Wise Psychiatry

6053 S. Quebec Street ~ Suite 203
Centennial, CO 80111

PATIENT DEMOGRAPHICS
INSURANCE / AOB

Phone: 720.708.4287
Fax: 720.815.2581

First _____ Last _____ M.I. ____ Preferred Name _____
Street Address _____ Apt. _____
City _____ State ____ Zip _____ Email _____

DOB _____ Gender _____ Marital Status: Single Married Divorced Widowed

May we send a confidential voice message or send an appointment reminder text using any of the numbers below?

Home Phone _____ Cell Phone _____ Work Phone _____
☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

GUARANTOR Name _____ Relationship _____ DOB _____
Street Address _____ City _____ State ____ Zip _____
Email _____

May we leave a confidential voice message at any of the numbers below?

Home Phone _____ Cell Phone _____ Work Phone _____
☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

PREFERRED PHARMACY Name _____ Phone Number _____

Address _____

INSURANCE INFORMATION - Patient has: Private Insurance Medicare Medicaid Tricare None / SELF PAY

Primary insurance _____ Address _____
Provider services phone number _____ Policy Effective Date _____
Policy Holder's name _____ DOB _____ Relationship _____
Policy# _____ Group #_____ BIN_____ PCN_____

Secondary insurance _____ Address _____
Provider services phone number _____ Policy Effective Date _____
Policy Holder's name _____ DOB _____ Relationship _____
Policy# _____ Group #_____ BIN_____ PCN_____

REQUIRED: PLEASE PROVIDE IMAGES OF THE FRONT AND BACK OF YOUR INSURANCE CARD, VIA EMAIL TO OFFICE@WISEPSYCH.COM OR VIA ONPATIENT PORTAL MESSAGE.

ASSIGNMENT OF BENEFITS - Our office will accept an assignment of benefits from your insurance company. The contract regarding your benefits is between you, your employer, and your insurance company. We are not responsible for the outcome of claims submitted. We do not guarantee that insurance will pay for treatment you receive from our practice. If your claim is denied, you will be responsible for paying the full amount. Patients must sign this form and any other documents required by insurance. This instructs your insurance company to make payment directly to our office. Patients must pay the co-payment (the amount not covered by insurance) at the time the service is provided. Our office will not enter a dispute with your insurance company over a claim, beyond providing requested documentation to support the claim. We will follow the regulations of your insurance company. It is the patient's responsibility to resolve disputes 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. I accept financial responsibility for charges incurred by the above-named patient.

GUARANTOR SIGNATURE:_____ **DATE:**_____

Printed Name: _____

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HIPAA EMAIL CONSENT

EMAIL CORRESPONDENCE

DISCLOSURE OF PRIVATE HEALTH INFORMATION

Our office offers optional e-mail and patient portal correspondence to address questions and concerns regarding your care. **Email communication or portal messaging will not substitute for follow-up visits with the clinician.** In reply to your e-mail, you may be instructed to follow up via an office/video visit.

The contents of the clinician's e-mails may reference personal health information, which may 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 e-mails regardless of how it occurred.

HIPAA (the Health Insurance Portability and Accountability Act) was passed by the U.S. government in 1996 to establish privacy and security protections for health information. Under the HIPAA Privacy Rule patients may request that a healthcare provider communicate with him/her by alternative means. **When we send you an email, or you send us an email, the information that is sent may not be encrypted.** This means that a third party may be able to access the information since it is transmitted over the Internet. Also, once you receive it, someone may access your email account and read it. When an individual initiates email communication with a healthcare provider, the provider can assume that email communications are acceptable. On the other hand, when the provider initiates email communication with an individual, the provider must get consent from the individual.

We highly recommend communication solely through our online portal, OnPatient, which is completely secure. Information conveyed through the OnPatient portal is also preserved as part of your patient record.

However, scheduling, billing and other communications may occur outside of OnPatient, through secure emails. Reminders of upcoming appointments are sent automatically via e-mail and text, and this cannot be changed.

PLEASE CHOOSE ONE OPTION BELOW.

☐ I, (print name)_____have read and understood the information above. **Secure email is an acceptable option for providers and office staff to communicate with me about my care.** I will be responsible for securing private emails, once they reach my email box, and are displayed on my own computer. Patient name (if different from signer)_____

Please use the following email address: _____

☐ I (print name) _____have read and understood the information above. **I do not wish to receive emails pertaining to my care**, and prefer to communicate entirely through the OnPatient portal. Reminders of upcoming appointments are sent automatically via e-mail and text, and this cannot be changed. Patient name (if different from signer) _____

PLEASE SIGN.

_____ _____

Signature Date

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CUSTODIAL/CONSENT

CUSTODIAL INFORMATION

In circumstances involving separation or divorce, we request that one individual be responsible for all appointments and billing. Please provide us a copy of any legal documents establishing custodial arrangements, and update them whenever necessary. If family members are unwilling or unable to follow this agreement, ongoing care may be transferred elsewhere.

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

_____

_____

_____

_____

Primary Contact Responsible for appointment scheduling and billing _____

Preferred Contact Information _____

Parent Names _____ _____

Parent Signatures _____ _____

Date _____

CONSENT TO SHARE INFORMATION WITH FAMILY MEMBERS

(Must be signed by patients over the age of 18 who CHOOSE to include parents or others in their care)

Patient Name _____ SS# _____ Birth Date: _____

I understand that the information contained in medical records is confidential. However, if I would like to have any family members/friends involved in my care, I must specifically provide consent. **I consent for Wise Psychiatry to share information about my care with the following individuals:**

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

By written request, this consent may be revoked at any time. The consent will automatically expire no later than one (1) year from the date signed, unless otherwise stated.

It is further understood that the information released should not be provided in whole or in part to any agency, organization, or person other than stated above. I understand that treatment services are not contingent upon my signing or not signing this consent form. I freely and voluntarily consent to this release of information.

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) prohibit 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 PART 2.

Signature of Patient: _____ Date: _____

Printed Name of Signer: _____

OTHER NAMES PATIENT MAY BE KNOWN AS (Maiden, Married) _____

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FINANCIAL POLICIES

We will bill your insurance and send you a statement for any balance due. These statements will be sent to your OnPatient portal for privacy, security, and ease of use. Please note that any balance due from you per your insurance carrier should be paid immediately. If you are unable to pay your balance in full, please contact us to arrange a payment plan that fits your needs. ***Balances of less than $100 may not be eligible for a payment plan.***

PAYMENT PLAN OPTIONS - Please note that any payment plan that is not adhered to or defaults will be sent to Collections for balance resolution. **ALL Payment Plans require that a credit/debit card be kept on file.** Payments will be run automatically until the balance is resolved.

Option 1: Initial Payment - 25% of your total outstanding balance, 3 Recurring Payments - weekly or bi-weekly

Option 2: Initial Payment - 50% of your total outstanding balance, 2 Recurring Payments - weekly or bi-weekly

Option 3: Initial Payment - 75% of your total outstanding balance, 1 Recurring Payment of remaining balance

Option 4: A one-time payment of the balance in full, no credit/debit card on file necessary.

COLLECTIONS - Any balance still open after ninety (90) days without a payment plan in place may be sent to Collections. You may be placed on appointment/medication restriction until the balance is resolved. You will be responsible for the **28% COLLECTIONS FEE** per date of service sent to Collections, even if you pay the balance directly to the practice. Wise Psychiatry partners with: Colorado Collections.

SELF-PAY PAYMENT POLICY - All self-pay patients are required to have a credit/debit card on file which will be charged for self-pay services prior to each appointment. *Prices may vary if additional services are rendered.

PROVIDER	20 MIN SESSION	30 MIN SESSION	40 MIN SESSION	60 MIN SESSION
Dr. Brian Wise	$195.00		$390.00	$585.00
Kate Ziesenheim, PA		$145.00		$390.00
Ashley Tetrault, APN		$130.00		$360.00
Laine Morgan, NP		$130.00		$360.00
Hope Manning, PA		$100.00		$300.00

NO SHOW / LATE CANCELLATION FEES - To avoid these fees, please call at least 24 hours before the appointment to cancel or reschedule. No Show Fees CANNOT be billed to insurance and are the financial responsibility of the patient. No Show Fees must be paid prior to rescheduling any appointment.

No Show Fees for New Patient Appointments (1 hour) - 50% of the appointment cost

Provider	New Patient Appt Charges	No Show Charge
Dr. Brian Wise	$535.00	$268.00
Kate Ziesenheim	$385.00	$193.00
Ashley Tetrault	$310.00	$155.00
Laine Morgan	$310.00	$155.00
Hope Manning	$270.00	$135.00

No Show Fees for followup appointments will be the full reimbursement amount from your insurance provider. No Show Fees for Self Pay appointments will be half the cost of the Self Pay appointment.

By signing below I acknowledge that I am the responsible party for this patient account, and I have read, understand, and agree to the Wise Psychiatry Financial Policies and charges outlined above.

Patient Name (printed) _____

Guarantor's Name (printed) _____

Signature _____ Date _____

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Privacy Official - Catherine Wise, Office Manager
Phone - 720-708-4287
Email - office@wisepsych.com

***This notice describes how medical information about you may be used and disclosed and how you can get access to this information*. Please review it carefully.**

YOUR RIGHTS - When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. *NOTE - as a mental health practice, Wise Psychiatry does not provide psychotherapy notes to our patients - only to another agency, or a new provider.*
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (i.e. home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice - You can ask for a paper copy of this notice at any time, even if you have received the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. Legal documentation of this must be provided to the practice, to ensure the person has this authority and can act for you, before we take any action.

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File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

YOUR CHOICES - For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care (indicated on a Release of Information form, signed by you)
- Share information in a disaster relief situation
- If you are not able to tell us your preference, (i.e. if you are unconscious), we may share your information if it is in your best interest, or when needed to lessen a serious and imminent threat to health or safety.
- We never share your psychotherapy notes unless you give us written permission. (Psychotherapy notes are never shared directly to the patient or family members - only to another health care professional or an agency)

OUR USES AND DISCLOSURES - We typically use/share your health information in the following ways:

Treat you - We can use your health information and share it with other professionals who are treating you, with written permission from you (on a Release of Information form signed by you). We would do this without written permission ONLY if you appear to be in danger, or to be dangerous to others.

Run our organization - We can use/share your health information to run our practice, improve your care, and contact you when necessary.

Bill for services - We can use/share your health information to bill and get payment from health plans or other entities.

We are allowed or required to share your information in ways that contribute to the public good, such as public health and research - We have to meet many conditions in the law before we can share your information for these purposes. Visit: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues -

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research - We can use or share your information for health research.

Comply with the law - We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

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Work with a medical examiner or funeral director - We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests -

- For workers' compensation or disability claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions - We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice - We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

By signing below I indicate that I have read and understood the HIPAA PRIVACY PRACTICES provided to me by Wise Psychiatry.

PATIENT NAME (printed) _____

Signature of Patient _____ Date: _____

GUARDIAN NAME (printed) _____

Signature of Guardian _____ Date: _____

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REASONS FOR SEEKING SERVICES

Primary reason(s) for seeking services:

- ☐ Aggression
- ☐ Argumentative
- ☐ Alcohol dependence
- ☐ Anger
- ☐ Anxiety
- ☐ Avoiding people
- ☐ Coping Skills
- ☐ Cyber addiction
- ☐ Depression
- ☐ Thoughts Racing
- ☐ Distractibility
- ☐ Dizziness
- ☐ Drug dependence
- ☐ Eating disorder
- ☐ Elevated mood
- ☐ Fatigue
- ☐ Frustrated
- ☐ Hallucinations
- ☐ Hopelessness
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Irritability
- ☐ Judgment errors
- ☐ Loneliness
- ☐ Memory impairment
- ☐ Mood shifts
- ☐ Panic attacks
- ☐ Paranoia
- ☐ Parenting Concerns/Issues
- ☐ Phobias/fears
- ☐ Recurring thoughts/Ruminations
- ☐ Sexual addiction
- ☐ Sexual difficulties
- ☐ Sick often
- ☐ Sleeping problems
- ☐ Self-Injurious Behaviors/Cutting
- ☐ Suicidal thoughts
- ☐ Thoughts disorganized
- ☐ Traumatic experience(s)
- ☐ Tremors/Trembling
- ☐ Withdrawing/Isolating
- ☐ Worrying

Other mental health concerns (specify): _____

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PHYSICAL HEALTH / OTHER PROVIDERS

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□ General Symptoms: □ Weight Loss □ Weight Gain □ Fever □ Chills □ Fatigue □ "Wired and Tired" □ Chronic Pain

□ Eyes/Ears/Nose/Throat: □ Blurred/Worse Vision □ Sore Throat □ Ringing in ears □ Sinusitis □ Bloody Noses □ Eye Pain/Dry Eyes

□ Respiratory/Pulmonary: □ Asthma □ RAD □ Chronic Cough □ Shortness of Breath □ COPD/Emphysema

□ Cardiac/Vascular: □ Chest Pain □ Hypertension □ Heart Palpitations □ Syncope/Fainting □ Swelling/Edema □ Heart Attacks

□ Gastrointestinal: □ Nausea/Vomiting □ Diarrhea □ Constipation □ Reflux/GERD □ Encopresis □ Hepatitis B/C

□ Genitourinary: □ Enuresis □ Burning Urination □ Kidney Disease □ Erectile Dysfunction □ Loss of Labido □ Not able to Orgasm

□ Musculoskeletal: □ Muscle Aches □ Joint Aches □ Muscle Weakness/Hypotonia □ Joint Laxity/Hyperelasticity

□ Skin/Dermatologic: □ Acne □ Eczema/Dermatitis □ Rash □ Itching □ Bruises easily □ Vasculitis

□ Neurological: □ Seizures/Epilepsy □ Migraine Headaches □ Headaches □ Tremors □ Dizzy/Vertigo □ Concussions □ Head Trauma

□ Endocrine: □ Hypothyroid □ Diabetes I or II □ Adrenal Fatigue □ Always Cold □ Always Hot □ Hasimoto's Thyroiditis

□ Hematology/Oncology: □ Anemia □ Easily Bruise □ Blood Clots □ Swollen Glands □ History of Cancer – please list below

□ Rheumatologic/Autoimmune: □ Arthritis □ Fibromyalgia □ Lupus □ Chronic Fatigue

□ Allergy/Immunity: □ Sinusitis/Rhinitis □ Hives □ Immunodeficiency □ Sick Often □ Mold Exposure □ Chronic Fatigue

Other Doctors/Healthcare Providers with Name/Practice/Address/Phone/Fax

Primary Care Physician: _____

Other Doctors: _____

Other Doctors: _____

Other Doctors: _____

Other Doctors: _____

YES (list below)	NO	ANY KNOWN DRUG/MEDICATION ALLERGIES?		
Medication Allergies		**Allergic Reaction**	**Medication**	**Allergic Reaction**

YES (list below)	NO	ANY PAST SURGERIES?		
Surgery		**When? (Mo/Yr)**	**Surgery**	**When? (Mo/Yr)**

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PERSONAL HISTORY - 1

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.)

NAME	Relationship	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??
Elementary School		☐ Y ☐ N		As Bs Cs Ds		
Middle School		☐ Y ☐ N		As Bs Cs Ds		
High School		☐ Y ☐ N		As Bs Cs Ds		
College		☐ Y ☐ N		As Bs Cs Ds		
Graduate School		☐ Y ☐ N		As Bs Cs Ds		
Professional		☐ Y ☐ N		As Bs Cs Ds		

Employment and Military Experience

Current Employment Status:

☐ Full-time ☐Part-time ☐ Student ☐ Homemaker ☐ Disabled ☐ Retired ☐ Temp 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

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PERSONAL HISTORY - 2

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

How important to you is religion/spirituality?	None		Little	Moderate	Very Much
Were you raised within a spiritual/religious belief?	No	Yes	Describe:		
Are you currently affiliated with a spiritual/religious group?	No	Yes	Describe:		

Abuse History

Are there special, unusual, or traumatic circumstances that affected your development? □ Yes □ No
If Yes, please describe: _____

Type of Abuse:	Number of Separate Incidents	Age Started	Age Stopped	Reported?	Prosecuted?
Sexual – Physical – Emotional – Neglect					
Sexual – Physical – Emotional – Neglect					
Sexual – Physical – Emotional – Neglect					
Sexual – Physical – Emotional – Neglect					
Sexual – Physical – Emotional – Neglect					
Sexual – Physical – Emotional – Neglect					

Drug/Substance Use History

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

Clean and Sober for how long? _____ Years _____Months

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

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PERSONAL HISTORY - 3

Please fill out the below medication history form as thoroughly as possible so that we can know what medications you have tried before and what effect they had on you. Although medications can be used for multiple reasons, it is helpful for us to know if you have been prescribed or tried any of these medications for any reason at all.

PAST MEDICATIONS TAKEN	When		Duration		Dose/Day		Response	Side Effects/Comments
Mood Stabilizers	Mo	Year	# Mos	# Years	Min	Max	+++/---	Side Effects/Comments
Lithium/Eskalith/Lithobid								
Depakote (ER)/Valproate								
Tegretol/Carbatrol								
Lamictal/Lamotrigine								
Trileptal/Oxcarbamazepine								
Topamax/Topiramate								
Gabapentin/Neurontin								
Lyrica								
Antidepressants	Mo	Year	# Mos	# Years	Min	Max	+++/---	Side Effects/Comments
Zoloft/Sertraline								
Lexapro/Escitalopram								
Celexa/Citalopram								
Prozac/Fluoxetine								
Paxil (CR)/Paroxetine								
Wellbutrin (SR) (XL)								
Cymbalta								
Effexor XR/Venlafaxine/Pristiq								
Remeron/Mirtazapine								
Brintillix								
Other:								
Anxiolytics	Mo	Year	# Mos	# Years	Min	Max	+++/---	Side Effects/Comments
Ativan/Xanax/Klonopin/Valium								
Buspirone/Buspar								
Beta blocker/Inderal								
Antipsychotics	Mo	Year	# Mos	# Years	Min	Max	+++/---	Side Effects/Comments
Risperdal and/or Invega								
Seroquel (XR)/Quetiapine								
Abilify/Aripipazole								
Geodon/Ziprasidone								
Zyprexa/Olanzapine								
Latuda/Lurasidone								
Other:								
ADHD Meds/Stimulants	Mo	Year	# Mos	# Years	Min	Max	+++/---	Side Effects/Comments
Adderall (XR)								
Vyvanse								
Dexedrine								
Concerta								
Daytrana patch								
Ritalin/Ritalin SR/Ritalin LA								
Focalin/Focalin XR								
Strattera								
Intuniv/Tenex/Guanfacine								
Clonidine								
Provigil/Nuvigil								
Sleepers/Hypnotics	Mo	Year	# Mos	# Years	Min	Max	+++/---	Side Effects/Comments
Ambien (CR)								
Lunesta								
Trazadone								
Melatonin								
Other:								
OTHER MEDS/SUPPLEMENTS	Mo	Year	# Mos	# Years	Min	Max	+++/---	Side Effects/Comments

Wise Psychiatry

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PERSONAL HISTORY - 4

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																			
Post-Traumatic Stress Disorder																			
Obsessive-Compulsive Disorder																			
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	# Yrs	# Mos	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: _____							