Osika & Scarano Psychological Services, P.C.

125 Broad Street, One Broad Street Plaza, Glens Falls, NY 12801
430 Franklin Street, Schenectady, NY 12305

phone: 518.745.0079 fax: 518.745.4291 www.OSPsychServices.com

Intake Form

Patient Information:

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

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:

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.

Back:

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Informed Consent to Individual and Group Psychotherapy

This form documents that I, ________________________________, give my consent to my provider at 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, 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.

Patients (or parents) may audio record sessions, but only with our express written permission. Any violation of this policy will result in our beginning a treatment termination process.

If you are in crisis after hours or on weekends, please text URGENT to both 518-744-7978 and 518-791-5904. Also, please call the Suicide Crisis Line at 988.

If you need a refill on your medication as prescribed by New Hope, please text 518-744-7978 and state your name, date of birth, the name of your prescriber, and the medications you need refilled. Please do this 72 hours in advance of your last dose.

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

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

   Primary Care Physician:

   Others:

   New Hope Psychology and Nurse Practitioner-Psychiatry Services, PLLC

2. I hereby authorize the disclosure and receipt of the following protected health information:
   Examinations, treatment plans, and progress notes.
3. This protected health information is being used, disclosed, or received for the following purposes:
   To collaborate regarding diagnosis and treatment of the patient.
4. This authorization shall be in force and effect 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., 125 Broad Street, One Broad Street Plaza, 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:

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

Check here **only** if you **refuse** to give consent.

Please check any of the following reasons why you feel 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 Osika & Scarano.

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: Date of Birth:

Hixny Electronic Data Access Consent Form

Osika & Scarano Psychological Services, PC

In this Consent Form, you can choose whether to allow Osika & Scarano Psychological Services, PC to obtain access to your medical records through a computer network operated by the Healthcare Information Xchange of New York (Hixny), which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow Osika & Scarano Psychological Services, PC to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, Osika & Scarano Psychological Services, PC staff involved in my care may see and get access to all of my medical records through Hixny."

If you check the **"I DENY CONSENT"** box below, you are saying "No, Osika & Scarano Psychological Services, PC may not be given access to my medical records through Hixny for any purpose."

Hixny is a not-for-profit organization. It shares information about people's health electronically and securely to improve the quality of health care services.

Please carefully read the information on both pages of this form before making your decision.
You have two choices:

- ☐ **I GIVE CONSENT for Osika & Scarano Psychological Services, PC to access ALL of** my medical records through Hixny in connection with providing me any health care services, including emergency care.

- ☐ **I DENY CONSENT for Osika & Scarano Psychological Services, PC to access** my medical records through Hixny for any purpose, *even in a medical emergency*. Unless you check this box, New York State law allows medical providers treating you in an emergency to get access to your medical records, including records that are available through Hixny.

______________________________________ ______________ ________________

Print Name of Patient Date of Birth Date

______________________________________ __________________________________

Signature of Patient or Patient's Legal Representative Print Name of Legal Representative (if applicable)

____

Relationship of Legal Representative to Patient (if applicable)

Details about patient information in Hixny and the consent process:

How Your Information Will Be Used

Your electronic health information will be used by Osika & Scarano Psychological Services, PC only to:

- Provide you with medical treatment and related services
- Check whether you have health insurance and what it covers
- Evaluate and improve the quality of medical care

NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

What Types of Information About You Are Included

If you give consent, Osika & Scarano Psychological Services, PC may access ALL of your electronic health information available through Hixny. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

- Alcohol or drug use problems*
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Mental health conditions
- Sexually transmitted diseases

***If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, such as medications and dosages, lab test results, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social support, and health insurance claims history.**

Where Health Information About You Comes From

Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current Information Sources is available from Hixny. You can obtain an updated list of Information Sources at any time by checking the Hixny website: www.hixny.org.

Who May Access Information About You, If You Give Consent

Only these people may access information about you: doctors and other health care providers who serve on Osika & Scarano Psychological Services, PC medical staff who are involved in your medical care; health care providers who are covering or on call for Osika & Scarano Psychological Services, PC 's doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

Penalties for Improper Access to or Use of Your Information

There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Osika & Scarano Psychological Services, PC at: (518) 744-7302; or call Hixny at (518) 640-0021; or call the NYS Department of Health at 518-474-4987.

Re-disclosure of Information

Any electronic health information about you may be re-disclosed by Osika & Scarano Psychological Services, PC to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. Hixny and persons who access this information through the Hixny must comply with these requirements.

Effective Period

This Consent Form will remain in effect until the day you withdraw your consent or until such time Hixny ceases operation.

Withdrawing Your Consent

You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to Osika & Scarano Psychological Services, PC's. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from any Hixny provider, from the Hixny website at www.hixny.org, or by calling (518) 640-0021.

NOTE: Organizations that access your health information through Hixny while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

Copy of Form

You are entitled to get a copy of this Consent Form after you sign it.

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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 breached 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: 125 Broad Street, One Broad Street Plaza

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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Psychosocial History Introduction

What follows are questions about your entire life history, which we feel are critical to pinpointing an accurate diagnosis. An accurate diagnosis helps your therapist know best how to proceed. A proper diagnosis can speed up the process and trial and error required to find the medications that fit you best, especially when it comes to medication management. Gathering this history takes time, but in order to bill your insurance company, this information is required by the end of your first session.

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Psychosocial History

Family of Origin

Were you every adopted as a child?
At what age?

Were you ever told that you were conceived as a result of rape or sexual abuse?
Who told you that?

Is the identity of one (or both) of your birth parents unknown?
Who is unknown?

Did your birth (or adopted) parents ever divorce or separate?
What was your age at the time?

Do you have any step-parents?
How many?

How many birth siblings (both parents are the same) do you have?

How many half-siblings (one parent is the same) do you have?

How many step siblings do you have?

In terms of birth order you are…

__ the oldest
__ the youngest
__ somewhere in the middle

Childhood Substance Use and Abuse

The following questions pertain to birth, step, foster, adopted parents and childhood guardians.

Was anyone addicted to alcohol?
Who?

Was anyone addicted to cannabis?
Who?

Was anyone addicted to an illegal substance?
Who?

Which drugs?

Was anyone verbally abusive (i.e., name-calling or cursing)?
Who was verbally abusive to whom, and what was said?

Was anyone physically violent (i.e., put their hands on others when they were angry)?
Who was violent to whom?
What ages did this impact you as a child?

Were you ever the victim of sexual abuse or fondling as a child?
By whom?
What age were you when the abuse started?
What age were you when the abuse ended?

As a child, were you (or sexualized pictures of you) ever prostituted or sold?
Please explain:

Were you bullied by peers?
Please explain:

Do any of your relatives have a (un)diagnosed mental illness?
Who?
What do they have?

Educational and Occupational History

Which is true?

__ I dropped out of high school.

__ I attended high school all 12 grades.

Which is true?

__ My highest education is a GED or high school.

__ I have attempted college but didn't complete a degree.

__ I have an Associate Degree.

__ I have a Bachelor's Degree.

__ I have a Master's Degree or Doctorate.

Which is true?

__ I am currently attending college.

__ I am currently attending college and working 10 or more hours per week.

__ I am working part-time.
__ I am working full-time.
__ I am unemployed and seeking a job.
__ I am not working and collecting disability benefits.
__ I am not working due to a disability and not collecting benefits.
__ I am working and collecting benefits.
__ I am retired.

Have you ever been fired?
Please explain:

Which describes your work history best?
__ I can never seem to keep or stay at a job more than 6-12 months.
__ I stay at my jobs for 1-2 years typically.
__ I usually have lengthy stays (more than 2 years) at my jobs.
__ I don't want to work at all.
__ I am retired.

Medical History

Have you ever tested positive for COVID-19?
When?
What symptoms remain, if any?

What mental health diagnosis do you have?

What medical illnesses is your PCP, MD, or PA treating you for currently?

What prescribed medications do you take daily?

Which best describes you?
__ I take my prescribed medications 100% of the time.
__ I sometimes forget to take my medications, but it is only once a week or less.
__ I want to be 100% compliant but I can't stay organized enough to remember to take my medications.
__ I am prescribed medications, but I don't feel they are helpful, or the side effects are unbearable.
__ I am very much against medications at this time.
__ I am not prescribed any medications at this time.

What drug allergies do you have?

Are you currently prescribed a controlled substance?
Which one(s)?
Who is the prescriber?

Have you ever been knocked unconscious?
When?
From what?

Are you currently taking birth control?

If you are female, are you getting your menstrual cycle at least semi-regularly?

Have you ever had a negative experience on psychiatric medications?
Please explain:

Substance Use

Do you currently drink 14 or more servings of alcohol in one week?

Do you smoke cannabis?
How many times per week?
Is it due to poor sleep, pain, or anxiety?
Please explain:

Have you used an illegal drug in the past six months?
Which one(s)?

In the past six months, have you taken someone else's controlled medication, or purchased a controlled substance (without billing your insurance)?

Do you smoke cigarettes or take nicotine products?
How many times a day?
Do you smoke in your home or car?
Are your children present?

How many servings of caffeine do you have daily?

Adult Social History

Since the age of 18, have you ever been physically abused?
When?
By whom?

Since the age of 18, have you ever been sexually assaulted or raped?

When?
By whom?

How many times have you been married?

How long was your longest romantic relationship?

Are you currently living with anyone who is physically or sexually or verbally abusive?
Who?
What type of abuse?

How many children do you have?

With how many different people have you had children?

Are you physically or verbally abusing someone at the current time?

Have you ever sexually assaulted anyone or molested a child?

Do you have unlocked firearms in your home?

Have you ever been arrested?
How many times?
For what?

Mood Symptoms

If I had to choose, my mood most days is…

__ mostly depressed and sad.
__ anxious and worried.
__ both depressed and anxious.
__ irritable and angry.
__ I feel all of those and can't decide.
__ none of the above.

Which best describes when it started?

__ as long as I can remember, even in childhood.
__ within the past 12 months, in response to an event.
__ over the past few years pretty much every day.
__ none of the above.

Do you worry all day about bad things happening?

Do you have panic attacks?

Sleep

Do you have trouble falling asleep?

Do you awaken more than once a night and can’t get back to sleep?

Which describes your sleep?

- __ I sleep more than 8 hours each night.
- __ I sleep 6-8 hours per night, and awaken briefly to go to the bathroom.
- __ I sleep 6-8 hours per night, but I awaken and can't get back to sleep.
- __ I sleep 4-6 hours per night.
- __ I sleep less than 4 hours per night.
- __ Sometimes for multiple nights in a row I get no sleep whatsoever.

Do you dream of past abuses?

Appetite

Do you feel somewhat in control of your appetite, and have relatively good eating habits?
Which is most true?

- __ I can't stop grazing all day.
- __ I binge eat.
- __ I think I may excessively under-eat/restrict.
- __ all of the above.

Are you currently trying to drop weight?

Do you feel fat?

Have you ever self-induced vomiting for fear of getting fat?
When was the last time you purged?
How many times a week do you purge?

Have you ever taken diet pills, diuretics, or laxatives for fear of getting fat?
What did you take?
When did you take these?

How tall are you?

How much do you weigh?

Behavioral Symptoms

Are you struggling with a behavior you can’t control, or that consumes time during the day?

Please explain:

Have you ever been so angry that you struck someone or vandalized property?

Has your gambling ever caused financial pressure or distress?

Have you ever thought of killing someone?

Suicide and Self-harm

Have you ever felt you wanted to die?
When did that start for the first time in your entire life?
When was the LAST TIME you wanted to die?

Have you ever tried to kill yourself?
How many times?
When was your first attempt?
How did you attempt?
When was your last attempt?
How did you attempt?

Have you ever actually harmed yourself to feel better or different (not necessarily to die)?
When did that start for the first time in your entire life?
When was the last time you self-harmed?
How do you typically harm yourself?
How many times have you harmed yourself in your lifetime?

Previous Psychiatric Care

Have you ever been hospitalized for psychiatric reasons?
How many times?
Where?
What were you doing or feeling that made you need the hospital?

Have you ever seen a psychiatric medication prescriber in the past?
Who?
When?

Have you ever seen a counselor or psychologist for talk therapy?
Who?
When?

Are you attending any community support groups like AA, NA, church, online, or school-based?

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