Oleksandr Osipchuk, MD, PhD
Psychiatric Services, LLC

PATIENT REGISTRATION FORM

Thank you for choosing our Practice. Please completely fill out this form to ensure the fastest and best healthcare service.
We may ask you to look over this information from time to time to make sure it stays up to date. (Please Print)

Today's date:	Family Doctor:

PATIENT INFORMATION

Patient's last name:	First:	Middle Initial:	Marital status (circle one) Single / Mar / Div / Sep / Wid
Street address:			Age: / Sex: ❑ M ❑ F Birth date:
City:	State:	Zip:	Social Security no.:

Occupation:	Employer:

Who referred you to Dr. Osipchuk?	❑ Dr.:	❑ Insurance Plan	❑ Hospital	❑ Family / Friend	❑ Yellow Pages

CONTACT INFORMATION

I authorize Dr. Osipchuk and/or his representatives to contract me in the following manner, and allow the practice to leave a message at any/all contacts below: (default if none is selected is detailed message)

Home ( )	Detailed Message ☐ / Call Back # Only ☐
Cell ( )	Detailed Message ☐ / Call Back # Only ☐
Email:	It is Okay to email me at this address ☐

INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )
Subscriber's S.S. no.:	Employer:	Employer address:	Employer phone no.: ( )

PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE COMPANY:				
Policy Number:		Group Number:	Co-payment:	$

SECONDARY INSURANCE INFORMATION

NAME OF INSURANCE COMPANY:				
Policy Number:		Group Number:	Co-payment:	$

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

I accept full financial responsibility for all charges resulting from the medical care provided by Oleksandr Osipchuk MD, PhD Psychiatric Services, LLC. Further I understand that Dr Osipchuk will file my insurance as a courtesy to me; however it is my responsibility to pay my charges in full

I hereby assign all medical benefits, including major medical benefits, MEDICARE, MEDICAID, private insurance and any other health coverage to which I have entitlement to Oleksandr Osipchuk MD, PhD Psychiatric Services, LLC. This agreement will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as an original. I hereby authorize Dr. Osipchuk to release all information necessary to secure payment. Should I carry a balance for greater than thirty days, I understand and agree to being billed and paying interest charges. If my account is assigned to an agency for collection and/or legal action is required, I accept full financial liability for all collection cost, attorney's fees and court cost.

Patient/Guardian signature: _____ *Date* _____

Oleksandr Osipchuk, MD, PhD
Psychiatric Services, LLC

Financial Policy

I authorize direct payment of benefits from my insurance plan to *Oleksandr Osipchuk MD, PhD, Psychiatric Services, LLC (the Practice*). I understand that I am responsible for payment of professional fees charged by "the Practice" for services rendered, but not covered or not properly reimbursed by my insurance plan. I further understand that I am responsible for any fees that are not typically covered by my insurance plan, as defined but not limited to the list below:

PRACTICE FEES (subject to change)

Typically covered services:	**Billed to Insurance**	**Self Pay**
• Initial Psychiatric Evaluation:	$350	$200
• Follow up for medication management only 15 minutes:	$150	$100
• Follow up medication management with brief psychotherapy 20 minutes:	$250	$150
• Follow up psychotherapy 20 minutes:	$150	$100
• Follow up medication management with psychotherapy 45 minutes:	$275	$200
• Follow up psychotherapy 45 minutes:	$275	$200

Typically not covered by insurance:

- Prescription Preauthorization's: $20 per prescriptions.
- No Show Fee: $100
- Copy of medical record: $20 for first 40 pages, $.25 cents per page thereafter, plus postage.
- Review of medical records for disability insurance or other outside insurance $200.
- Letters, reports, treatment plans: $50.00 (per 15 minutes)
- Telephone consultations / interventions: $50.00 (per 15 minutes)
- After hours, non-emergency calls: $50.00 (per 15 minutes)
- Review of medical or psychological records longer than 10 minutes: $50.00 (per 15 minutes)
- Court preparation and/or testimony: $600.00 (per 60 minutes)
- Unpaid Balance/ Late Fee (per month after 60 days): $35.00
- Returned Check Fee: $35.00

I have read, understand and discussed "the Practice" Financial Policy. I agree to make other arrangements for payment if any of services are declined by my insurance or not covered by my insurance.

SIGNATURE DATE

Oleksandr Osipchuk, MD, PhD
Psychiatric Services, LLC

Credit Card Authorization Form

Name on the Card: _____

Type of Card: ☐ Visa ☐ MC ☐ Am Ex ☐ Discover

Account Number: _____

Expiration Date: _____ Security Code: _____

Billing Address: _____

_____

Check which applies:

☐ I hereby authorize this card to be used to charge $ _____ on this date _____

☐ One Time, ☐ Weekly or ☐ Monthly.

☐ I hereby authorize this card to be used for the future payments.

_____

Signed Date

Oleksandr Osipchuk, MD, PhD
Psychiatric Services, LLC

Controlled Substances Therapy Agreement.

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, barbiturate sedatives, stimulants, appetite suppressors is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of Dr. Osipchuk, whose signature appears below, to consider the initial and/or continued prescription of controlled substances to treat your condition.

1. All controlled substances must come from the physician whose signature appears below or, during his absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to unwanted drug interactions or poor coordination of treatment).
2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:***(Pharmacy Name & Phone Number)***:_____
3. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.
4. Dr. Osipchuk has your permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care and you give permission to check your prescription history on Tennessee PMP Web Center and similar databases for purposes of maintaining accountability.
5. You may not share, sell, or otherwise permit others to have access to these medications.
6. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.
7. Unannounced urine or serum toxicology screens may be requested, and your cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder.
8. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.
9. Original containers of medications should be brought in to each office visit.
10. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.
11. Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made.
12. Early refills will generally not be given.
13. Prescriptions may be issued early if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they not be refilled prior to the appropriate date.
14. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.
15. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribed by Dr. Osipchuk .
16. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.
17. It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit.
18. The risks and potential benefits of these therapies are explained to you and you acknowledge that you have received such explanation.
19. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.
20. To satisfy the *Tennessee Prescription Safety Act of 2012* I give Dr. Osipchuk my permission to review my records ongoing, on the TN State Controlled Substance website.

_____

Patient Signature Date

_____

Patient Name Printed

Oleksandr Osipchuk, MD, PhD
Psychiatric Services, LLC

No Show Policy

Please note it is our practice policy that if you do not show for a scheduled appointment you will be charged a **NO SHOW fee of $100.00.** This fee must be paid before we can schedule you for your next appointment. Your insurance company does not pay your NO SHOW fee.

Part of your commitment to us is that if a situation arises where you cannot make your appointment time you call us 24 hours before your appointment time to change your appointment (Mon-Fri, if you cancel on Sunday except in emergency it is considered a No Show and you will be charged the fee). The only exception is in emergency situations.

I understand and promise to comply with this NO SHOW Policy.

Patient Signature Date

Oleksandr Osipchuk, MD, PhD
Psychiatric Services, LLC

Termination Agreement

In our efforts to provide quality care to our patients we believe it is necessary follow treatment plan and see our patients on regularly scheduled basis.

You agreed to be terminated from further care in our office starting **immediately** and **without additional notification** if:

- you have not kept appointments for the period 2 month (1 month if you prescribed controlled substances)
- have an outstanding balance more than $200
- have two consecutive cancelation (more than 24 hours)
- have second no show/late cancelation (less than 24 hours)
- have violated controlled substances contract or have not been compliant with treatment plan (proper medication use, proper monitoring, drug screen, etc.)
- have engaged in criminal activities.

Upon termination you agreed to seek necessary care on your own. Alternative Mental health services in Lebanon, TN:

- Cumberland Mental Health – 615-444-4300
- LifeCare Family Practice - 615-453-1606
- Hendrick Counseling Services – 615-449-9611

If you wish to continue to receive treatment, you are of course, free to contact any psychiatrist or mental health providers of your choice. If needed, I will be happy to forward your clinical records to your new doctor on your written authorization and paid customary fees for this service.

Upon termination office will provide emergency consultations for 30 days without refill of prescriptions on cash only basis.

_____
Patient Signature

_____
Patient Name (Printed)

_____
Date

Oleksandr Osipchuk, MD, PhD
Psychiatric Services, LLC

AUTHORIZATION TO RELEASE INFORMATION

Instructions: This form Allows the Release of Information about a Recipient of Services under Title 33, Tennessee Code Annotated, and the Privacy Notice required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. I understand that this Authorization is Voluntary, and that if the Person or Organization Authorized to Receive the Information is Not a Health Plan or Health Care Provider, the Released Information May No Longer Be Protected by Federal Privacy Regulations (HIPAA).

I,_____/_____, authorize
(Print your name) (Print date of birth)

Doctor:_____ /_____
(Print name) (Mailing address of agency/program making disclosure)

Therapist:_____ /_____
(Print name) (Mailing address of agency/program making disclosure)

Family Member:_____ /_____
(Print name) (Mailing address of agency/program making disclosure)

Other:_____ /_____
(Print name) (Mailing address of agency/program making disclosure)

To disclose to and from Oleksandr Osipchuk MD, PhD, Psychiatric Services, LLC @ 430 West Main Street, Lebanon TN 37087 - FAX 615-552-0089, the following information:

- ☐ Medical records relating to
- ☐ Emergency department record
- ☐ Physician office note(s)
- ☐ Billing records
- ☐ Consultation report
- ☐ History and physical
- ☐ Diagnosis/treatment relating to
- ☐ Operative report
- ☐ Discharge summary
- ☐ Entire medical record
- ☐ Other_____

The purpose of the authorized disclosure is to:

- ☐ At request of Patient
- ☐ Legal purposes - e.g. Attorneys
- ☐ Insurance - e.g. life insurance application
- ☐ Continuing Care - e.g. Other Healthcare Providers, Hospital, Physicians
- ☐ Other _____

I understand that I am not required to sign this authorization, and that my treatment, payment, enrollment, or eligibility for benefits, is not conditioned on my execution of this authorization. I may revoke this consent in writing at any time, except to the extent that action has been taken in reliance on it, and that, in any event, this consent expires automatically in 12 month from the date of signing:

_____
Signature of Patient or Legally Authorized Person Date

****If a recipient gives oral consent or signs with an X, the form must be signed by two (2) witnesses:**

(Witness)_____ **(Date)**_____

(Witness)_____ **(Date)**_____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

PRIVACY PRACTICES:

We are required to provide you with a copy of our Notice of Privacy Practices to review, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment if you wish.

I acknowledge that I have reviewed a copy and agree with the office's Notice of Privacy Practices,

_____

Patient Signature Date

_____

Patient Name Printed

PRACTICE POLICY:

We are required to provide you with a copy of our Practice Policy to review. Please sign this form to acknowledge receipt of the Policy. You may refuse to sign this acknowledgment if you wish.

I acknowledge that I have reviewed a copy and agree with the office's Practice Policies,

_____

Patient Signature Date

_____

Patient Name Printed

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy Practices from this patient. It could not be obtained because (indicate all that apply):

- The patient refused to sign
- Due to an emergency situation it was not possible to obtain an acknowledgment
- We weren't able to communicate with the patient
- Other (Please provide specific details)

_____ _____

Employee Signature Date

PATIENT ACKNOWLEDGMENTS

ASSIGNMENT OF BENEFITS

(Initial) _____I hereby assign to Oleksandr Osipchuk, MD, PhD, Psychiatric Services, LLC, (the Practice) any insurance or third-party benefits available for health care services provided to me. I understand that the Practice has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to the Practice, I agree to forward to the Practice all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt. I authorize any holder of medical information about me to release to the third party payer and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorize the release of medical and psychological information necessary to pay the claim.

INSURANCE COVERAGE WAIVER

(Initial) _____I understand that my eligibility for coverage by **(Name of insurance)** _____ cannot be confirmed at this time. I wish to receive medical service from the Practice. If it is determined that I am not eligible for coverage, I understand that I am responsible for full payment of all services provided.

MEDICARE/MEDICAID WAIVER (DO NOT INITIAL IF YOU HAVE MEDICARE OR MEDCAID)

(Initial) _____I agree that I am NOT enrolled in Medicare/Medicaid and therefore understand that I accept personal responsibility for payment of all services provided by the Practice.

QUALITY ASSURANCE/QUALITY CONTROL

(Initial) _____I understand that the Practice has the right to record phone conversations or psychotherapy sessions for quality assurance/quality control and educational purposes only. All recordings will remain confidential.

NOTICE OF PRESCRIPTION POLICY

(Initial) _____I acknowledge that it is the policy of the Practice to not prescribe Xanax or other addictive opioids or narcotics. I understand that safe and effective alternatives may be prescribed if deemed medically necessary. I understand that if I feel that I cannot comply with this policy that I have the right to transfer my care to another provider.

Oleksandr Osipchuk, MD, PhD
Psychiatric Services, LLC

CONSENT TO TREAT / SAFETY CONTRACT

(Initial) _____I have been sufficiently informed about provided services, benefits and possible side effects of treatment and voluntarily authorize and give consent to the Practice to provide ongoing evaluation and treatment of me. I understand that I may refuse services at any time. I have read, understand and agree with Practice Policies, Financial Policies, and Notice of Privacy Policy.

I acknowledge that no one has made any promises about the results of the evaluation and/or treatment to be provided. I also acknowledge that I have received no warrantees, representations or assurances regarding the benefits or results of the evaluation and/or treatment.

I also understand that the Practice provides outpatient services and I accept that if any time I experience a medical emergency (for example, significant side effects from psychiatric medications) or a psychiatric emergency (for example, feel danger toward self and/or others), I will proceed to the nearest emergency room and/or call 911 (and/or crisis number 1-800-704-2651) and ask provider of ER to inform Oleksandr Osipchuk, MD, PhD, Psychiatric Services, LLC about the nature of my emergency.

- I, _____ agree that I will not attempt to cause harm to myself.
- I promise to never attempt to commit suicide.
- I promise to not participate in any activity that could result in myself intentionally causing harm or death.
- If I am ever having thoughts of suicide, am feeling like I want to kill myself, and/or have the urge to cause harm to myself, I will:
    - ✓ Remind myself that I can never attempt to commit suicide.
    - ✓ I will call 911 immediately if I feel that I could hurt myself that day.
    - ✓ I will proceed to the nearest emergency room.
    - ✓ I will call the following phone numbers, if I am feeling suicidal, but do not feel that I will cause harm to myself immediately: 615-444-4300 Mobile Crisis Team, Lebanon TN
    - ✓ _____
      _____
      _____
    - ✓ If I am feeling like I want to die, and/or commit suicide and cannot reach the above persons, I will call 1-800-Suicide.

_____
Patient Signature Date

_____
Patient Name Printed

Oleksandr Osipchuk, MD, PhD
Psychiatric Services, LLC

INFORMED CONSENT

Name:_____ **DOB** _____

Discussed the nature of the proposed treatment:
1. ☐ Psychotropic medications 2. ☐ Psychotherapy 3. ☐ ECT 4. ☐ Others

Discussed the material risks, benefits, side effects and need of monitoring of the proposed treatment and alternatives:
2. Psychotropic medications:

☐ Antipsychotics:

Abilify		Clozaril		Compazine		Contra		Fanapt	
Geodon		Haldol		Invega		Latuda		Mellaril	
Moban		Navane		Orap		Prolixin		Risperidal	
Saphris		Seroquel		Stelazine		Thorazine		Trilalfon	
Zyprexa									

☐ Mood stabilizers:

Depakote		Lamictal		Lithium		Lyrica		Neurontin	
Tegretol		Topomax		Trileptal					

☐ Antidepressants:

Amitriptiline		Anafranil		Celexa		Cymbalta		Effexor	
Emsam		Lexapro		Luvox		Marplan		Milnacipran	
Nardil		Nortriptyline		Parnate		PaxilPristiq		Prozac	
Remeron		Sarafem		Symbyax		Trazadone		Wellbutrin	
Zoloft									

☐ Antianxiety medications:

Ativan		Benadryl		Buspiron		Klonopin		Librium	
Propranolol		Vistaril		Xanax					

☐ Insomnia Medications:

Ambien		Lunesta		Restoril		Roserem		Sonata	
Trazadone									

☐ Stimulants:

Adderral		Concerta		Daytrana		Focalin		Intuniv	
Ritalin		Strattera		Vyvanse					

☐ Alcohol treatment medications:

Antabuse		Campral		Revia	

☐ Opioid dependence medications:

Suboxon		Revia	

☐ Others :

Chantix		Cogentin		Nicotine gum		Nicoderm		Zyban	

3. Psychotherapy: ☐ Individual ☐ Group ☐ Family
4. ☐ ECT
5. ☐ Others _____

☒ Discussed the material risks and benefits of doing nothing

☐ Informed refusal signed

☒ The material risks, benefits, and alternatives were discussed with the patient. The patient asked questions and understood. The patient consented and made decision to start treatment.

☒ Contact information has been given to the patient in case emergency : Carey Counseling Crisis Hotline 1-800-353-9918, 911. Safety Plan/Other Interventions/Education: Patient/family provided the suicide prevention hotline# 1-800-273-TALK (8255) Toll-Free Adult Statewide Crisis Telephone Line 1-800-809-9957, Western State Mental Health 1-731-228-2000.

Patient/family knows to come to Urgent Care/Emergency (or if necessary call 911). Patient/family agrees to take appropriate action if patient feels at risk.

_____

Patient Signature Date

Authorization for Electronic Communication and TeleMedicine.

I understand that Oleksandr Osipchuk, MD, PhD LLC, has the ability to provide me with a TeleMedicine visit from my home or from the office location at 430 West Main Street, Lebanon, TN.

I understand the following:

1. The video connection may not work or that it may stop working during the appointment.
2. The video connection used is secure and HIPPA compliant.
3. This is considered a regular appointment and you will need to pay your copay/deductible/balance before the visit.
4. You may need to come to the office to pick up prescriptions.
5. This may not be used for your first visit with the doctor.
6. In order to use this system from home we need a current email address to send the proper link and a computer with a web camera or a cell phone with a web camera.
7. If the link doesn't work from your home because of internet or computer limitations you will need to come into the office, our staff is not able to help you set up your PC.
8. You will need to check in 10 minutes before your appointment.

Email address (please print clearly):_____

_____

Signed Date

DASS21

Name: *Date:*

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

Oleksandr Osipchuk, MD, PhD
Psychiatrc Services, LLC

Adult Questionnaire

Please fill the form, typing or check with "X" (letter X) what is pertinent to.

Name: _____ **Date mm/dd/yyyy** _____
Last *First* *Middle*

DOB _____ **SSN** _____

Why? Mental Problem [ ] Consult [ ] Injury [ ] Job Related [ ] Disability [ ] Legal [ ] Other [ ]

Describe the problems:

When did these problems begin? _____

What do you belive caused it? _____

What has made problems worse? _____

What has made problems better? _____

Have you been diagnosted with mental illnes: _____ If Yes, What is your diagnosis? _____

What are you current medications? _____ _____
(Including over the counter) _____ _____
_____ _____
_____ _____

Are you taking them as prescribed? Yes [ ] No [ ]

Medical History

Please indicate if you have any of folowing conditions/illneses:

Yes		Yes		Yes	
_____	Skin conditions	_____	Abdominal pain	_____	Falling
_____	Frequent Headaches	_____	Heartburn/reflux	_____	Memory loss
_____	Migraines	_____	Ulcers	_____	Stroke
_____	Past head injury	_____	Nausea/vomiting	_____	Seizures
_____	Loss of consciousness	_____	Diarrhea/constipation	_____	Poor coordination
_____	Dizziness/Vertigo	_____	Gallstones	_____	Motor tics
_____	Glasses/contact lenses	_____	Liver problems/hepatitis	_____	Numbness/Tingling
_____	Blurry vision	_____	Rectal Pain/bleding	_____	Hyperthyroid
_____	Double vision	_____	Hernias	_____	Hypothyroid
_____	Cataracts	_____	Frequent urinary infections	_____	Diabetes mellitus
_____	Glaucoma	_____	Urinary problem	_____	Heat/cold intolerance
_____	Hearing loss	_____	Incontinence	_____	Weight gain/loss
_____	Ringing in the ears	_____	Kidney stones	_____	Changes to hair
_____	Nose bleeds	_____	Gynecological problems	_____	Fatigue
_____	Frequent sinusitis	_____	Menopause	_____	Anemia
_____	Seasonal allergies	_____	Muscle weakness	_____	Bruise easily
_____	Sore throat	_____	Joint pain	_____	Past blood transfusions
_____	Respiratory problems	_____	Back pain	_____	Blood disorder
_____	Shortness of breath	_____	Arthritis	_____	AIDS
_____	Asthma			_____	Cancer
_____	Frequent cough			_____	Tuberculosis
_____	Chest pain				
_____	Cardiac problems				
_____	Heart murmur				
_____	Heart attack				
_____	High cholesterol				
_____	High blood pressure				

Allergy _____
_____

Major Surgery _____

430 West Main Street – Lebanon TN 37087 – 615.444.3836 (phone) – www.DrAleks.com

Name: **DOB:** **Date:**

HPI

Please indicate if any of folowing concerns you in past and/or you experiencing currently:

Past	Current		Past	Current	
		Feeling sad			Hearing voices
		No fun in life			Lose track of time
		Sleep Disturbance			Feelings that you are not real
		Appetite disturbance			Unclear thinking
		Low energy			Excessive spending/gambling
		Cannot focus			Easily distractable
		Hopelesness			Disorganization
		Low self-esteem			Easily angered/irritable
		Isolation/Social withdrowing			Physical aggression
		Weight loss/gain			Nightmares
		Guilt			Flaskbacks
		Wanting to die			Physical Abuse Issues
		Wanting to kill myself			Sexual Abuse Issues
		Wanting to cut myself			Sposal Abuse Issues
		Thoughts of harming others			Many relationship problems
		Elated mood			Sexual problem
		Mood swings			Don't feel like eating
		Fear of dying			Making myself throw up
		Fear of going crazy			Using too many laxatives
		Phobias			Eating too much
		Anxiety/Panic atacks			Increasing forgetfulness
		Worrying all the time			Chronic pain
		Thoughts racing			Planning pregnancy
		Checking things over and over			Problem with medication side effects of
		Cleaning myself all the time			Muscles are always tense
		Difficulty leaving home			Excessive use of prescribed medications
		Shyness			Excessive use of Drugs & Alcohol
		People are out to get me			

Primary Care Physician: _____ Other _____

_____ _____

_____

Psychiatric Services, LLC

Name: DOB: ate:

Past Psychiatric History:

Number of past psychiatric inpatient hospitalization _____

Name of Previous psychiatrist? _____

When, why and where you been treated by cliniciar _____

Past Medications:

Name of Previous Therapi: _____

When, why and where you been treated by cliniciar _____

Past treatment for alcohol/substance dependance _____

When and where? _____

_____

Have you ever threatened or attempted to hurt yourself/c _____

When and how? _____

Substance Use/Abuse History

Which of the following are you using?

	Never	Daily	Weekly	Monthly	Last time	how much
Alcohol						
Marijuana						
Cocaine/Crack						
Heroin						
Amphetamines (speed)						
Benzodiazapines(downers)						
Inhalants (gasoline,clue, etc)						
PCP						
Acid/LSD						
Caffiene						
Tobacco						

	yes	no
Have you ever felt that you should cut down on your substance use?		
Has a friend or relative expressed concern about your use?		
Have you ever felt guilty about your substance use?		
Have you ever needed use substance early in the morning?		
Have you ever been confronted by your employer about your use?		
Are you a recovering alcoholic or drug addict?		
Have you ever been arrested because of your substance use?		
Have you ever had blackouts?		
Has your substance use ever created problems in your family?		
Have you ever medical problems related to a substanceuse?		
Heart problem		
Seisures		
Shakes		
Delirium		

Name: **DOB:** **Date:**

Family History

Please identify any previous medical/psychiatric diagnoses in your family (parents, siblings, grandparents, aunts, uncles, cousins)

	Parents	Siblings	GrandParents	Aunts/Uncles/Cousins
Heart disease/HTN/Stroke				
Cancer				
Diabetes				
Depression				
Anxiety				
Bipolar Disorder/Manic Depression				
Schizophrenia				
Eating Disorder				
Developmental Disorders/Autism				
Mental Retardation				
Commit/Attempted suicide				
Substance/Alcohol Use				

Social History

Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐

Children/Age: _____

Grew up with both parents: ☐ Problems with Parents ☐ Drugs/Alchol ☐ Abuse ☐

School: Regular _____ Special _____ Grade _____ Problem at school _____

Grades Excellend _____ Good _____ Fair _____ Poor _____ Failing _____

Employed Unemployed ☐ Student ☐ Disabled ☐ Retired ☐

Employer _____

Ocupation _____

Religion _____

Housing Own Home _____ Apartment _____ Homeless ☐

Have legal charges ever been pressed against you? Yes ☐ No ☐

If Yes Describe _____

Have you served in military? Saw combat? Honorable Discharge?

Patient Signature Date

Psychiatric Services, LLC