

Psychiatric, Health and Wellness, LLC

SECTION A

REASON FOR VISIT

MAJOR COMPLAINT IN ORDER OF SIGNIFANCE:(DEPRESSION, ANXIETY, ETC)

1. _____ For How Long? _____

2. _____ For How Long? _____

PLEASE INDICATE IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS WITHIN THE LAST MONTH (PLACE AN X BESIDE SYMPTOM)

- | | |
|----------------------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> DEPRESSED MOOD | <input type="checkbox"/> PERSISTENT ELEVATED MOOD (> 1wk) |
| <input type="checkbox"/> TEARFULNESS/CRYING | <input type="checkbox"/> FEEL HYPERPRODUCTIVE |
| <input type="checkbox"/> DIFFICULTY FALLING ASLEEP | <input type="checkbox"/> FEEL EXTREMELY CONFIDENT |
| <input type="checkbox"/> DIFFICULTY STAYING ASLEEP | <input type="checkbox"/> FEEL RESTED AFTER 3 HRS OF SLEEP |
| <input type="checkbox"/> EXCESSIVE SLEEPING | <input type="checkbox"/> TALKING TOO FAST OR TOO MUCH |
| <input type="checkbox"/> EARLY MORNING AWAKENING | <input type="checkbox"/> RACING THOUGHTS |
| <input type="checkbox"/> DECREASED ENERGY/FATIGUE | <input type="checkbox"/> JUMPS FROM TOPIC TO TOPIC |
| <input type="checkbox"/> LOSS OF INTEREST IN THINGS | <input type="checkbox"/> EASILY DISTRACTED |
| <input type="checkbox"/> APPETITE INCREASE/DECREASE | <input type="checkbox"/> IMPULSIVE AND/OR RECKLESS BEHAVIOR |
| <input type="checkbox"/> WEIGHT LOSS/GAIN | <input type="checkbox"/> PROMISCUITY |
| <input type="checkbox"/> HOPELESSNESS/HELPLESSNESS | <input type="checkbox"/> INCREASE NEED TO SHOP/SPEND MONEY |
| <input type="checkbox"/> FEELINGS OF WORTHLESSNESS | <input type="checkbox"/> SYMPTOMS LAST > 7 DAYS |
| <input type="checkbox"/> LOSS OF INTEREST | <input type="checkbox"/> SYMPTOMS LAST < 7 DAYS > 4 DAYS |
| <input type="checkbox"/> LOSS OF SEXUAL DESIRE | |
| <input type="checkbox"/> SEXUAL DYSFUNCTION | |
| <input type="checkbox"/> MEMORY DIFFICULTIES-SHORT TERM | <input type="checkbox"/> FLASHBACKS OF TRAUMATIC EVENT |
| <input type="checkbox"/> MEMORY DIFFICULTIES-LONG TERM | <input type="checkbox"/> NIGHTMARES |
| <input type="checkbox"/> DIFFICULTY CONCENTRATING | <input type="checkbox"/> HYPERVIGILANCE |
| <input type="checkbox"/> DIFFICULTY MAKING DECISIONS | <input type="checkbox"/> OUTBURSTS OF ANGER |
| <input type="checkbox"/> FEELINGS OF GUILT | |
| <input type="checkbox"/> SUICIDAL THOUGHTS | |
| <input type="checkbox"/> POST PARTUM DEPRESSION | |
| <input type="checkbox"/> RESTLESSNESS/ON EDGE | <input type="checkbox"/> FEELINGS OF PARANOIA |
| <input type="checkbox"/> EASILY FATIGUED | <input type="checkbox"/> HEARING VOICES |
| <input type="checkbox"/> FORGETTING/MIND GOING BLANK | <input type="checkbox"/> SEEING THINGS OTHERS DO NOT SEE |
| <input type="checkbox"/> IRRITABILITY | <input type="checkbox"/> INTRUSIVE THOUGHTS |
| <input type="checkbox"/> NERVOUSNESS | <input type="checkbox"/> BELIEVING THINGS THAT ARE NOT TRUE |
| <input type="checkbox"/> EXCESSIVE WORRY/FEAR | |
| <input type="checkbox"/> MUSCLE TENSION | |
| <input type="checkbox"/> OBSESSIVE THOUGHTS | <input type="checkbox"/> EATING DISORDER |
| <input type="checkbox"/> COMPULSIVE BEHAVIORS | <input type="checkbox"/> RELATIONSHIP DIFFICULTIES |
| <input type="checkbox"/> SOCIAL ANXIETY | <input type="checkbox"/> LEGAL TROUBLE |
| <input type="checkbox"/> PERFECTIONISM | <input type="checkbox"/> THOUGHTS OF HARMING SOMEONE |
| <input type="checkbox"/> PERFORMANCE ANXIETY | |
| <input type="checkbox"/> AGORAPHOBIA (difficulty leaving home) | |
| <input type="checkbox"/> PANIC ATTACKS | |

PATIENT SIGNATURE: _____

DATE

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**SECTION B
MEDICATIONS**

PREVIOUS PSYCHIATRIC DIAGNOSIS: (Include Psychiatric Hospitalizations)

ALLERGIES TO MEDICATIONS:

CURRENT PSYCHIATRIC MEDICATIONS

<u>NAME</u>	<u>MG</u>	<u>DOSING</u>	<u>DURATION</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PAST PSYCHIATRIC MEDICATIONS

<u>NAME</u>	<u>MG</u>	<u>DOSING</u>	<u>DURATION</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

VITAMINS/SUPPLEMENTS: _____

PATIENT SIGNATURE: _____ DATE _____

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SECTION C

MEDICATIONS/MEDICAL HISTORY

GENERAL MEDICATIONS (For high blood pressure, diabetes, or other)

NAME	MG	DOSING	DURATION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Use back of this form for more space)

MEDICAL HISTORY:

CURRENT MEDICAL HISTORY:

____ THYROID DISORDER DATE OF LAST PHYSICAL EXAM: _____

____ DIABETES DATE OF LAST BLOOD WORK: _____

____ HIGH BLOOD PRESSURE

____ HIGH CHOLESTEROL

____ HIGH TRIGLYCERIDES

____ HEART DISEASE

____ OTHER _____

PATIENT SIGNATURE: _____ **DATE** _____

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SECTION D

FAMILY HISTORY

FAMILY MEDICAL HISTORY: (Place an X beside any disorder that applies and also which relative-include immediate family and grandparents)

DISORDER:		RELATIVE:
Thyroid Disorder	_____	_____
Diabetes	_____	_____
High Blood Pressure	_____	_____
Heart Disease	_____	_____
Other	_____	_____

FAMILY MENTAL HEALTH HISTORY (Place an X beside disorder that applies and list relatives-include immediate family and grandparents)

DISORDER:		RELATIVE:
Depression	_____	_____
Anxiety	_____	_____
Panic Attacks	_____	_____
Bipolar	_____	_____
Schizophrenia	_____	_____
ADD/ADHD	_____	_____
Autism	_____	_____
Addictions	_____	_____
Other	_____	_____

LIVING ENVIRONMENT

Are you married? Yes____No____ 1st Marriage____2nd Marriage ____3rd Marriage

Please list all persons currently in the home (and ages) _____

IF THE PATIENT IS A CHILD (UNDER THE AGE OF 18) PLEASE COMPLETE THIS

SECTION- Are you the biological parent? Yes____No____

Normal Pregnancy Yes____No____Complications: _____

Any Developmental Delays? Yes____NO____

Age child performed the following: walked____talked____potty trained____

Other important information:_____

PATIENT SIGNATURE: _____

DATE

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SECTION E

ALCOHOL/DRUG ASSESSMENT

Do you smoke cigarettes? Yes _____ No _____ How many per day? _____ How many years? _____
Do you drink alcohol? Yes _____ No _____ Have you ever had a problem with alcohol? Yes _____ No _____
(If you answered No, skip to next section if yes, continue to complete this section)

How much do you drink? _____(daily) _____(weekly) _____Binge (weekends)
Has alcohol ever caused problems in your relationships? Yes _____ No _____

Have you ever experienced blackouts from your drinking? Yes _____ No _____
Have you ever thought you needed to cut back on your drinking? Yes _____ No _____
Have you ever been annoyed with people when they criticize your drinking? Yes _____ No _____
Have you ever felt bad or guilty about your drinking? Yes _____ No _____
Have you ever had a drink first thing in the morning to steady your nerves? Yes _____ No _____
What age did you take your first drink? _____ When did you last drink alcohol? _____

Do you currently use recreational drugs? Yes ___ No ___ Have you ever used recreational drugs? Yes ___ No ___
What age did you start using recreational drugs? ___ Date of last use of a recreational drug? _____
Have you ever used prescription medications that were not prescribed for you or used them longer than you should have? Yes _____ No _____ Name of Drug/Drugs: _____

Please indicate (place an X) the type of drug used

	PAST	CURRENT	PRESCRIBED	NOT PRESCRIBED
Marijuana _____	_____	_____		
Cocaine _____	_____	_____		
Heroin _____	_____	_____		
Xanax _____	_____	_____	_____	_____
Klonopin _____	_____	_____	_____	_____
Vicodin _____	_____	_____	_____	_____
Percocet _____	_____	_____	_____	_____
Oxycontin _____	_____	_____	_____	_____
Adderall _____	_____	_____	_____	_____
Ecstasy _____	_____	_____		
Other: _____				

What is the longest period of time you have not used drugs or alcohol? _____

PATIENT SIGNATURE: _____

DATE _____

Psychiatric, Health and Wellness, LLC
810 Michael Drive, Suite L Chesterton, IN 46304
MEDICATION AND TREATMENT AGREEMENT

PLEASE INITIAL EACH STATEMENT

1. ____ I understand this agreement is essential to the trust and confidence necessary in a provider/patient relationship and my mental health provider agrees to treat me based on this agreement.
2. ____ I understand if I breach this agreement in any way, my mental health provider may stop treatment (including prescribing medication) for me. In this case, I understand that I may suffer withdrawal symptoms that are of my choosing due to non-adherence to recommended treatment.
3. ____ I agree to assume responsibility in informing my mental health provider of any medications being prescribed by other health care providers (including but not limited to pain meds, narcotics, muscle relaxers, etc.) within 24 hours.
4. ____ I agree to choose the provider listed above as my provider in prescribing mental health medication and I will not seek medication with any other provider. If I receive medications from any other provider (including visits to the emergency room, urgent care, etc.), I agree to inform my mental health provider within 24 hours. If I fail to do so, I understand I breach this agreement.
5. ____ I agree to inform my mental health provider of using any recreational drugs (including but not limited to alcohol, marijuana, cocaine, heroin, crystal meth or other). If I fail to do so, I will breach this agreement and my mental health provider may terminate my care.
6. ____ I understand it is my responsibility for the safekeeping of my medication to ALL other persons. I understand my medications may be lethal to others who may not be tolerant to them, such as children, adolescents, elderly and pets. Also, lost or stolen medicines will not be replaced. It is my responsibility to report any lost or stolen prescriptions or medications to the police so a report is filed.
7. ____ I will not drive or operate machinery if my medications impair my ability to safely perform these activities (note medication label and drug information warnings).
8. ____ **I understand and agree prescriptions will be refilled only at the time of my office visit. No refills will be available after hours, evenings, weekends, or Holidays. This office does not accept auto refills from your pharmacy. I accept this responsibility and realize if I run out of my medication, I may experience withdrawal which is of my own choosing from non-adherence to treatment. I understand it is my responsibility to obtain all necessary refills at the time of my appointment.**
9. ____ I agree to use my medication as prescribed by my mental health provider and not exceed the prescribed dose.
10. ____ I will not alter my medication in any way (e.g. crushing, chewing, injection, insufflation) or any other method of delivery.
11. ____ I agree to notify my mental health provider within 24 hours if I am pregnant or become pregnant while taking medication.
12. ____ I agree to pill counts as requested and a random blood/ urine drug screens without notice to determine my compliance with my provider's recommended treatment. If I fail this test, I understand I will be counseled by my mental health provider and offered a chemical dependency treatment plan as appropriate. If I refuse or fail to seek such treatment, my mental health provider may terminate my care.
13. ____ I authorize my mental health provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency in the investigation of any possible misuse, sale, or other diversion of my medication. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations set forth herein.
14. ____ I agree to provide my mental health provider of name and phone number of any other health care providers (pain doctors, etc.) that I am currently receiving medications. I also authorize to release any of my records and for providers to share information in regards to my compliance with treatment.
Doctors Name _____ City: _____ Phone#: _____
15. ____ I agree to comply with my providers recommended follow up appointments. Failure to keep recommended appointments may result in termination of my care.
16. ____ I understand the choice of pharmacy I use is mine; however, I agree this will be the only pharmacy I will use.
Pharmacy name: _____ City: _____ Phone #: _____
If I change pharmacies, I will notify my mental health provider within 24 hours.
I agree to follow ALL these guidelines. I have a complete understanding of this Agreement and I have been given a copy.

****PLEASE NOTE: THIS OFFICE IS CLOSED EVERY FRIDAY.**

PRINT NAME

SIGNATURE

DATE

