PATIENT HISTORY DATA FORM

Psychiatric, Health and Wellness, LLC
119 BROADWAY, SUITE 101 Chesterton, IN 46304

PRINT THIS FORM, COMPLETE AND BRING WITH YOU
(DO NOT COMPLETE ONLINE)

DATE: _____

NAME: _____
LAST FIRST MI

DATE OF BIRTH: _____AGE:_____ GENDER: FEMALE____ MALE_____

ADDRESS: _____
STREET CITY STATE ZIP

PHONE: _____ _____ _____
HOME CELL WORK

BEST WAY TO CONTACT YOU: _____EMAIL:_____

SOCIAL SECURITY#_____DRIVERS LICENSE # _____

RELATIONSHIP STATUS: SINGLE / MARRIED / SEPARATED /DIVORCED / WIDOWED

RELIGIOUS/SPIRITUAL BACKGROUND: _____

EDUCATION: _____OCCUPATION: _____

SIGNIFICANT OTHER'S NAME & OCCUPATION: _____

CHILDREN: _____
NAMES AGES

EMERGENCY CONTACT INFORMATION

IN CASE OF EMERGENCY NOTIFY: _____
NAME PHONE

PRIMARY CARE PHYSICIAN: _____
NAME PHONE

HOW DID YOU HEAR ABOUT THIS OFFICE? FRIEND_____FAMILY MEMBER_____
DR. REFERRAL_____ OTHER_____

PATIENT NAME: _____
(PRINT) FIRST LAST

PATIENT SIGNATURE:_____
FIRST LAST DATE

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)

_____DEPRESSED MOOD
_____TEARFULNESS/CRYING
_____DIFFICULTY FALLING ASLEEP
_____DIFFICULTY STAYING ASLEEP
_____EXCESSIVE SLEEPING
_____EARLY MORNING AWAKENING
_____DECREASED ENERGY/FATIGUE
_____LOSS OF INTEREST IN THINGS
_____APPETITE INCREASE/DECREASE
_____WEIGHT LOSS/GAIN
_____HOPELESSNESS/HELPLESSNESS
_____FEELINGS OF WORTHLESSNESS
_____LOSS OF INTEREST
_____LOSS OF SEXUAL DESIRE
_____SEXUAL DYSFUNCTION
_____MEMORY DIFFICULTIES-SHORT TERM
_____MEMORY DIFFICULITIES-LONG TERM
_____DIFFICULTY CONCENTRATING
_____DIFFICULTY MAKING DECISIONS
_____FEELINGS OF GUILT
_____SUICIDAL THOUGHTS
_____POST PARTUM DEPRESSION

_____PERSISTENT ELEVATED MOOD (> 1wk)
_____FEEL HYPERPRODUCTIVE
_____FEEL EXTREMELY CONFIDENT
_____FEEL RESTED AFTER 3 HRS OF SLEEP
_____TALKING TOO FAST OR TOO MUCH
_____RACING THOUGHTS
_____JUMPS FROM TOPIC TO TOPIC
_____EASILY DISTRACTED
_____IMPULSIVE AND/OR RECKLESS BEHAVIOR
_____PROMISCUITY
_____INCREASE NEED TO SHOP/SPEND MONEY
_____SYMPTOMS LAST > 7 DAYS
_____SYMPTOMS LAST < 7 DAYS > 4 DAYS

_____FLASHBACKS OF TRAUMATIC EVENT
_____NIGHTMARES
_____HYPERVIGILANCE
_____OUTBURSTS OF ANGER

_____RESTLESSNESS/ON EDGE
_____EASILY FATIGUED
_____FORGETTING/MIND GOING BLANK
_____IRRITABILITY
_____NERVOUSNESS

_____FEELINGS OF PARANOIA
_____HEARING VOICES
_____SEEING THINGS OTHERS DO NOT SEE
_____INTRUSIVE THOUGHTS
_____BELIEVING THINGS THAT ARE NOT TRUE

_____EXCESSIVE WORRY/FEAR
_____MUSCLE TENSION
_____OBSESSIVE THOUGHTS
_____COMPULSIVE BEHAVIORS
_____SOCIAL ANXIETY
_____PERFECTIONISM
_____PERFORMANCE ANXIETY
_____AGORAPHOBIA (difficulty leaving home)
_____PANIC ATTACKS

_____EATING DISORDER
_____RELATIONSHIP DIFFICULTIES
_____LEGAL TROUBLE
_____THOUGHTS OF HARMING SOMEONE

PATIENT SIGNATURE: _____

DATE

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SECTION B

MEDICATIONS

PREVIOUS PSYCHIATRIC DIAGNOSIS: (Include Psychiatric Hospitalizations)

_____

_____

ALLERGIES TO MEDICATIONS:

_____

CURRENT PSYCHIATRIC MEDICATIONS

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

PAST PSYCHIATRIC MEDICATIONS

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

VITAMINS/SUPPLEMENTS: _____

_____

PATIENT SIGNATURE: _____

DATE

Psychiatric, Health and Wellness, LLC

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

_____DIABETES

_____HIGH BLOOD PRESSURE

_____HIGH CHOLESTEROL

_____HIGH TRIGLYCERIDES

_____HEART DISEASE

_____OTHER _____

DATE OF LAST PHYSICAL EXAM:_____

DATE OF LAST BLOOD WORK: _____

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
119 Broadway, Suite 101 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 breech 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 breech 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 breech 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