

South Denver

National Jewish - Downtown

Cherry Creek

Phone: 1.877.667.4366

Fax: 1.877.676.9763

**PATIENT INFORMATION**

Patient Name: First: \_\_\_\_\_ Last: \_\_\_\_\_  
 Date of Birth (Mo/Da/Yr): \_\_\_\_\_ Age: \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Home Address: (No PO box #s) \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_ Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_  
 At what number(s) may we leave a message? \_\_\_\_\_  
 Emergency Contact (Name and Phone): \_\_\_\_\_  
 Marital Status:  Single  Married  Divorced  Widowed  
 Occupation: \_\_\_\_\_ Employer/School: \_\_\_\_\_  
 Employer Address: \_\_\_\_\_  
 Referred by: \_\_\_\_\_

**Billing Information**

Person responsible for payment:  SELF  Other \_\_\_\_\_  
 Address (include city/state/zip): \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_ Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_  
 Are you covered by medical insurance?  No, I am Self-Pay (skip this section)  Yes (complete this section)  
 Do you have a co-pay?  No  Yes and it is \$ \_\_\_\_\_ Do you have a deductible?  No  Yes and it is \$ \_\_\_\_\_

**Primary Insurance Information:**

Insurance Company: \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_  
 Address of Insurance Co.: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Name of Policy Holder \_\_\_\_\_ Policy's Holder Social Security #: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_ Identification # \_\_\_\_\_ Group # \_\_\_\_\_

**Secondary Insurance Information (if applicable):**

Insurance Company: \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_  
 Address of Insurance Co.: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Name of Policy Holder \_\_\_\_\_ Policy's Holder Social Security #: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_ Identification # \_\_\_\_\_ Group # \_\_\_\_\_

**Office Policy**

PAYMENT IS EXPECTED AT TIME OF APPOINTMENT. WE PARTICIPATE WITH MANY, BUT NOT ALL INSURANCE COMPANIES. IT IS YOUR RESPONSIBILITY TO DETERMINE IF WE ARE PARTICIPATING PROVIDERS OR NOT.

IF WE ARE NOT A PARTICIPATING PROVIDER WITH YOUR INSURANCE COMPANY AND YOU HAVE OUT OF NETWORK BENEFITS: THIS OFFICE IS NOT RESPONSIBLE FOR COLLECTING YOUR INSURANCE CLAIM OR FOR NEGOTIATING A SETTLEMENT ON A DISPUTED CLAIM. YOU ARE RESPONSIBLE FOR PAYMENT OF YOUR ACCOUNT. AT EACH VISIT, WE WILL PROVIDE YOU WITH A STATEMENT OF SERVICES THAT CONTAINS ALL THE INFORMATION YOU NEED TO FILE YOUR CLAIM WITH YOUR INSURANCE CARRIER.

**A FULL CHARGE OF OUR CLINICIAN'S STANDARD PROFESSIONAL FEES IS MADE IF A PATIENT DOES NOT SHOW FOR AN APPOINTMENT OR DOES NOT CANCEL THE APPOINTMENT WITH ADVANCE NOTICE OF LESS THAN 24 HOURS.**

I HAVE READ THE ABOVE AND PROVIDED THE INFORMATION TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT.

\_\_\_\_\_  
Signature Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

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ASSIGNMENT OF BENEFITS AGREEMENT

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your medical and mental health benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- ✍ Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- ✍ We require you to sign this form and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.
- ✍ We require you to pay the co-payment, which is the amount not covered by your insurance company, company, at the time we provide service to you.
- ✍ Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company at that time.
- ✍ Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- ✍ Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY MEDICAL AND MENTAL HEALTH BENEFITS DIRECTLY TO THE PRACTICE.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Name of Insurance Policy

\_\_\_\_\_  
Group #

\_\_\_\_\_  
Insurance Phone #

\_\_\_\_\_  
Subscriber's Name

\_\_\_\_\_  
SSN or Subscriber ID

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Signature of Parent/Responsible Party

\_\_\_\_\_  
Date

Pt's name: \_\_\_\_\_ Date of Appointment: \_\_\_\_\_

**Consent to Obtain or Release Information**

I, \_\_\_\_\_, SS# \_\_\_\_\_, DOB \_\_\_\_\_

Understand that the information obtained in medical records are confidential. However, I specifically give my consent for Brian K. Wise, MD, MPH to release and/or obtain the following medical records or information:

Psychiatric  Substance Abuse Treatment  Insurance Information  Coordination of Patient Care and/or medical information including:

Discharge Summary  Lab Reports  Office Chart Notes  History & Physical  Consultations

Medical Imaging Reports

Other Medical Records/Information: \_\_\_\_\_

Other Medical Records/Information: \_\_\_\_\_

**NAME OF THE OTHER PARTY OBTAINING/RELEASING INFORMATION:**

NeuroAssessment Centre ~ 6197 Lehman Dr; #105; Colorado Springs, CO 80918 ~ 719.487.7943/877.321.4010

NeuroBehavioral Institute of CO ~ 9218 Kimmer Dr; #203; Lonetree, CO 80124 ~ 720.763.9017/720.763.9027

Compass Colorado Healthcare ~ 8671 S. Quebec St; #200; Littleton, CO 80130 ~ 303.683.5620/303.683.5609

**(If you have been a patient of any of the above, please fill out separate Consent to Obtain or Release of Information for each.)**

To/From \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax#: \_\_\_\_\_

At the following address: \_\_\_\_\_

I was treated \_\_\_\_\_ (approx. dates) for mental health and/or substance abuse care. The above listed information is to be disclosed for the specific purpose of medical evaluation and, or coordination of Patient care.

By written request, this consent may be revoked at any time up to the time that action is taken. The consent will automatically expire upon completion of this transaction and no later than one (1) year from the date signed unless otherwise stated herein.

It is further understood that the information released is for professional purpose only and should not be provided in whole or part to any other agency, organization, or person other than stated above.

I understood that treatment services are not contingent upon my signing or not signing this consent form. I freely and voluntarily give my consent for the release of information from my medical record.

For Substance Abuse Treatment Only: TO THE PARTY RECEIVING THE INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by federal law. Federal regulations (42 CFR, part 2) prohibits you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. FOR PATIENT RECORD APPLICABLE UNDER LAW 42 CFR PART2.

\_\_\_\_\_  
SIGNATURE OF PATIENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PATIENT'S OTHER/PAST LEGAL NAMES (e.g. maiden)

\_\_\_\_\_  
WITNESS

Pt's name: \_\_\_\_\_

Date of Appointment: \_\_\_\_\_

**FINANCIAL ACCEPTANCE FORM**

To our patients:

As you know if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company as it makes checkout faster, easier, and more efficient.

We have a similar policy. You will be asked for a credit card number at the time of check in or check out and this information is held safely and securely until you accrue a balance. At this point you may satisfy the balance in whichever format you prefer. However, ANY remaining balance may be charged to your credit card. This method is typically a safeguard for the office and will only be charged if necessary including, but not limited to, missed appointments, office administration fees, etc.

This is an advantage to you, since you will no longer have to write out checks or carry cash equivalents. It will be advantageous to us as well since it will greatly decrease the number of statements that we have to generate and mail. The combination will benefit everyone in helping reduce the cost of healthcare.

If you have any question about this payment method, please do not hesitate to ask.

Sincerely yours,

Brian K. Wise, MD, MPH  
Wise Psychiatry, PC

I, \_\_\_\_\_, agree to pay my co-pay, deductible, co-insurance, and any past-due balance on my account at the time of service. In order to assure that all financial agreements are adhered to, I authorize Brian K. Wise and/or Wise Psychiatry, PC to charge outstanding balances on my account to the following credit card:

Visa       MasterCard       American Express

Account Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ CVV Code: \_\_\_\_\_

Name on card (please print) \_\_\_\_\_

Billing Address (please print) \_\_\_\_\_

Billing Address (please print) \_\_\_\_\_

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

Pt's name: \_\_\_\_\_

Date of Appointment: \_\_\_\_\_

**E-MAIL CORRESPONDENCE DISCLOSURE OF  
PROTECTED HEALTH INFORMATION**

**Our office does send out complimentary reminders of upcoming appointments via e-mail.**

Our office offers **optional** e-mail correspondence to address after office hours questions and concerns regarding your mental health care including general inquiries about medications and treatment. The purpose of this option is **not to substitute** follow-up visits with the clinician, but to serve as an alternate means of communication with your mental health care provider. In reply to your e-mail, you may sometimes be instead instructed to follow up in our office to address your concerns if the provider recommends so based on his/her professional medical opinion.

The contents of the clinician's corresponding e-mails may include your personal health information. In relevance to your e-mail question or concern, this could include (but may not be limited to) your psychiatric diagnosis, prescribed medications, alcohol and drug history, and other medical diagnoses. Our office will **NOT** be held responsible for any individual who gains access to the contents of the corresponding e-mails regardless of the means by which it occurred.

If you are interested in our optional e-mail correspondence, complete the following appropriately.  
If not, **DO NOT FILL OUT THIS FORM.**

I, \_\_\_\_\_, agree to participate in the e-mail correspondence option.

I certify that I have read and understand the above information. If I decide to change my decision to participate in this option I agree to do so by notifying our staff and completing the bottom of this form, dating it, and returning it to our office.

My e-mail address is

\_\_\_\_\_@\_\_\_\_\_.\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

I **no longer agree** to participate in the email correspondence option.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Pt's name: \_\_\_\_\_

Date of Appointment: \_\_\_\_\_

### **Medication Refill Policy:**

*Interruption of regularly scheduled medications can potentially cause unpleasant or dangerous withdrawal symptoms or a relapse of the condition being treated.*

*It is **your** responsibility to monitor the amount of medication remaining as well as the number of refills left. This allows refills to be provided in a timely fashion.*

1. Please contact your pharmacy and request that they fax a refill request to our office. Our fax # is **(877) 676-9763**. Please allow 72 hours or three business days for us to respond. Please ask your pharmacy if they would be willing to contact us via fax and/or electronic prescribing.
2. Certain medicines (especially medications used for Attention Deficit Hyperactive Disorder) cannot be refilled by phone or fax. A paper (hard copy) prescription should be requested by phone to our office at **(877) 667-4366**. If the refill is approved, office staff will contact you to find out if you wish to have the prescription mailed to you or if you wish to pick it up at the office.
3. Urgent prescription refill requests after hours or on weekends require you to call the office and follow the recorded instructions to contact the on-call clinician. Please be aware that from the hours of Friday at 1 pm until Monday at 8 am this call will be returned by an on-call clinician. This person is likely to provide a limited prescription, if any, to cover until you can speak with your provider. However, the clinician may decide to not refill the medication, especially, but not solely, if there are concerns to a medication being abused/misused.
4. We will not authorize refills if you have no future appointment, since we are legally required to ensure that you are in active treatment if we prescribe medications. Please note that in the event of a missed, rescheduled, or cancelled appointment, you medications may not be refilled.
5. We are unwilling to provide refills of medications provided by other doctors or for other medical conditions, including narcotic pain medications.
6. No controlled medications will be called in during hours when the office is not open for business such that medical records can be reviewed if necessary.

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Guardian Name: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Provider's signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Pt's name: \_\_\_\_\_ Date of Appointment: \_\_\_\_\_

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PREFERRED PHARMACY OF RECORD

Date \_\_\_\_\_

Wise Psychiatry, PC has committed to using electronic prescriptions to insure accuracy and speed in prescribing your medication. We are currently transitioning over from typical paper prescriptions to electronic prescriptions (with the exception of some controlled medications that require paper prescription.) The prescriptions will be sent to your pharmacy while you are here and you can pick up at your convenience. To ensure that your prescriptions are delivered to the correct pharmacy, please complete the following information.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

**OR**

Pharmacy Cross Streets: \_\_\_\_\_

Pharmacy Phone Number: \_\_\_\_\_

Pharmacy Fax Number: \_\_\_\_\_

Pt's name: \_\_\_\_\_ Date of Appointment: \_\_\_\_\_

**CUSTODIAL INFORMATION (if applicable)**

**Briefly Describe Custodial Arrangements (Parenting Time, Medical Decision Making Power, Payment):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Due to the complexity of the marital structure and the implicit issues that arise during and following the process of a separation and divorce, it is required that a single adult be responsible for all appointments and billing.

If legal documents exist regarding custodial agreements, it is required that a copy be on file with our office and that the identified parent responsible for scheduling and billing update this as required.

I understand that if I am unwilling or unable to follow this agreement, ongoing care will need to be transferred to an alternate treatment provider.

**Primary Parent Contact:**

Responsible for appointment scheduling and billing: \_\_\_\_\_

Preferred Contact Information: \_\_\_\_\_

Parent Signatures: \_\_\_\_\_

Parent Names: \_\_\_\_\_

Date: \_\_\_\_\_

Witness(es): \_\_\_\_\_

# Brian K. Wise, MD, MPH - Wise Psychiatry, PC

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Pt's name: \_\_\_\_\_ Date of Appointment: \_\_\_\_\_

Patient Name ~ First: \_\_\_\_\_ Last: \_\_\_\_\_ Gender: F M Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Form completed by (if someone other than patient): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (home): \_\_\_\_\_ (cell): \_\_\_\_\_ (work): \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Primary reason(s) for seeking services:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Aggression               | <input type="checkbox"/> Elevated mood     | <input type="checkbox"/> Parenting concerns/issues      |
| <input type="checkbox"/> Alcohol abuse/dependence | <input type="checkbox"/> Fatigue           | <input type="checkbox"/> Phobias/fears                  |
| <input type="checkbox"/> Anger management         | <input type="checkbox"/> Gambling          | <input type="checkbox"/> Recurring thoughts/Ruminations |
| <input type="checkbox"/> Antisocial behavior      | <input type="checkbox"/> Hallucinations    | <input type="checkbox"/> Sexual addiction               |
| <input type="checkbox"/> Anxiety                  | <input type="checkbox"/> Hopelessness      | <input type="checkbox"/> Sexual difficulties            |
| <input type="checkbox"/> Avoiding people          | <input type="checkbox"/> Hyperactivity     | <input type="checkbox"/> Sick often                     |
| <input type="checkbox"/> Coping skills            | <input type="checkbox"/> Impulsivity       | <input type="checkbox"/> Sleeping problems              |
| <input type="checkbox"/> Cyber addiction          | <input type="checkbox"/> Irritability      | <input type="checkbox"/> Speech problems                |
| <input type="checkbox"/> Depression               | <input type="checkbox"/> Judgment errors   | <input type="checkbox"/> Suicidal thoughts              |
| <input type="checkbox"/> Disorientation           | <input type="checkbox"/> Loneliness        | <input type="checkbox"/> Thoughts disorganized          |
| <input type="checkbox"/> Distractibility          | <input type="checkbox"/> Memory impairment | <input type="checkbox"/> Traumatic experience(s)        |
| <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Mood shifts       | <input type="checkbox"/> Tremors/Trembling              |
| <input type="checkbox"/> Drug abuse/dependence    | <input type="checkbox"/> Panic attacks     | <input type="checkbox"/> Withdrawing/Isolating          |
| <input type="checkbox"/> Eating disorder          | <input type="checkbox"/> Paranoia          | <input type="checkbox"/> Worrying                       |

Other mental health concerns (specify): \_\_\_\_\_

**Medical/Physical Health:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Seasonal Allergies  | <input type="checkbox"/> Fibromyalgia                | <input type="checkbox"/> Sleeping disorders - type: _____                         |
| <input type="checkbox"/> Anemia  | <input type="checkbox"/> Fainting                    | <input type="checkbox"/> Hepatitis-type: _____                                    |
| <input type="checkbox"/> Lupus   | <input type="checkbox"/> Mononucleosis               | <input type="checkbox"/> Migraine Headaches: ~ <input type="checkbox"/> Menstrual |
| <input type="checkbox"/> High blood pressure   | <input type="checkbox"/> Thyroid problems            | <input type="checkbox"/> Neurological disorders-type: _____                       |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Headaches (non-migraine)    | <input type="checkbox"/> Seizures-type: _____                                     |
| <input type="checkbox"/> Migraine Headaches  | <input type="checkbox"/> COPD/Emphysema              | <input type="checkbox"/> Sexual problems-type: _____                              |
| <input type="checkbox"/> Bed wetting   | <input type="checkbox"/> Epilepsy-type: _____        | <input type="checkbox"/> Chronic pain-type: _____                                 |
| <input type="checkbox"/> Cardiac Event/Heart Attack(s)   | <input type="checkbox"/> Arthritis-type: _____       | <input type="checkbox"/> Cancer-type: _____                                       |
| <input type="checkbox"/> Diabetes: <input type="checkbox"/> DM Type 1 <input type="checkbox"/> DM Type 2 | <input type="checkbox"/> Kidney problems-type: _____ | <input type="checkbox"/> Head Trauma (w/ Loss of Consciousness): # _____          |

<input type="checkbox"/> YES (list below)	<input type="checkbox"/> NO	ANY KNOWN DRUG/MEDICATION ALLERGIES?	
Medication	Allergic Reaction	Medication	Allergic Reaction

<input type="checkbox"/> YES (list below)	<input type="checkbox"/> NO	ANY PAST SURGERIES?	
Surgery	When? (Mo/Yr)	Surgery	When? (Mo/Yr)

Pt's name: \_\_\_\_\_ Date of Appointment: \_\_\_\_\_

**Family Information**

Please give the names of family members and significant others in your life beginning with those living in your home currently. Significant others may include: (e.g., brothers, sisters, grandparents, step-relatives, half-relatives. Please specify relationship.)

Relationship	Name	Age	Living in Home		Living	
			Yes	No	Yes	No

**Current Marital Status:** (more than one answer may apply)

*Assessment of current relationship (if applicable):*  Great  Good  Average  Poor  Abusive

Marital Status	For How Long? (months/years)	Marital Status	For How Long? (months/years)
Single		Single; Stable Relationship	
Married		Unmarried, Living Together	
Divorced		Widowed	
Separated		Annulled	
Total Number of Marriages (Past and Present)			

**Parental Marital Information:**

Parental Marital Status	For How Long? (months/years)	Parental Marital Status
Legally Married		Number of times Mother Married
Parents Separated		Number of times Father Married
Parents Divorced		

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.):

\_\_\_\_\_

\_\_\_\_\_

**Education**

Highest Grade	# of Years	Graduate?	Degree?	Grades	Major(s):	504? IEP??
High School		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> As <input type="checkbox"/> Bs <input type="checkbox"/> Cs <input type="checkbox"/> Ds		<input type="checkbox"/> Yes-504 <input type="checkbox"/> Yes-IEP <input type="checkbox"/> No either
GED		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> As <input type="checkbox"/> Bs <input type="checkbox"/> Cs <input type="checkbox"/> Ds		<input type="checkbox"/> Yes-504 <input type="checkbox"/> Yes-IEP <input type="checkbox"/> No either
Vocational/Tech		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> As <input type="checkbox"/> Bs <input type="checkbox"/> Cs <input type="checkbox"/> Ds		<input type="checkbox"/> Yes-504 <input type="checkbox"/> Yes-IEP <input type="checkbox"/> No either
College		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> As <input type="checkbox"/> Bs <input type="checkbox"/> Cs <input type="checkbox"/> Ds		<input type="checkbox"/> Yes-504 <input type="checkbox"/> Yes-IEP <input type="checkbox"/> No either
Graduate School		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> As <input type="checkbox"/> Bs <input type="checkbox"/> Cs <input type="checkbox"/> Ds		
Professional		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> As <input type="checkbox"/> Bs <input type="checkbox"/> Cs <input type="checkbox"/> Ds		

**Employment and Military Experience**

**Current Employment Status:**

Full-time  Part-time  Student  Homemaker  Disabled  Retired  Temporary Work  Laid-off

Current Job Description: \_\_\_\_\_ Employer: \_\_\_\_\_

Past Job Description: \_\_\_\_\_ Employer: \_\_\_\_\_

Past Job Description: \_\_\_\_\_ Employer: \_\_\_\_\_

**Military Experience:**

Military experience?  Yes  No Combat experience?  Yes  No # Tours: \_\_\_\_\_ Where: \_\_\_\_\_

Branch: \_\_\_\_\_ Discharge date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Mo/Yr enlisted: \_\_\_\_ / \_\_\_\_ Type of discharge: \_\_\_\_\_ Rank at discharge: \_\_\_\_\_

**Legal**

**Current Status**

Are you involved in any active cases (traffic, civil, criminal)?  No  Yes ~ Describe: \_\_\_\_\_ Are you presently on probation or parole?  No  Yes

**Past History**

Traffic violations:  No  Yes ~ How Many? \_\_\_\_\_ DWAI, DUI, etc.:  No  Yes ~ How Many? \_\_\_\_\_

Criminal involvement:  No  Yes ~ How Many? \_\_\_\_\_ Civil involvement:  No  Yes ~ How Many? \_\_\_\_\_

Charges/Arrests	Date (Mo/Yr)	Where (City/State)	Results

PT's name: \_\_\_\_\_ Date of Appointment: \_\_\_\_\_

**Leisure/Recreational**

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	What keeps you from doing the activity more than current?

**Spiritual/Religious**

<b>How important to you is religion/spirituality</b>	<input type="checkbox"/> None	<input type="checkbox"/> Little	<input type="checkbox"/> Moderate	<input type="checkbox"/> Very Much
<b>Are you currently affiliated with a spiritual/religious group?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>Describe:</b> _____		
<b>Were you raised within a spiritual/religious belief?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>Describe:</b> _____		

**Abuse History**

Are there special, unusual, or traumatic circumstances that affected your development?  Yes  No

If Yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Type of Abuse:	Age Started	Age Stopped	Reported?	Prosecuted?	One or Multiple Occurrences?	Did You Receive Treatment?
<input type="checkbox"/> Sexual <input type="checkbox"/> Physical <input type="checkbox"/> Emotional <input type="checkbox"/> Neglect			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> One <input type="checkbox"/> Multiple	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Sexual <input type="checkbox"/> Physical <input type="checkbox"/> Emotional <input type="checkbox"/> Neglect			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> One <input type="checkbox"/> Multiple	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Sexual <input type="checkbox"/> Physical <input type="checkbox"/> Emotional <input type="checkbox"/> Neglect			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> One <input type="checkbox"/> Multiple	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Sexual <input type="checkbox"/> Physical <input type="checkbox"/> Emotional <input type="checkbox"/> Neglect			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> One <input type="checkbox"/> Multiple	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Sexual <input type="checkbox"/> Physical <input type="checkbox"/> Emotional <input type="checkbox"/> Neglect			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> One <input type="checkbox"/> Multiple	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Drug/Substance Use History**

Substance Use Abuse/Dependence History	Amount Used	Frequency of Use	Age First Used	Age Last Used	Used Last 72 hours		Used Last 30 days	
	(drinks/cups/cigs/grams/vials/bags/ # and mg of pills)	(daily/weekly/monthly)			Yes	No	Yes	No
Alcohol								
Barbiturates								
Benzodiazepines								
Cocaine/Crack								
Heroin/Opiates								
Marijuana/THC/Synthetics								
PCP/LSD/Mescaline								
Inhalants								
Caffeine								
Nicotine								
Over the counter								
Prescription drugs								
Other drugs								

Clean and Sober for how long? \_\_\_\_\_ weeks \_\_\_\_\_ months \_\_\_\_\_ years

	Drug/Substance(s) of Preference:	What do/did you like about the specific Drug/Substance?
1.		
2.		
3.		



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Pt's name: \_\_\_\_\_

Date of Appointment: \_\_\_\_\_

FAMILY PSYCHIATRIC HISTORY	PATIENT	Nuclear Family						Maternal Side					Paternal Side						
		Mother	Father	Sister	Brother	Daughter	Son	Grandmother	Grandfather	Aunt	Uncle	Cousin	UNKNOWN	Grandmother	Grandfather	Aunt	Uncle	Cousin	UNKNOWN
Psychiatric Hospitalizations																			
Bipolar/Manic Depression																			
Depression																			
ADD/ADHD																			
Alcohol Abuse																			
Substance Abuse																			
Schizophrenia/Psychosis																			
Schizoaffective																			
Panic/Anxiety																			
Suicide Attempt																			
Suicide Completed																			
Developmental Delays																			
Suspected Mental Illness																			
Relative was Adopted																			
Other: _____																			
Other: _____																			
Other: _____																			

Past Types of Treatment	When Last Seen		Duration		Frequency	Response	Name/Comments of Past Psychotherapists/IOP/PHP Hospital and/or ER Visits
	Month	Year	# Mos	# Yrs	Xs/Mo	+++/--	
Psychiatrist (Meds) – First Time							
Psychiatrist (Meds) – Last Time							
Individual Therapy – First Time							
Individual Therapy – Last Time							
Family Therapy – First Time							
Family Therapy – Last Time							
Group Therapy – First Time							
Group Therapy – Last Time							
Intensive Outpatient - First							
Intensive Outpatient - Last							
Partial Hospitalization – First							
Partial Hospitalization - Last							
Inpatient Hospitalization – First							
Inpatient Hospitalization - Last							
Drug/Alcohol Rehab - First							
Drug/Alcohol Rehab - Last							
AA/Al-Anon/NA – First							
AA/Al-Anon/NA – Last							
ER Mental Health Visit - Last							
Other: _____							
Other: _____							
Other: _____							
Other: _____							