Patient Name: ___________________________ DOB: _______________________

Limitations on Confidential Nature of Communications

Communications between a licensed psychologist, psychiatrist, licensed clinical social worker, or licensed professional counselor and the patient are confidential and will not be released without the expressed authorization of the patient. However, certain communication may occur where confidentiality is limited. They are as follows:

- Should a provider believe the patient is a threat to others or themselves
- When records are ordered to be released by a Judge or Court
- When information involves child abuse or abuse of the elderly
- When information is given about the transmission of contagious or transmittable diseases
- Should the patient's account be turned over to an attorney/collection agency for non-payment
- When you are determined incapacitated by your health care provider information may be given to your guardian or medical power of attorney

I acknowledge that I understand and agree to the above payment policy and limitations of confidentiality.

_____________________________________ _________________

Patient/Parent/ Responsible Party Date

_____________________________________ _________________

Staff Date

Consent to Treat

I understand that as in all types of medical and psychological treatment, there are certain risks. This includes the general risk that there may be emotional pain, stress, and/or life changes associated with mental health treatment helps many individuals, it is not always completely effective. I hereby give written consent for mental health treatment. My clinician will inform me of other specific treatment risks that may be involved in my case, and/or I will ask any questions I may have about specific treatment risks.

_____________________________________ _________________

Patient/Parent/ Responsible Party Date

Understanding Health Information Privacy

The HIPAA Privacy Rule provides federal protections for individually identifiable health information held by covered entities and their business associates and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of health information needed for patient care and other important purposes. HMC can receive and share health information with other health professionals and hospitals who are treating you.

The Security Rule specifies a series of administrative, physical, and technical safeguards for covered entities and their business associates to use to assure the confidentiality, integrity, and availability of electronic protected health information.

By completing below, I am acknowledging that I have read the Highland Medical Center's Privacy Notice, have been offered a copy, and had an opportunity to ask question.

Printed Name of Patient: ____

Date of Birth of Patient: ____________________________

Printed Name of Guardian, if appropriate: ____________________________________

Signature of Patient or Guardian: ______________________________Date: ______________

RELEASE OF INFORMATION

Often it is difficult to reach a patient to convey physician orders or test results. In this event, with your signed authorization, we would release such information to a person you designate. Please complete the section below.

I authorize Highland Medical Center, Inc. to release any information required in the course of my examination or treatment to the following designated person(s):

PLEASE CIRCLE WHICH ONE IS YOUR EMERGENCY CONTACT

Name: ______________________________ Relationship & Phone #: __________________________

Name: ______________________________ Relationship & Phone #: __________________________

Name: ______________________________ Relationship & Phone #: __________________________

ADVANCE DIRECTIVE (Living Will/ Medical Power of Attorney)

An Advance Directive is a legal document that states your wishes regarding medical treatment in the event that you are unable to communicate these decisions. *It is very important that all of your healthcare providers have a current copy of these documents.*

____ I HAVE completed an Advance Directive.
Copy provided to HMC? Yes / No

____ I HAVE NOT completed an Advance Directive.
I would like more information. Yes / No

Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you!

Name____**Date**___________________

Date of Birth____________________**Primary Care Physician** ______________________________________

Do you give permission for ongoing regular updates to be provided to your primary care physician? __________

Current Therapist/Counselor_________________________**Therapist's Phone**_________________________

What are you being seen for?

1.____
2.____
3.____

What are your treatment goals?

____
____
____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

( ) Depressed mood
( ) Unable to enjoy activities
( ) Sleep pattern disturbance
( ) Loss of interest
( ) Concentration/forgetfulness
( ) Change in appetite
( ) Excessive guilt
( ) Fatigue
( ) Decreased libido
( ) Racing thoughts
( ) Impulsivity
( ) Increase risky behavior
( ) Increased libido
( ) Decrease need for sleep
( ) Excessive energy
( ) Increased irritability
( ) Crying spells
( ) Excessive worry
( ) Anxiety attacks
( ) Avoidance
( ) Hallucinations
( ) Suspiciousness
( ) ________________
( ) ________________

Past Medical History:

Past Medical problems, nonpsychiatric hospitalization, or surgeries:
____
____
____
____

Have you ever had an EKG? ( ) Yes ( ) No If yes, when and the reason for EKG
____
____

Was the EKG ( ) normal ( ) abnormal or ( ) unknown

For women only:

Date of last menstrual period________________________

Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No

Are you planning to get pregnant in the near future? ( ) Yes ( ) No

Birth control method __________________________

How many times have you been pregnant?_________How many live births? _________

Relationship History and Current Family:

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed

How long? ___________________

If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? ____________________

Are you sexually active? ( ) Yes ( ) No

How would you identify your sexual orientation?

( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual

( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer

What is your spouse or significant other's occupation? ____

Describe your relationship with your spouse or significant other:

____

Have you had any prior marriages? ( ) Yes ( ) No.

If yes, how many? and How long? ______________________________________

Do you have children? ( ) Yes ( ) No

If yes, list ages and gender: ____

Family Medical History (what medical problems and which family member) :

____

____

____

____

____

____

____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	( ) Yes	( ) No	Schizophrenia	( ) Yes	( ) No
Depression	( ) Yes	( ) No	Post-traumatic stress	( ) Yes	( ) No
Anxiety	( ) Yes	( ) No	Alcohol abuse	( ) Yes	( ) No
Anger	( ) Yes	( ) No	Other substance abuse	( ) Yes	( ) No
Suicide	( ) Yes	( ) No	Violence	( ) Yes	( ) No

If yes, please explain

____

____

Have any family members been treated with a psychiatric medication? ( ) Yes ( ) No

If yes, please explain?

____

____

Childhood History:

Were you adopted? ( ) Yes ( ) No Where did you grow up? ______

List your siblings and their ages: ______

______

What is or was your father's occupation? ______

What is or was your mother's occupation? ______

Describe your father and your relationship with him: ______

______

Describe your mother and your relationship with her: ______

______

Did your parents' divorce? ( ) Yes ( ) No If so, how old were you when they divorced? ______

______

If your parents divorced, who did you live with? ______

How old were you when you left home? ______

Has anyone in your immediate family died? ______

Who and when? ______

Past Psychiatric History

Outpatient treatment ( ) Yes ( ) No

If yes, please describe when, by whom, and nature of treatment.

Reason	Dates Treated	By Whom

Psychiatric Hospitalization ( ) Yes ( ) No

If yes, describe for what reason, when and where.

Reason	Year/Date Hospitalized	Where

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

	Dates	Dosage	Response/Side-Effects
Antidepressants			
Prozac (fluoxetine)			
Zoloft (sertraline)			
Luvox (fluvoxamine)			
Paxil (paroxetine)			
Celexa (citalopram)			
Lexapro (escitalopram)			
Effexor (venlafaxine)			
Cymbalta (duloxetine)			
Wellbutrin (bupropion)			
Remeron (mirtazapine)			
Serzone (nefazodone)			
Anafranil (clomipramine)			

Pamelor (nortrptyline) ____
Tofranil (imipramine) ____
Elavil (amitriptyline) ____
Other____

Mood Stabilizers

Tegretol (carbamazepine)____
Lithium____
Depakote (valproate) ____
Lamictal (lamotrigine) ____
Topamax (topiramate) ____
Other ____

Antipsychotics/Mood Stabilizers	Dates	Dosage	Response/Side-Effects

Seroquel (quetiapine) ____
Zyprexa (olanzepine) ____
Geodon (ziprasidone) ____
Abilify (aripiprazole) ____
Clozaril (clozapine) ____
Haldol (haloperidol) ____
Prolixin (fluphenazine) ____
Risperdal (risperidone) ____
Other____

Sedative/Hypnotics

Ambien (zolpidem) ____
Sonata (zaleplon) ____
Rozerem (ramelteon)____
Restoril (temazepam) ____
Desyrel (trazodone) ____
Other____

ADHD medications

Adderall (amphetamine) ____
Concerta (methylphenidate) ____
Ritalin (methylphenidate) ____
Strattera (atomoxetine) ____
Other____

Antianxiety medications

Xanax (alprazolam) ____
Ativan (lorazepam)____
Klonopin (clonazepam) ____
Valium (diazepam) ____
Tranxene (clorazepate) ____
Buspar (buspirone) ____
Other ____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No
If Yes, for which substances?____
Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No
Have you used any street drugs in the past 3 months? ( ) Yes ( ) No
If yes, which ones? ____
Have you ever abused prescription medication? ( ) Yes ( ) No
If yes, which ones and for how long? ____

Check if you have ever tried the following:

	Yes	No	If yes, how long and when did you last use?
Methamphetamine	( )	( )	________________
Cocaine	( )	( )	________________
Stimulants (pills)	( )	( )	________________
Heroin	( )	( )	________________
LSD or Hallucinogens	( )	( )	________________
Marijuana	( )	( )	________________
Pain killers (not as prescribed)	( )	( )	________________
Methadone	( )	( )	________________
Tranquilizer/sleeping pills	( )	( )	________________
Alcohol	( )	( )	________________
Ecstasy	( )	( )	________________
Other			________________

How many caffeinated beverages do you drink a day? Coffee _______ Sodas ________ Tea ________

Tobacco History:

Have you ever smoked cigarettes? ( ) Yes ( ) No

Currently? **( )** Yes **( )** No How many packs per day on average? ____________ How many years? __________

In the past? **( )** Yes **( )** No How many years did you smoke? _________ When did you quit? ______________

Pipe, cigars, or chewing tobacco: Currently? **( )** Yes **( )** No In the past? **( )** Yes **( )** No What kind?________________How often per day on average?_______How many years? _____________

Education History

Highest Grade Completed? ___________________________ Where?____________________________________

Did you attend college?_________Where?___________________________Major?__________________________

What is your highest educational level or degree attained? ____

Occupational History:

Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired

How long in present position? ____

What is/was your occupation? ____

Where do you work? ____

Have you ever served in the military?________If so, what branch and when? ______________________________

Honorable discharge ( ) Yes ( ) No Other type discharge____

Signature____Date________________________________

Guardian Signature (if under age 18)_____________________________Date_________________________________

Emergency Contact____Telephone # ________________________

HMC
HIGHLAND MEDICAL CENTER
Caring for the health of the Highlands

Patient Name: ___________________________ DOB: ______________ Date: _____________

PHQ9
(Age 18 and up)

How often have you been bothered by the following over the past 2 weeks?

0- None; 1- Several days; 2- More than half the days; 3- Nearly every day

Question				
1) Have you had little interest or pleasure in doing things	**0**	**1**	**2**	**3**
2) Have you been feeling down, depressed or hopeless	**0**	**1**	**2**	**3**
3) Have you had trouble falling or staying asleep, or sleeping too much	**0**	**1**	**2**	**3**
4) Have you been feeling tired or having little energy	**0**	**1**	**2**	**3**
5) Have you had a poor appetite or overeating	**0**	**1**	**2**	**3**
6)Have you been feeling bad about yourself or that you are a failure or have let yourself or your family down	**0**	**1**	**2**	**3**
7) Have you had trouble concentrating on things, such as reading the newspaper or watching television	**0**	**1**	**2**	**3**
8) Have you been moving or speaking so slowly that other people could have noticed? Or so fidgety or restless that you have been moving a lot more than usual	**0**	**1**	**2**	**3**
9) Have you had thoughts that you would be better off dead, or of hurting yourself in some way	**0**	**1**	**2**	**3**

Question				
10) Have you had thoughts of hurting or killing someone else	**0**	**1**	**2**	**3**
11) How difficult have these problems made it to do work, take care of things at home, or get along with others?	**None**			
	Somewhat			
	Very			
	Extremely			

HMC
HIGHLAND MEDICAL CENTER
Caring for the health of the Highlands

Patient Name: ___________________________ DOB: ______________ Date: _____________

GAD7
(Age 12 and up)

How often have you been bothered by the following over the past 2 weeks?

0- None; 1- Several days; 2- More than half the days; 3- Nearly every day

1) Have you been feeling nervous, anxious, or on edge	**0**	**1**	**2**	**3**
2) Do you feel that you have not been able to stop or control worrying	**0**	**1**	**2**	**3**
3) Have you been worrying too much about different things	**0**	**1**	**2**	**3**
4) Have you had trouble relaxing	**0**	**1**	**2**	**3**
5) Do you feel that you have been so restless that you find it hard to sit still	**0**	**1**	**2**	**3**
6) Have you been becoming easily annoyed or irritable	**0**	**1**	**2**	**3**
7) Have you been feeling afraid as if something awful might happen	**0**	**1**	**2**	**3**
8) If you checked any problem, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?	**None** **Somewhat** **Very** **Extremely**			