psychiatric solutions
Behavioral Health Services

ADULT

Welcome to Psychiatric Solutions. We are fully committed to you and promise to deliver the highest quality of care in a welcoming, friendly, and confidential environment.

The contents of this packet are intended to help us meet your needs. Please read and review the enclosed information, sign and date all forms where indicated, and bring the completed packet to your appointment.

Please note: You will not be able to attend your appointment unless this packet is completed.

In this packet, you will find the following information:

- **Consent for Services**: You have the right to give or refuse consent to treatment.
- **Patient Financial Responsibilities**
- **Notice of Privacy Practices: Acknowledgement of Receipt**
- **Authorization for Disclosure of Health Information**: You give us permission to release medical records to individuals, therapists, and/or doctors pertaining to your care. (Optional)
- **New Patient Packet**: Please provide us with as much accurate information as possible in this packet to allow us to provide you with the best possible care.

We look forward to working with you and want to provide you with the best possible care. If you have any questions, comments, or concerns, please ask a member of your team.

COUNSELOR DISCLOSURE STATEMENT

The State of Washington requires us to disclose the following information to you about Psychiatric Solutions:

SPOKANE ADDRESS:

Psychiatric Solutions
1620 North Mamer Rd. Building B-100
Spokane Valley, WA 99216

Division of Behavioral Health and Recovery (DBHR) License Number: 200528

AGENCY PHILOSOPHY:

At Psychiatric Solutions, we believe that a multi-disciplinary approach is the most effective method to providing quality care. We are proud of our high patient satisfaction. Our staff is knowledgeable, compassionate, and skilled in the most effective psychotherapeutic techniques.

Our Spokane behavioral health facility has a psychiatrist, psychologists, marriage and family therapists, social workers and a psychiatric health nurse practitioner available to help our patients. Together, we work under the direction of board-certified psychiatrists with a long history of service to patients in Eastern Washington. Our psychiatrists assess patients, prescribe and manage medications, and provide individualized treatment as needed.

COUNSELOR EDUCATION & CREDENTIALS:

1. **Clinician Name:** Alicia Tomlinson, LSWAIC
   Credential Type: Social Worker Associate Independent Clinical License
   Credential Number: SC60998709
2. **Clinician Name:** Jennah Kay Marie Blossom, LMHCA
   Credential Type: Mental Health Counselor Associate
   Credential Number: MC61053752
3. **Clinician Name:** Lindsey Barre, LSWAIC
   Credential Type: Social Worker Associate Independent Clinical License
   Credential Number: SC61151736
4. **Clinician Name:** Victoria Marie Facciola, LMHCA
   Credential Type: Mental Health Counselor Associate
   Credential Number: MC61024422

METHODS OR TECHNIQUES AND TYPE OF COUNSELING USED BY PSYCHIATRIC SOLUTIONS CLINICIANS:

Psychiatric Solutions provides comprehensive, personalized treatment programs for behavioral health disorders. We combine our evidence-based treatment with personalized integrative interventions. We utilize person-centered, strengths-based and solution-focused therapies during the course of the treatment program.

FEE INFORMATION/BILLING PRACTICES:

Please refer to the Financial Responsibility Agreement and Attendance Policy Acknowledgement.

COUNSELOR DISCLOSURE STATEMENT *(CONTINUED)*

CONFIDENTIALITY:

Please refer to the Informed Consent for Therapeutic Services.

COMPLAINTS/GRIEVANCES:

Please refer to the Grievance Procedure.

Contact information to make a complaint about a healthcare provider to the Department of Health (DOH) is available upon request.

SIGNATURE

My signature indicates that I have provided the client listed below with a copy of Psychiatric Solutions Counselor Disclosure Statement for my location (where applicable). I have reviewed the education, training, experience, methods and/or techniques and type of counseling used by Psychiatric Solutions clinicians with the client listed below.

Counselor Signature: _____ Date: _____

Counselor Name (printed w/credential): _____

My signature indicates that I have been provided with a copy of Psychiatric Solutions Counselor Disclosure Statement and that I have read and understand the information. I understand that during the course of my treatment at Psychiatric Solutions, my treatment team may consist of any or all of the therapists listed on this disclosure in addition to any or all of the disciplines listed above.

Patient's Name: _____ Birth Date: _____

Patient's Signature: _____ Date: _____

INDIVIDUAL RIGHTS

You Have the Right to:

1. Receive services without regard to race, color, creed, national origin, religion, sex, sexual orientation, age, or disability, except for bona fide program criteria.
2. Practice the religion of choice as long as the practice does not infringe on the rights and treatment of others or the treatment service.
3. Be reasonably accommodated in the event of sensory or physical disability, limited ability to communicate, limited English proficiency, and cultural differences.
4. Be treated with respect, dignity, and privacy, except that staff may conduct reasonable searches to detect and prevent possession or use of contraband on the premises.
5. Be free of any sexual harassment.
6. Be free of exploitation, including physical and financial.
7. Have all clinical and personal information treated in accord with state and federal confidentiality regulations.
8. Review your clinical records in the presence of the Administrator or designee and be given an opportunity to request amendments or corrections.
9. Participate in the creation of your individualized care plan and be offered a copy.
10. Receive a copy of patient grievance procedures upon request and to lodge a complaint or grievance with the agency, if you believe that your rights have been violated.
11. File a complaint with the Department of Health when you feel the agency has violated a requirement that regulates behavioral health agencies.
12. Report concerns about the safety and quality of your care to The Joint Commission. A report can be filed with The Joint Commission here: www.jointcommission.org/report_a_complaint.aspx. The Joint Commission's Customer Service line can also be reached at (630) 792-5800.

SIGNATURE

Insured's Name: _____ Birth Date: _____

Insured's Signature: _____ Date: _____

Staff Signature: _____ Date: _____

STATEMENT OF UNPROFESSIONAL CONDUCT

Counselors are subject to discipline by the Department of Health. Cause for disciplinary action for unprofessional conduct is found in RCW 18.130.180 and includes the following:

1. The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder or applicant of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purposes of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW.
2. Misrepresentation or concealment of a material fact in obtaining a license or in reinstatement thereof;
3. All advertising which is false, fraudulent, or misleading;
4. Incompetence, negligence, or malpractice which result in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;
5. Suspension, revocation, or restriction of the individual's license to practice any health care profession by competent authority in any state, federal, or foreign jurisdiction, a certified copy of the order, stipulation, or agreement being conclusive evidence of the revocation, suspension, or restriction;
6. The possession, use, prescription for use, or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diversion of controlled substances or legend drugs, violation of any drug law, or prescribing controlled substances for oneself;
7. Violation of any state of federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice;
8. Failure to cooperate with the disciplining authority by:
    a. Not furnishing any papers, documents, records, or other items;
    b. Not furnishing in writing a full and complete explanation covering the matter contained in the complaint filed with the disciplining authority.
    c. Not responding to subpoenas issued by the disciplining authority, whether or not the recipient of the subpoena is the accused in the proceeding; or
    d. Not providing reasonable and timely access for authorized representatives of the disciplining authority seeking to perform practice reviews at facilities utilized by the license holder.
9. Failure to comply with an order issued by the disciplining authority or a stipulation for informal disposition entered into with the disciplining authority;
10. Aiding or abetting an unlicensed person to practice when a license is required;
11. Violation of rules established by any health agency;
12. Practice beyond the scope of practice as defined by law or rule;
13. Misrepresentation or fraud in any aspect of the conduct of the business or profession;
14. Failure to adequately supervise auxiliary staff to the extent that the consumer's health or safety is at risk;
15. Engaging in a profession involving contact with the public while suffering from a contagious or infectious disease involving serious risk to public health;

STATEMENT OF UNPROFESSIONAL CONDUCT *(CONTINUED)*

16. Promotion for personal gain of any unnecessary or inefficacious drug, device, treatment, procedure, or service;
17. Conviction of any gross misdemeanor or felony relating to the practice of the person's profession. For the purpose of this subsection, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96 RCW.
18. The procuring, or aiding or abetting in procuring, a criminal abortion;
19. The offering, undertaking, or agreeing to cure or treat disease by a secret method, procedure, treatment, or medicine, or the treating, operating, or prescribing for any health condition by a method, means or procedure which the licensee refuses to divulge upon demand on the disciplining authority;
20. The willful betrayal of a practitioner-patient privilege as recognized by law;
21. Violation of chapter 19.68 RCW;
22. Interference with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representative, or by the use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding or any other legal action, or by the use of financial inducements to any patient or witness to prevent or attempt to prevent him or her from providing evidence in a disciplinary proceeding;
23. Current misuse of:
    a. Alcohol;
    b. Controlled substance; or
    c. Legend drugs;
24. Abuse of a client or patient or sexual contact with a client or patient;
25. Acceptance of more than a nominal gratuity, hospitality, or subsidy offered by a representative or vender of medical or health-related products or services intended for patients, in contemplation of a sale of for use in research publishable in professional journals, where a conflict of interest is presented, as defined by rules of the disciplining authority, in consultation with the department, based on recognized professional ethical standards.

Anyone having questions or wishing to file a complaint should write or call:

Washington State Department of Health
Health Systems Quality Assurance
Complaint Intake
P.O. box 47857
Olympia, WA 98504-7857
Local: 360-236-4700
Email: HSQAComplaintIntake@doh.wa.gov

SIGNATURE

Patient's Name: _____ Birth Date: _____

Patient's Signature: _____ Date: _____

Staff Signature: _____ Date: _____

CONSENT FOR SERVICES

The Right to Consent

Washington law provides that all patients, including those who receive behavioral health services, have the right to give or refuse consent of treatment. All mental health patients have the right to:

An explanation of their diagnosis;

Information about their recommended treatment, including the possible risks and expected benefits;

Any alternatives to the recommended treatment, along with the risks and benefits of such alternatives; and

Give or refuse to give consent for treatment.

By signing below, I am voluntarily agreeing to receive mental health services from Psychiatric Solutions. These services may include psychiatric evaluation, psychotherapy and medication management. I understand that I may decide to stop such treatment or services at any time. I understand that my medical information is protected by federal and state confidentiality laws and that my treatment information will be kept confidential to the extent possible by law.

_____ **I have read and have understood the information above regarding Consent for Services.**
(Initial)

NOTICE OF PRIVACY PRACTICE

Notice of Privacy Practices: Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the 'Notice of Privacy Practices' of Psychiatric Solutions, P.C. Our 'Notice of Privacy Practices' provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our 'Notice of Privacy Practices' is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at 509-863-9608.

If you have any questions about our 'Notice of Privacy Practices', please contact Psychiatric Solutions, P.C.

I acknowledge receipt of the 'Notice of Privacy Practices' of Psychiatric Solutions, P.C.

_____ **I acknowledge receipt of the "Notice of Privacy Practices" of Psychiatric Solutions, P.C.**
(Initial)

SIGNATURE

Patient's Name: _____ Birth Date: _____

Patient's Signature: _____ Date: _____

SUBSTANCE USE CONTRACT

Patient (Name): _____

Agrees to avoid the use of any non-prescribed substances for recreational or self-medication purposes while participating in this program at Psychiatric Solutions. I understand that failing to do so will jeopardize my eligibility to participate further in the program through Psychiatric Solutions. This agreement is based on my understanding of the fact that using illicit drugs will interfere with my ability to achieve therapeutic gains. I also agree to the following:

1. I agree to be assessed for Agonist therapy and agree to consider this treatment if the treatment team believes it would be beneficial for my progress.
2. I agree to consider residential substance abuse treatment, if I experience multiple failures in compliance.
3. It is the policy of Psychiatric Solutions that when you enter the program we have the right to require you to submit to a urinalysis. The testing will be at random and may or may not be required during your program attendance.
4. I understand that the purpose of this agreement is to ensure my successes in treating my mental health issues without the interference of substances. I also understand that this agreement will be utilized as a treatment tool to help me comply with my treatment goals. I also understand that failing to comply with the above terms repeatedly will jeopardize my ability to participate in the program.

_____ **I have read and have understood the information above regarding the Substance Use Contract.**
(Initial)

CONSENT FOR DRUG TEST

Patient (Name): _____

Hereby gives his/her permission for testing his/her urine at a lab designated for such for the duration of his/her treatment attendance.

The results of the urine analysis will be kept confidential to the extent possible by law. If the lab report returns positive, this does not necessarily mean that you will be unable to continue treatment with Psychiatric Solutions. The purpose of this test is to help measure and formulate your needs and treatment strategy. Thank you for your cooperation.

Psychiatric Solutions would also like to notify you that there will be a collection charge from our office and the urine analysis will be sent to an outside source for processing. Billing for this service will be in accordance with standard Psychiatric Solutions, P.C., policies.

_____ **I have read and have understood the information above regarding Consent for Drug Test.**
(Initial)

SIGNATURE

Patient's Name: _____ Birth Date: _____

Patient's Signature: _____ Date: _____

CONFIDENTIALITY STATEMENT

GENERAL

All information concerning patients, their presence in this program, and their medical condition is confidential. This privacy is protected by both federal and state laws. In signing below, I acknowledge that I have been informed of the requirement for confidentiality with respect to patients, and that I agree to abide by the same.

CONFIDENTIALITY OF SUBSTANCE ABUSE PATIENT RECORDS

The confidentiality of alcohol and drug abuse patient records maintained by Psychiatric Solutions is protected by federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser, unless:

- The patient consents in writing;
- The disclosure is allowed by a court order; or
- To report suspected abuse of a child or vulnerable adult;
- The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the federal law and regulations (Federal Regulations 45 CFR Parts 160 & 164 and 42CFR, Part 2) by this program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations

Federal law and regulations do not protect any information about a crime committed by a patient either at this program or against any person who works for this program or about any threat to commit such a crime.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

PARTICIPATION IN GROUPS

I understand that all issues discussed in groups in which I participate are highly confidential. Such information shall not be discussed outside the group sessions with anyone other than my therapist or physician.

My signature below indicates my agreement to comply with the confidentiality policy.

_____ **I have read and have understood the information above regarding the Confidentiality Statement.**
(Initial)

SIGNATURE

Patient's Name: _____ Birth Date: _____

Patient's Signature: _____ Date: _____

INSURANCE BENEFITS

I hereby authorize payment of the insurance benefits otherwise payable to me to be paid directly to my physician. I hereby authorize release of information necessary to file a claim with my insurance company. I understand that I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

_____ **I have read and have understood the information above regarding Insurance Benefits.**
(Initial)

SIGNATURE

Insured's Name: _____ Birth Date: _____

Insured's Signature: _____ Date: _____

Staff Signature: _____ Date: _____

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION (PERSONAL)

I, _____, (DOB) _____ hereby authorize **Psychiatric Solutions** to release/request information from the medical records of the patient listed above obtained in the course of treatment and diagnosis to:

Outside Entity: _____

Address: _____

Phone #: _____

The type and amount of information to be used or disclosed is as follows:

A. ☐ All health information pertaining to my medical history, mental or physical condition and treatment received, OR

B. ☐ Only the following records or types of health information (including any dates):

_____

_____

C. ☐ I specifically authorize release of the following information (check as appropriate)

- ☐ Mental health treatment information
- ☐ HIV test results
- ☐ Alcohol/drug treatment information
- ☐ Psychotherapy notes

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Psychiatric Solutions office, or I may submit my revocation to Psychiatric Solutions at this address: 1620 N Mamer Road, Building B-100, Spokane, WA 99216. I understand the revocation will not apply to health information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in one year from this date: _____

If I fail to specify an expiration date, this authorization will expire sixty days from the date last signed below.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the health information I am being asked to allow the use or disclosure of. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the office at 509-863-9779. I understand that I have the right to receive a copy of the authorization.

SIGNATURE

Patient's Name: _____ Birth Date: _____

Patient's Signature: _____ Date: _____

PATIENT FINANCIAL RESPONSIBILITIES

The fundamental ingredient in the psychotherapeutic relationship is clear communication between the doctor and the patient. This philosophy extends to our policies on fees and services. Please feel free to discuss these with us at any time.

INSURANCE: If you have insurance that covers this service, we will be happy to bill your insurance company. **Your co-payment is due and payable at the time of each session**. If you are unable to make payment at the time of service, your appointment will be rescheduled.

****We will need a copy of your current insurance card at the time of your appointment. If you do not have your insurance card with you at the time of your appointment, you must present one within 30 days of your appointment or all charges will be billed to you.**

Please note that the Mental Health portion of insurance coverage often differs from other medical coverage. Pre-authorization is often required. Some mental health services may not be covered by your health insurance plan or may only be partially covered. We strongly suggest you contact your insurance company before treatment begins to be certain that you thoroughly understand both your obligation and that of the insurance company regarding mental health coverage. If we provide services to you that are not covered by your health insurance plan, you will be responsible for payment in full for those services. If we provide services to you that are only partially covered by your health insurance plan, you may be responsible for the remainder of payment for those services. Your signature below constitutes agreement to pay for such services.

As a courtesy, our office will contact your insurance company on your behalf to check your benefits and work to obtain authorization for services rendered. If we are not contracted with your insurance company, and if no out-of-network benefits are available, we will work with your insurance company to try and obtain 'Single Case Agreement.' Please understand an authorization of a Single Case Agreement is not a guarantee of payment and we will be unaware of how your benefits will be applied until your claim is processed by your insurance company. We highly recommend and encourage you to call your insurance company to verify your benefits and understand them prior to any service rendered. Any questions regarding how your insurance company processed your claim needs to be directed to your insurance company. All co-pays are required at the time of service. If you are in one of our programs it is required that your care, be followed by a physician. Your co-pay is required at each of those office visits.

I understand that I am financially responsible for any balance not covered by my insurance carrier, including but not limited to deductibles, co-pays, co-ins, or any out-of-pocket percentages. A copy of this signature is as valid as the original.

LATE CANCELLATIONS AND MISSED APPOINTMENTS: Your appointment time has been reserved for you. If you must cancel an appointment, contact us within 24 hours at (509) 863-9779 so that we may schedule another patient on the waiting list. If our office is not notified of a cancellation 24 hours in advance of your scheduled appointment, **you will be charged $125 fee for a no-show for appointments. As a courtesy to our office and other patients, we ask that you please cancel your appointments within the 24-hour period to avoid the no-show charge, and to allow us to schedule another patient during that time. The PHP and IOP programs are excluded from this policy but we strongly encourage all patients to provide as much notice as possible prior to missing a session. Please be informed that three consecutive no-shows could lead to termination of care.**

CONSULTATIVE REPORTS AND FORMS: As a courtesy, we will send a report to the professional who referred you at no additional charge. You may need to request completion of other reports or forms. Fees for this service are determined on an individual basis; **typically, the charge is $15** depending on the length and complexity of the report. Insurance does not cover this service and payment is due upon completion of the report.

You may have a copy of this for your records upon request.

_____ **I have read and have understood the information above regarding Patient Financial Responsibilities.**
(Initial)

SIGNATURE

Patient's Name: _____ Birth Date: _____

Patient's Signature: _____ Date: _____

NEW PATIENT PACKET

How did you hear about us? ☐ Website ☐ Billboard ☐ Referred by: _____ ☐ Other: _____

For what problem(s) do you seek help?

DEMOGRAPHICS

Name:		Date of Birth (DOB):	☐ Male ☐ Female	
Primary Care Physician:			SSN:	
Home Address:		City	State	Zip
Mailing Address:		City	State	Zip
Phone Numbers:	Home: OK to leave Msg: ☐ Yes ☐ No	Cell: OK to leave Msg: ☐ Yes ☐ No		
	Work: OK to leave Msg: ☐ Yes ☐ No	Other: OK to leave Msg: ☐ Yes ☐ No		
Email Address:				
Emergency Contact:	Phone #:	Relationship:		

IF PATIENT IS A MINOR:

Do you have legal custody? ☐ Yes ☐ No	If divorced, has either parent had parental rights terminated? ☐ Yes ☐ No
Legal Guardian's Name:	Relationship to Patient:
Legal Guardian's SSN:	Guardian's DOB:
Is Patient a Full-Time Student? ☐ Yes ☐ No	School:

INSURANCE INFORMATION

Primary Insurance:	Policy Holder Name:
Patient ID #:	Policy Holder DOB:
Group #:	Relationship:
Secondary Insurance:	Policy Holder Name:
Patient ID #:	Policy Holder DOB:
Group #:	Relationship:

PSYCHIATRIC HISTORY *(Please check any that apply)*

	DURING THE PAST 4 WEEKS, HOW MUCH HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?	NOT BOTHERED (0)	BOTHERED A LITTLE (1)	BOTHERED A LOT (2)
	Stomach pain	☐	☐	☐
	Back pain	☐	☐	☐
	Pain in your arms, legs, or joints (knees, hips, etc.)	☐	☐	☐
	Menstrual cramps or other problems with your periods (WOMEN ONLY)	☐	☐	☐
	Headaches	☐	☐	☐
	Chest pain	☐	☐	☐
	Dizziness	☐	☐	☐
	Fainting spells	☐	☐	☐
	Feeling your heart pound or race	☐	☐	☐
	Shortness of breath	☐	☐	☐
	Pain or problems during sexual intercourse	☐	☐	☐
	Constipation, loose bowels, or diarrhea	☐	☐	☐
	Nausea, gas, or indigestion	☐	☐	☐
	Feeling tired or having low energy	☐	☐	☐
	Trouble sleeping	☐	☐	☐

	OVER THE LAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?	NOT AT ALL (0)	SEVERAL DAYS (1)	MORE THAN HALF THE DAYS (2)	NEARLY EVERY DAY (3)
	Little interest or pleasure in doing things	☐	☐	☐	☐
	Feeling down, depressed, or hopeless	☐	☐	☐	☐
	Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
	Feeling tired or having little energy	☐	☐	☐	☐
	Poor appetite or overeating	☐	☐	☐	☐
	Feeling bad about yourself—or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
	Trouble concentrating on things, such as reading or watching television	☐	☐	☐	☐
	Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
	Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

IF YOU CHECKED OFF <u>ANY</u> OF THESE PROBLEMS, HOW <u>DIFFICULT</u> HAVE THESE PROBLEMS MADE IT FOR YOU TO DO YOUR WORK, TAKE CARE OF THINGS AT HOME, OR GET ALONG WITH OTHER PEOPLE?

NOT DIFFICULT AT ALL	SOMEWHAT DIFFICULT	VERY DIFFICULT	EXTREMELY DIFFICULT
☐	☐	☐	☐

	CHOOSE THE ONE STATEMENT IN EACH GROUP THAT BEST DESCRIBES THE WAY YOU HAVE BEEN FEELING FOR THE PAST WEEK.
	Check the box next to the number/statement selected. Please note: the word "occasionally" when used here means once or twice; "often" means several times or more; and "frequently" means most of the time.
QUESTION 1	
☐	**0** I do not feel happier or more cheerful than usual.
☐	**1** I occasionally feel happier or more cheerful than usual.
☐	**2** I often feel happier or more cheerful than usual.
☐	**3** I feel happier or more cheerful than usual most of the time.
☐	**4** I feel happier or more cheerful than usual all of the time.
QUESTION 2	
☐	**0** I do not feel more self-confident than usual.
☐	**1** I occasionally feel more self-confident than usual.
☐	**2** I often feel more self-confident than usual.
☐	**3** I feel more self-confident than usual most of the time.
☐	**4** I feel extremely more self-confident all of the time.
QUESTION 3	
☐	**0** I do not need less sleep than usual.
☐	**1** I occasionally need less sleep than usual.
☐	**2** I often need less sleep than usual.
☐	**3** I frequently need less sleep than usual.
☐	**4** I can go all day and night without any sleep and still not feel tired.
QUESTION 4	
☐	**0** I do not talk more than usual.
☐	**1** I occasionally talk more than usual.
☐	**2** I often talk more than usual.
☐	**3** I frequently talk more than usual.
☐	**4** I talk constantly and cannot be interrupted.
QUESTION 5	
☐	**0** I have not been more active (either socially, sexually, at work, home or school) than usual.
☐	**1** I have occasionally been more active than usual.
☐	**2** I have often been more active than usual.
☐	**3** I have frequently been more active than usual.
☐	**4** I am constantly active or on the go all the time.

Permission for use granted by EG Altman, MD

	OVER THE LAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?	NOT AT ALL (0)	SEVERAL DAYS (1)	MORE THAN HALF THE DAYS (2)	NEARLY EVERY DAY (3)
	Feeling nervous, anxious, or on edge	☐	☐	☐	☐
	Not being able to stop or control worrying	☐	☐	☐	☐
	Worrying too much about different things	☐	☐	☐	☐
	Trouble relaxing	☐	☐	☐	☐
	Being so restless that it's hard to sit still	☐	☐	☐	☐
	Becoming easily annoyed or irritable	☐	☐	☐	☐
	Feeling afraid as if something awful might happen	☐	☐	☐	☐

	QUESTIONS ABOUT PANIC ATTACKS *Panic attacks are discrete episodes of intense fear, apprehension, or terror that are accompanied by several physical symptoms. Panic attacks can either occur for no apparent reason (spontaneously) or upon entering into or being in situations which have become associated with them (e.g., long lines, closed spaces, driving over bridges). Do not consider fear to be a panic attack if it lasts several hours or most of the day.*	YES	NO
	During the last six months, have you had a panic attack or a sudden rush of intense fear or anxiety?	☐	☐
	When was the most recent time this occurred? Date:		
	IF NO (you have not experienced a panic attack), please leave the remainder of this section blank. IF YES, please continue.	**YES**	**NO**
	Was at least one panic attack unexpected, as if it came out of the blue?	☐	☐
	Did it happen more than once?	☐	☐
	IF YES to the previous question, approximately how many panic attacks have you had in your lifetime?	☐	☐
	IF NO to ALL of the previous three questions, please leave the remainder of this section blank; otherwise, continue.	**YES**	**NO**
	Have you ever worried a lot (for at least one month) about having another panic attack?	☐	☐
	Have you ever worried a lot (for at least one month) that having the attacks meant you were losing control, going crazy, having a heart attack, seriously ill, etc.?	☐	☐
	Did you ever change your behavior or do something different (for at least one month) because of the attacks?	☐	☐
	IF YES to ANY of the previous three questions, please answer the following questions:	**YES**	**NO**
	Think back to your most severe panic attack. Did you experience any of the following symptoms?		
	Shortness of breath or smothering sensations?	☐	☐
	Feeling dizzy, unsteady, lightheaded, or faint?	☐	☐
	Palpitations, pounding heart, or rapid heart rate?	☐	☐
	Trembling or shaking?	☐	☐
	Sweating?	☐	☐

QUESTIONS ABOUT PANIC ATTACKS *(CONTINUED)*	YES	NO
Feelings of choking?	☐	☐
Nausea or abdominal distress?	☐	☐
Numbness or tingling sensations?	☐	☐
Flushes (hot flashes) or chills?	☐	☐
Chest pain or discomfort?	☐	☐
Fear of dying?	☐	☐
Fear of going crazy or doing something uncontrolled?	☐	☐

How much do these symptoms interfere with your daily functioning? (Choose one)

Not at all (0)	Mildly (1)	Moderately (2)	Severely (3)	Very Severely/Disabling (4)
☐	☐	☐	☐	☐

How distressing do you find these symptoms? (Choose one)

Not at all (0)	Mildly (1)	Moderately (2)	Severely (3)	Very Severely/Disabling (4)
☐	☐	☐	☐	☐

	YES	NO
When you have bad panic attacks, does it often take **minutes** from the point at which the attack begins to the point at which it reaches a peak or becomes most intense?	☐	☐
Just before you began having panic attacks, were you taking any drugs or excessive amounts (more than four cups daily) of stimulants (e.g., coffee, tea, or cola with caffeine)?	☐	☐
IF YES, what were you taking?		
How much of it were you taking (in cups, cans, etc.)?		
Have you ever been diagnosed with a medical problem (hyperthyroidism, a seizure or cardiac condition, etc.) that could have caused your panic symptoms?	☐	☐

	IN THE PAST MONTH, HOW MUCH HAVE YOU BEEN BOTHERED BY…	NOT AT ALL (1)	A LITTLE BIT (2)	MODERATELY (3)	QUITE A BIT (4)	EXTREMELY (5)
1.	Repeated, disturbing *memories*, *thoughts*, or *images* of a stressful experience from the past?	☐	☐	☐	☐	☐
2.	Repeated, disturbing *dreams* of a stressful experience from the past?	☐	☐	☐	☐	☐
3.	Suddenly *acting* or *feeling* as if a stressful experience *were happening* again (as if you were reliving it)?	☐	☐	☐	☐	☐
4.	Feeling *very upset* when *something reminded* you of a stressful experience from the past?	☐	☐	☐	☐	☐
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past?	☐	☐	☐	☐	☐

	NOT AT ALL (1)	A LITTLE BIT (2)	MODERATELY (3)	QUITE A BIT (4)	EXTREMELY (5)
6. Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?	☐	☐	☐	☐	☐
7. Avoid *activities* or *situations* because they *remind* you of a stressful experience from the past?	☐	☐	☐	☐	☐
8. Trouble r*emembering important part*s of a stressful experience from the past?	☐	☐	☐	☐	☐
9. Loss of *interest in things that you used to enjoy*?	☐	☐	☐	☐	☐
10. Feeling *distant* or *cut off* from other people?	☐	☐	☐	☐	☐
11. Feeling *emotionally numb* or being unable to have loving feelings for those close to you?	☐	☐	☐	☐	☐
12. Feeling as if your *future* will somehow be *cut short*?	☐	☐	☐	☐	☐
13. Trouble *falling* or *staying asleep*?	☐	☐	☐	☐	☐
14. Feeling *irritable* or having *angry outbursts*?	☐	☐	☐	☐	☐
15. Having *difficulty concentrating*?	☐	☐	☐	☐	☐
16. Being "*super alert*" or watchful on guard?	☐	☐	☐	☐	☐
17. Feeling *jumpy* or easily startled?	☐	☐	☐	☐	☐

	THE CAGE (ACRONYM) IS A 4-ITEM QUESTIONNAIRE THAT CAN INDICATE POTENTIAL PROBLEMS WITH ALCOHOL ABUSE. PLEASE ANSWER YES OR NO TO THE FOLLOWING QUESTIONS:	YES (1)	NO (0)
Have you ever felt you need to **C**ut down on your drinking?		☐	☐
Have people **A**nnoyed you by criticizing your drinking?		☐	☐
Have you ever felt **G**uilty about drinking?		☐	☐
Have you ever felt you needed a drink first thing in the morning (**E**ye-opener) to steady your nerves or get rid of a hangover?		☐	☐

	COLUMBIA-SUICIDE SEVERITY RATING SCALE SUICIDE IDEATION DEFINITIONS AND PROMPTS	PAST MONTH	
	Ask questions 1 and 2	**YES**	**NO**
1)	**Wish to be Dead:** ***Have you wished you were dead or wished you could go to sleep and not wake up?*** (Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.)	☐	☐
2)	**Suicidal Thoughts:** ***Have you actually had any thoughts of killing yourself?*** (General non-specific thoughts of wanting to end one's life/commit suicide, *"I've thought about killing myself"* without general thoughts of ways to kill oneself/associated methods, intent, or plans.)	☐	☐

COLUMBIA-SUICIDE SEVERITY RATING SCALE *(CONTINUED)*	PAST MONTH	
If YES to 2, ask questions 3, 4, 5, and 6. If NO, go directly to question 6.	**YES**	**NO**
3) **Suicidal Thoughts with Method (without Specific Plan or Intent to Act):** ***Have you been thinking about how you might kill yourself?*** (Person endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place, or method details worked out. *"I thought about taking an overdose but I never made a specific plan as to when, where, or how I would actually do it…and I would never go through with it."*)	☐	☐
4) **Suicidal Intent (without Specific Plan):** ***Have you had these thoughts and had some intention of acting on them?*** (Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."*)	☐	☐
5) **Suicidal Intent with Specific Plan:** ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** (Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.)	☐	☐
6) **Suicide Behavior Question:** ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** (Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.)	☐	☐
If YES, ask: ***How long ago did you do any of these?*** ☐ Over a year ago? ☐ Between three months and a year ago? ☐ Within the last three months?		

QUESTIONS ABOUT PRIOR SUICIDE ATTEMPTS AND/OR SELF HARM	YES	NO
Have you attempted suicide in the past? (Over a year ago)	☐	☐
If yes, when was the last suicide attempt? Please describe how you attempted suicide:		
Altogether, how many suicide attempts have you had?		
Currently are you having thoughts about hurting someone else?	☐	☐
Have you ever harmed yourself without intending suicide? (I.e., cutting on yourself, burning yourself, etc.)	☐	☐

QUESTIONS ABOUT EATING HABITS	ALWAYS (3)	USUALLY (2)	OFTEN (1)	SOMETIMES (0)	RARELY (0)	NEVER (0)
I am terrified about being overweight.	☐	☐	☐	☐	☐	☐
I avoid eating when I am hungry.	☐	☐	☐	☐	☐	☐
I find myself preoccupied with food.	☐	☐	☐	☐	☐	☐
I have gone on eating binges where I feel that I may not be able to stop.	☐	☐	☐	☐	☐	☐
I cut my food into small pieces.	☐	☐	☐	☐	☐	☐

	ALWAYS (3)	USUALLY (2)	OFTEN (1)	SOMETIMES (0)	RARELY (0)	NEVER (0)
I am aware of the calorie content of foods that I eat.	☐	☐	☐	☐	☐	☐
I particularly avoid food with a high carbohydrate content (i.e., bread, rice, potatoes, etc.).	☐	☐	☐	☐	☐	☐
I feel that others would prefer if I ate more.	☐	☐	☐	☐	☐	☐
I vomit after I have eaten.	☐	☐	☐	☐	☐	☐
I feel extremely guilty after eating.	☐	☐	☐	☐	☐	☐
I am occupied with a desire to be thinner.	☐	☐	☐	☐	☐	☐
I think about burning up calories when I exercise.	☐	☐	☐	☐	☐	☐
Other people think I am too thin.	☐	☐	☐	☐	☐	☐
I am preoccupied with the thought of having fat on my body.	☐	☐	☐	☐	☐	☐
I take longer than others to eat my meals.	☐	☐	☐	☐	☐	☐
I avoid foods with sugar in them.	☐	☐	☐	☐	☐	☐
I eat diet foods.	☐	☐	☐	☐	☐	☐
I feel that food controls my life.	☐	☐	☐	☐	☐	☐
I display self-control around food.	☐	☐	☐	☐	☐	☐
I feel that others pressure me to eat.	☐	☐	☐	☐	☐	☐
I give too much time and thought to food.	☐	☐	☐	☐	☐	☐
I am uncomfortable after eating sweets.	☐	☐	☐	☐	☐	☐
I engage in dieting behavior.	☐	☐	☐	☐	☐	☐
I like my stomach to be empty.	☐	☐	☐	☐	☐	☐
I have the impulse to vomit after meals.	☐	☐	☐	☐	☐	☐
I enjoy trying new rich foods.	☐ (0)	☐ (0)	☐ (0)	☐ (1)	☐ (2)	☐ (3)

	NEVER	ONCE A MONTH OR LESS	2-3 TIMES A MONTH	ONCE A WEEK	2-6 TIMES A WEEK	ONCE A DAY OR MORE
A. Gone on eating binges where you feel that you may not be able to stop? *(Defined as eating much more than most people would under the same circumstances and feeling that eating is out of control.)*	☐	☐	☐	☐	☐	☐
B. Ever made yourself sick (vomited) to control your weight or shape?	☐	☐	☐	☐	☐	☐
C. Ever used laxatives, diet pills or diuretics (water pills) to control your weight or shape?	☐	☐	☐	☐	☐	☐
D. Exercised more than 60 minutes a day to lose or to control your weight?	☐	☐	☐	☐	☐	☐

ADULT ADHD SELF-REPORT SCALE

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right. As you answer each question, select the option that best describes how you have felt and conducted yourself over the past 6 months.

PART A	NEVER	RARELY	SOMETIMES	OFTEN	VERY OFTEN
How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	☐	☐	☐	☐	☐
How often do you have difficulty getting things in order when you have a do a task that requires organization?	☐	☐	☐	☐	☐
How often do you have problems remembering appointments or obligations?	☐	☐	☐	☐	☐
When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	☐	☐	☐	☐	☐
How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	☐	☐	☐	☐	☐
How often do you feel overly active and compelled to do things, like you were driven by a motor?	☐	☐	☐	☐	☐
PART B	**NEVER**	**RARELY**	**SOMETIMES**	**OFTEN**	**VERY OFTEN**
How often do you make careless mistakes when you have to work on a boring or difficult project?	☐	☐	☐	☐	☐
How often do you have difficulty keeping your attention when you are doing boring or repetitive work?	☐	☐	☐	☐	☐
How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?	☐	☐	☐	☐	☐
How often do you misplace or have difficulty finding things at home or at work?	☐	☐	☐	☐	☐
How often are you distracted by activity or noise around you?	☐	☐	☐	☐	☐
How often do you leave your seat in meetings or other situations in which you are expected to remain seated?	☐	☐	☐	☐	☐
How often do you feel restless or fidgety?	☐	☐	☐	☐	☐
How often do you have difficulty unwinding and relaxing when you have time to yourself?	☐	☐	☐	☐	☐
How often do you find yourself talking too much when you are in social situations?	☐	☐	☐	☐	☐
When you're in a conversation, how often do you find yourself finishing the sentence of the people you are talking to, before they can finish them themselves?	☐	☐	☐	☐	☐
How often do you have difficulty waiting your turn in situations when turn taking is required?	☐	☐	☐	☐	☐
How often do you interrupt others when they are busy?	☐	☐	☐	☐	☐

QUESTIONS ABOUT YOUR THOUGHT PROCESSES	YES	NO
While fully awake, have you heard voices talking that other people could not hear?	☐	☐
Have you seen things, such as faces, animals, or ghosts, that other people could not see?	☐	☐
Have you ever tasted, smelled, or felt things touching you or crawling on you when nothing was there?	☐	☐
Have you often felt or believed that people were watching you, following you, talking about you, reading your mind, putting thoughts into your mind, trying to hurt you, trying to control you in some way, or plotting against you?	☐	☐
QUESTIONS ABOUT YOUR SLEEP	**YES**	**NO**
How many hours do you sleep?		
Do you have problems falling asleep?	☐	☐
Do you have problems staying asleep?	☐	☐
Do you have problems waking up earlier than you should?	☐	☐
Does your spouse or significant other complain that you snore too loudly?	☐	☐
Do you have nightmares at night?	☐	☐
WERE YOU EVER A VICTIM OF:	**YES**	**NO**
Childhood physical abuse	☐	☐
Childhood sexual abuse (molestation)	☐	☐
Childhood neglect	☐	☐

PRIOR PSYCHATRIC HOSPITALIZATIONS ☐ NONE			
Name of Hospital	**City/State**	**Dates of Service/Duration**	**Reason For Hospitalization**

PREVIOUS AND CURRENT PSYCHIATRIC/COUNSELING CARE ☐ NONE			
Name of Psychiatrist/Counselor	**Address/Phone Number**	**Dates of Service/Duration**	**Frequency of Visits**
Do you have a Primary Care Physician? ☐ Yes ☐ No		Date of last physical exam:	
Physician's name:		Physician's phone number:	

PRIOR HISTORY OF ELECTROCONVULSIVE THERAPY OR TMS ☐ NONE			
ECT and/or TMS	**Dates of Treatment**	**Reason you had it done**	**Outcome**

PAST MEDICATIONS *(PLEASE PROVIDE INFORMATION TO ANY THAT APPLY)*					
ANTIPSYCHOTICS					
Medication Generic Name/Brand Name	**Date of Trial**	**Highest dose taken at any time**	**Duration of time on medication**	**Why was it discontinued**	**Benefits/Side effects from taking the medication**
Aripiprzole/Abilify					
Clozaril/Clozapine					
Geodon/Ziprasidone					
Haldol/Haloperidol					
Invega/Invega Sustenna					
Latuda/Lurasidone					
Navane/Thiothixene					
Prolixin/Fluphenazine					
Risperdal/Risperidone					
Saphris/Asenapine					
Seroquel/Quetiapine					
Stelazine/Trifluoperazine					
Symbyax/Olanzapine/Fluoxetine					
Trilafon/Perphenazine					
Vraylar/Cariprazine					
Zyprexa/Olanzapine					
ANTIDEPRESSANTS					
Anafranil/Clomipramine					
Asendin/Amoxapine					
Celexa/Citalopram					
Cymbalta/Duloxetine					
Deplin/Methylfolate					
Desyrel/Trazodone					
Effexor/Venlafaxine					
Elavil/Endep/Amitriptyline					
Lexapro/Escitalopram					
Luvox/Fluvoxamine					
Nardil/Phenelzine					
Norpramin/Desipramine					
Pamelor/Aventyl/Nortriptyline					
Paxil/Pexeva/Paroxetine					
Pristiq/Desvenlafaxine					
Prozac/Sarafem/Fluoxetine					
Remeron/Mirtazapine					
Serzone/Nefazodone					
Sinequan/Adapin/Doxepin					
Tofranil/Imipramine					
Trintellix/Vortioxetine					
Viibryd/Vilazodone					
Wellbutrin/Zyban/Bupropion					
Zoloft/Sertraline					

PAST MEDICATIONS *(CONTINUED)*					
MOOD STABILIZERS					
Medication Generic Name/Brand Name	**Date of Trial**	**Highest dose taken at any time**	**Duration of time on medication**	**Why was it discontinued**	**Benefits/Side effects from taking the medication**
Depakote/Depakene/Valproic Acid					
Lamictal/Lamotrigine					
Lithium/Eskalith/Lithobid					
Neurontin/Gabapentin					
Tegretol/Equetro/Carbamazepine					
Topamax/Topiramate					
Trileptal/Oxcarbazepine					
ANXIETY/SLEEP					
Ambien/Zolpidem					
Ativan/Lorazepam					
BuSpar/Buspirone					
Centrax/Prazepam					
Dalmane/Flurazepam					
Klonopin/Clonazepam					
Librium/Chlordiazepoxide					
Lunesta/Eszopiclone					
Restoril/Temazepam					
Rozerem/Ramelteon					
Serax/Oxazepam					
Sonata/Zaleplon					
Tranxene/Clorazepate					
Valium/Diazepam					
Xanax/Alprazolam					
STIMULANTS					
Adderall/Adderall XR					
Concerta/Methylphenidate					
Focalin/Dexmethylphenidate					
Metadate/Methylin/ Methylphendiate					
Ritalin/Methylphenidate					
Strattera/Atomoxetine					
OTHERS					
Aricept/Donepezil					
Artane/Trihexyphenidyl					
Cogentin/Benztropine					
Exelon/Rivastigmine					
Lyrica/Pregabalin					
Namenda/Memantine					
Provigil/Modafinil					
Reminyl/Galantamine					
Suboxone/Buprenorphine					

CURRENT MEDICATIONS		
Medication	**Dose/Frequency**	**Start Date**

PHARMACY	
Pharmacy Name	**Pharmacy Address/Phone Number**

MEDICAL HISTORY *(Please check any that apply)*							
☐	AIDS/HIV Positive	☐	Epilepsy or Seizures	☐	Porphyria	☐	Parathyroid Disease
☐	Alzheimer's Disease	☐	Esophageal reflux	☐	Hives or Rash	☐	Poisoning
☐	Anaphylaxis	☐	Excessive Bleeding	☐	Hypoglycemia	☐	Polycystic Ovarian Syndrome
☐	Anemia	☐	Excessive Thirst	☐	Incontinence	☐	Radiation Treatments
☐	Angina	☐	Fainting Spells/Dizziness	☐	Infertility	☐	Recent Weight Loss
☐	Arthritis	☐	Frequent Cough	☐	Irregular Heartbeat	☐	Renal Dialysis
☐	Artificial Heart Valve	☐	Frequent Diarrhea	☐	Irritable Bowel	☐	Rheumatic Fever
☐	Artificial Joint	☐	Frequent Headaches	☐	Jaundice	☐	Scarlet Fever
☐	Asthma	☐	Gallstones	☐	Kidney Problems	☐	Shingles
☐	Blood Disease	☐	Genital Herpes	☐	Kidney Stones	☐	Sickle Cell Disease
☐	Blood Transfusion	☐	Glaucoma	☐	Leukemia	☐	Sinus Trouble
☐	Breathing Problem	☐	Gonorrhea	☐	Liver Disease	☐	Stomach/Intestinal Disease
☐	Bruise Easily	☐	Hay Fever	☐	Low Blood Pressure	☐	Stroke
☐	Cancer:	☐	Head Injury	☐	Lung Disease	☐	Swelling of Limbs
☐	Cataract	☐	Hearing Loss	☐	Lyme Disease	☐	Syphilis
☐	Chemotherapy	☐	Heart Attack/Failure	☐	Meningitis	☐	Thyroid Disease
☐	Chest Pains	☐	Heart Murmur	☐	Migraine Headaches	☐	Tonsillitis
☐	Chronic Bronchitis	☐	Heart Pacemaker	☐	Mitral Valve Prolapse	☐	Traumatic Injury
☐	Crohn's Disease	☐	Heart trouble	☐	Mononucleosis	☐	Tuberculosis
☐	Congenital Heart Disorder	☐	Hemophilia	☐	Neurological Disorder	☐	Tumors or Growths
☐	Cortisone Medicine	☐	Hepatitis A	☐	Osteoporosis	☐	Ulcers
☐	Diabetes	☐	Hepatitis B or C	☐	Pacemaker insertion	☐	Urinary Tract Infections
☐	Diarrhea	☐	High Blood Pressure	☐	Pain in Jaw Joints	☐	Vision Loss
☐	Emphysema	☐	High Cholesterol	☐	Pancreatitis	☐	Wheezing

MEDICAL HISTORY *(CONTINUED)*		
Any special dietary needs or restrictions? ☐ Yes ☐ No	Describe:	
Any ongoing dental issues? ☐ Yes ☐ No	Describe:	
Any recent change in appetite? ☐ Yes ☐ No	Describe:	
Any weight loss or weight gain of more than 10 lbs in the last 60 days? ☐ Yes ☐ No	Describe: ☐ weight loss ☐ weight gain	
On a scale from 0–10, please choose your pain level **today**: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Excruciating) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Please explain:	
On a scale from 0–10, please choose your pain level for the **last 30 days**: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Excruciating) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Please explain:	
Are there other medical issues you would like us to consider during your treatment? Please explain:		
Do you have any implantable devices? ☐ Yes ☐ No		

Men ONLY:	Women ONLY:
☐ Prostate problems ☐ Vasectomy	**Number of:** Pregnancies ___ Caesarean sections ___ Abortions ___ Stillbirths ___ Miscarriages ___
	☐ D&C ☐ Hysterectomy ☐ Tubal Ligation ☐ Ovary Removal ☐ Breast Surgery
Other illnesses not listed above OR comments:	

ALLERGIES	
MEDICATIONS	**REACTION**
	☐ Mild ☐ Moderate ☐ Severe ☐ Lethal
	☐ Mild ☐ Moderate ☐ Severe ☐ Lethal
	☐ Mild ☐ Moderate ☐ Severe ☐ Lethal
	☐ Mild ☐ Moderate ☐ Severe ☐ Lethal
FOOD/OTHER	**REACTION**
	☐ Mild ☐ Moderate ☐ Severe ☐ Lethal
	☐ Mild ☐ Moderate ☐ Severe ☐ Lethal
	☐ Mild ☐ Moderate ☐ Severe ☐ Lethal
	☐ Mild ☐ Moderate ☐ Severe ☐ Lethal

SUBSTANCE USE HISTORY								
Substance	**Past OR Present**	**Route**	**Frequency**	**Quantity**	**Age of First Use**	**Date of Last Use**	**Heaviest Use (amount/ frequency)**	**# of days used in last 30 days**
Alcohol	☐ Past / ☐ Present							
Caffeine (pills or beverages)	☐ Past / ☐ Present							
Cocaine	☐ Past / ☐ Present							
Crystal / Meth-amphetamine	☐ Past / ☐ Present							
Heroin / Other Opiates	☐ Past / ☐ Present							
Inhalants	☐ Past / ☐ Present							
LSD or Hallucinogens	☐ Past / ☐ Present							
Marijuana	☐ Past / ☐ Present							
Methadone	☐ Past / ☐ Present							
Pain Killers	☐ Past / ☐ Present							
PCP	☐ Past / ☐ Present							
Stimulants (pills)	☐ Past / ☐ Present							
Tranquilizers / Sleeping Pills	☐ Past / ☐ Present							
Ecstasy	☐ Past / ☐ Present							
Nicotine	☐ Past / ☐ Present							
Barbiturates	☐ Past / ☐ Present							
Benzodiazepine	☐ Past / ☐ Present							

What is your drug of choice?

Have you ever experience any of the following in relation to your substance abuse? ***(Check all that apply; explain if yes)***

- ☐ **Have people around tell you that you have a problem with (substance)** _____
- ☐ **Taking larger amounts than intended** _____
- ☐ **Symptoms of dependence (needing larger amounts in order to get the same effects)** _____
- ☐ **Impaired ability to complete social-/home-/work-related tasks** _____
- ☐ **Symptoms of withdrawal (physical/emotional/mental)** _____
- ☐ **Substance related legal issues** _____

Have you received treatment for substance abuse? ☐ Yes ☐ No

If yes, please explain:

Do you think you need treatment, or are you open to treatment for substance abuse? ☐ Yes ☐ No

SOCIAL HISTORY

CHILDHOOD

Parents	☐ Married ☐ Divorced	Siblings	# of Siblings: _____ Your placement in birth order:_____
Place of birth:		Significant relationships:	
Significant life events from age 0–12:			

ADOLESCENCE

Describe any impact puberty had on your emotional development:
Describe relevant factors about your psychosexual history that impacted your emotional development:
Describe your school performance:
Describe your past relationships (peers, dating, other):
Describe any early experiences with drugs and alcohol:

ADULTHOOD

Education	Highest level of schooling completed: ☐ Grade _____ ☐ High School/GED ☐ Professional/Vocational School ☐ Some college ☐ Bachelor's Degree ☐ Graduate ☐ Other _____
Employment	Work History:
	Current: Employer: _____ Address: _____ Occupation: _____ Dates: _____
Military	☐ Yes ☐ No Branch: _____ ☐ Active Duty ☐ Reserves ☐ Veteran Did you receive a service-connected disability rating? ☐ Yes ☐ No If yes, what rating? _____
Legal	Have you ever been arrested or convicted? ☐ Yes ☐ No ☐ DUI ☐ Drug Related ☐ Domestic Violence ☐ Other _____ Please explain:

SOCIAL HISTORY *(CONTINUED)*

RELATIONSHIPS

Marital Status	☐ Single ☐ Married – How many times? _____ ☐ Divorced – How many times? ____ ☐ Widowed If married, describe relationship with spouse: _____ If divorced, length of previous marriage and reason for divorce: _____ If not married, describe significant relationships: _____

Do you have children? ☐ Yes ☐ No	Age	Sex	Quality of relationship

Current living situation (who lives in your home):

Do you have family nearby? ☐ Yes ☐ No Please describe:

Please list any spiritual/religious variables that may impact your treatment:

FAMILY HISTORY

***Please list the name(s) and relationship to you of any blood relative who have suffered from or been treated for mental/ emotional/ psychological problems, including depression, nervousness, suicide/suicide attempts, alcoholism, drug abuse, schizophrenia, phobias, etc., or from neurological or unusual diseases.*

Family Member Name & Relation	Diagnosis	Type of Problem
Father:		
Mother:		
Sibling: ☐ MALE ☐ FEMALE		
Sibling: ☐ MALE ☐ FEMALE		
Grandfather: ☐ PATERNAL ☐ MATERNAL		
Grandmother: ☐ PATERNAL ☐ MATERNAL		
Uncle: ☐ PATERNAL ☐ MATERNAL		
Aunt: ☐ PATERNAL ☐ MATERNAL		
Cousin: ☐ MALE ☐ FEMALE ☐ PATERNAL ☐ MATERNAL		

Notice of Privacy Practices

Psychiatric Solutions PC 1620 N Mamer, Spokane Valley, WA 99216

Effective Date: December 19, 2017

Edited: December 19, 2017

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

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A. How this Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We will not share information with other physicians or other health care providers without your written authorization to do so. Medical information about you may also be shared with members of your family if we believe you are in danger of harming yourself or another person.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates", such as our transcriptionist who performs services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4. Appointment Reminders. We **may** use and disclose medical information to contact and remind you about appointments. If you are not home, we **may** leave this information on your answering machine or in a message left with the person answering the phone. However, we make every attempt to protect your confidentiality by **not** leaving the name of your provider on your answering machine or with anyone who may answer the phone. It is our office policy to leave a message similar to the following when confirming your appointment: “This message is for [name of patient]. This is [name of staff person] calling from your doctor’s office to confirm your appointment on [date and time]. Please call our office at 899-3370 should you have any questions.”

5. Sign in sheet. We do not use sign in sheets. However, we may use and disclose medical information about you by calling out your **first name only** when we are ready to see you.

6. Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location or your general condition in the event of an emergency only. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. Under normal circumstances, we may also disclose information to someone who is involved with your care or helps pay for your care without your written authorization. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. We will not use or disclose your medical information without your written authorization at any point in the future related to such activities.

8. Required by law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities. **Duty to warn** or to take reasonable precautions to provide protection from violent behavior where the patient has communicated an actual threat of physical violence against a reasonably identifiable victim or victims. The duty to warn is discharged if reasonable efforts are made to communicate the threat to the victim or victims and to law enforcement personnel. **Volk-** If a statement of harm is made where a victim or victims cannot be identified the provider will make a report to crime check or law enforcement personnel.

9. Public health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

10. Health oversight activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

11. Judicial and administrative proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

12. Law enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

14. Organ or tissue donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

15. Public safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

16. Specialized government functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

17. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer. **Note: we are not currently accepting any worker's compensation cases at this time**.

18. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to

request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular address or contact you by phone only at a certain number. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. Mental Health records are not typically available for your inspection and copying. They are subject to different protections than other medical records, such as the records kept by your primary care physician. We are not required to provide you access to inspect and copy your mental health records; this access is at the discretion of the physician. If you wish to access your mental health records, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. Should your physician approve such a request, we may charge a reasonable fee, as allowed by California law. We may deny your request for the reasons stated above. If we deny your request to access your mental health records, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 4 (appointment reminders), 5 (check-in procedures), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to a paper copy of this Notice of Privacy Practices.

7. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted on the back of your physician's door, and will offer you a copy at each appointment.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.
If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

You will not be penalized for filing a complaint.