myself.

When?

I have wanted to die in the past.

First time was when I was years old.

I recently wanted to die.

When?

I have had a planned method of suicide.

What was the method?

I have hurt myself on purpose by cutting, bruising, or burning myself in the past.

First time was when I was years old.

I struggle with behaviors I can't control (e.g., spending, aggression, gambling, pornography).

I sometimes can't stop eating when I am full.
I sometimes ignore my feelings of hunger.
I have trouble maintaining weight loss.
When I diet, I eat less than 1300 calories per day.
I make myself vomit to get rid of calories.
I take diet pills.
I have stopped getting my menstrual cycle in the past for no explainable reason.
My lowest weight in my life was unhealthy.
My highest weight in my life was unhealthy.
I feel out of control when I overeat.
I sometimes eat alone because I am ashamed.
I avoid some foods (e.g., fatty, or high in sugar).
I am unhappy with my weight and body shape.
If I overeat, I eat quickly.
When I overeat, I got to extremes that other people don't.
I have been hospitalized overnight for psychiatric reasons.
    How many times?
    Which hospitals?
    When?
I have been placed on psychiatric medications in the past.
    Which ones?
    Who prescribed them?
I am currently taking psychiatric medications.
    Which medications, and how much of each?

I have seen a mental health professional for outpatient treatment in the past.
    How long in terms of month, years, or number of sessions?
    Did treatment help you in the past?
Members of my family have mental illnesses.
    Which illnesses?

Thank you for taking the time to complete this New Patient Packet. We look forward to working with you.