Patient name:
DOB:

Patient Questionnaire

Date: _____ Patient Name: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: _____ Marital Status: _____

SS#: _____-_____-_____ Hispanic : _____ Race: _____ Primary Language: _____

Address: _____

City: _____ State: _____Zip: _____

Home Phone: _____-_____-_____ Work Phone: _____-_____-_____

Cell Phone: _____-_____-_____ Email: _____

Contact Preference: _____

I consent to have detailed messages left on the preferred contact number? Yes No

Signature:_____ Date:_____

Emergency Contact: Name: _____ Phone: _____-_____-_____

Employer: _____ Work Phone:_____

Primary Care Physician: _____ Phone: _____-_____-_____

List Other Doctors: _____ Phone: _____-_____-_____

Referred By: _____ Phone: _____-_____-_____

Responsible Party: _____ DOB: _____/_____/_____

Relationship: _____

Address: _____ Phone: _____-_____-_____

Patient name:
DOB:

Primary Insurance: _____

Insured Member: _____Address: _____

Identification #: _____ Group #: _____

Employer: _____SS#:_____-_____-_____ DOB: _____/_____/_____

Secondary Insurance: _____

Insured Member: _____Address: _____

Identification #: _____ Group #: _____

Employer: _____SS#:_____-_____-_____ DOB: _____/_____/_____

I authorize payment of medical benefits to the physician listed on insurance claim for services described:

Signature: _____ Date: _____

I authorize release of information regarding _____ to my insurance company, if and when they request it (if you choose not to sign this line please keep in mind insurance might decide to not pay the bill at which time it will be due to the patient):

Signature: _____ Date: _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information and completed the above. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature: _____ Date: _____

Is the purpose of this evaluation to obtain disability? _____ Yes _____No

Patient name:
DOB:

OFFICE POLICY

Effective communication is a cornerstone of good relationships. In order to answer questions which are frequently asked by patients or clients regarding fees, confidentiality of services, etc., this policy statement was developed for your information and discussion. Please discuss any questions that you might have with your clinician. We will make every effort to develop a professional relationship that will be satisfactory to everyone.

APPOINTMENTS AND OFFICE HOURS: Services are by appointment only. The length of the appointment time varies on the basis of services provided ranging from 10-50 minutes. Because the appointment is reserved for you, it is necessary to charge for appointments which are not cancelled 24 hours in advance, unless there are circumstances which would be defined as an emergency. Failure to provide a 24 hour notice generally means that some other person is not able to use that appointment time. Office staff attempts a "courtesy" call to remind of appointments but it is ultimately patient's responsibility to know when appointments are.

On rare occasions an emergency situation may force a scheduled appointment to be missed by your clinician. Every attempt to reach you in advance will be made, but may not be successful. Again, this rarely happens. **In the event of a state of emergency for Vanderburgh County, we will be closed. This includes state of emergency for inclement weather. If at all possible, we will make every attempt to contact patients and Channel 14 News.**

As we work together, you will notice that we do not accept phone calls while with patients or clients except in an emergency. During those times, and at other times during the day, calls are answered by the receptionist or the answering service. Messages are received periodically through the day and most calls are returned the same day. Emergency services are available. If emergency coverage becomes an issue, we will discuss options with you.

FEE POLICY AND INSURANCE: Charges for services are based on the usual, customary, and reasonable fee profile for this area. Reports for the court or any third party will not be released until services are paid in full. It is customary to pay professional fees at each visit. This simplifies procedures and minimizes costs. Your health insurance may provide coverage for mental health services. Consult your policy for specifics. As a service, this office will submit services to your insurance carrier after this office has been given the necessary information. If you have assigned the benefits to us, we will require that your estimated co-pay be made at the time of service. Since we are not a party to the agreement with your insurance carrier, the entire bill always remains your responsibility. If your insurance has not paid within 90 days of our billing them for you, you will be responsible for the bill at that time. Should your insurance money arrive after your payment to us, we will promptly reimburse you. There will be a billing charge on accounts over 90 days past due of 5% per month on unpaid balances.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT: I authorize treatment of person named and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and

members of my family shown by statements, promptly upon presentment thereof, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be corrected reasonable unless protested in writing within 30 days of the billing date. In the event that legal action should become necessary to collect an unpaid balance due for psychological services rendered to me or my family, I/We agree to pay reasonable attorney fees or other such costs as the court determines proper. It is agreed that payments will not be delayed or withheld because of the pending insurance claims submitted to the carrier and practice. If there would be a credit balance from insurance payments I will be reimbursed by the practice. I understand that this assignment does not relieve me from the liability for unpaid services. In the event that insurance benefits to which I am entitled are paid directly to me for services incurred by me or a member of my family or for a person I am financially responsible, I agree that I will immediately deliver all such benefits received.

CONFIDENTIALITY: Any information obtained by this office is confidential. Information regarding services is controlled by you the patient or client and can only be released with your written permission. There are two exceptions to this rule. In the case of an emergency where there is imminent danger to you or other persons, confidentiality may be breached. Secondly, Indiana Law requires child abuse be reported.

When a patient or client is referred by a physician or another professional, communication regarding pertinent treatment considerations will be maintained with that professional unless the patient or client specifies to the contrary. Insurance companies are entitled to a diagnosis, and dates and types of service. While a patient's or client's diagnosis is very sensitive information and is generally treated as such by insurance carriers, we cannot guarantee how any particular insurance carrier or employer respects this information.

TREATMENT: We expect and encourage you to obtain knowledge of the procedures, goals, and possible side effects of mental health treatment. We expect to make our professional contact one where you receive the maximum benefit, and we will also keep you informed about alternatives in treatment. You will be expected to contribute to all decisions regarding interventions devised for you, including out-of-session assignments. You have the right to refuse or alter any interventions. Psychotherapy may be tremendously beneficial for some individuals, while at the same time, there are some risks. The risks may include the experience of intense and unwanted feelings, including: sadness, anger, guilt, or anxiety. It is important to remember that these feelings may be natural and normal and are an important part of the therapy process. Other risks of therapy might include: questioning of beliefs, increased awareness of feelings, values and experiences, alteration of an individual's ability or desire to deal effectively and harmoniously with others in relationships. In decisions involving separation within families, development of other types of relationships, changing employment, and changing lifestyles. These decisions are a legitimate outcome of the therapy experience as a result of an individual's calling into question many of their beliefs and values. We are available to discuss any of your assumptions, problems, or possible negative side effects of our work.

TERMINATION: Termination of treatment may occur at any time and may be initiated by either the client or the clinician. We request that if a decision is being made to terminate, that there be a

minimum of a seven day notice in order that a final termination session(s) may be scheduled. Termination may be a very constructive, useful process. If any referral is warranted, it will be made at that time.

I, the undersigned, reviewed and agree to the above policy and consent to participate in the mental health services offered. I understand that I am consenting and agreeing only to those mental health services this office is qualified to provide.

_____ _____

Signature **Date**

_____

Signature of Parent or Guardian

Patient name:
DOB:

What is (are) your chief concern (s) for seeking help? Please be specific.

_____
_____
_____
_____
_____
_____
_____
_____
_____

What has already been tried to treat your problem? What has worked best for this problem?

_____
_____
_____
_____
_____
_____
_____
_____
_____

Have you ever been hospitalized in a psychiatric facility? Yes _____ No _____

How many times? _____

When?

_____
_____

How do you spend your time? What are your hobbies or interests?

_____
_____
_____
_____
_____

Patient name:
DOB:

Past Medical History

Yes	No	Do you or have you had the following?
		Depression
		Previous know suicide attempt
		Self-inflicted injury
		Anxiety
		Alcohol abuse
		Drug abuse
		Bipolar disorder
		Schizophrenia
		Eating disorder
		Obesity
		Diabetes
		High blood pressure
		High cholesterol
		Heart disease (CAD)
		Heart attack
		Kidney problems
		Liver disease
		Stroke
		TIA
		Glaucoma
		Migraine
		Seizures
		COPD
		Sexually transmitted disease
		HIV
		Hyperthyroidism
		Hypothyroidism
		Obstructive sleep apnea
		Sleep disorders
		Alzheimer's disease
		Vascular dementia
		Traumatic brain injury
		ADHD
		Asperger syndrome
		Autism
		Learning disability

Other Past Medical History:

_____

_____

Surgical History

Yes	No	Have you had the following surgeries?
		Appendectomy
		Back surgery
		Cholecystectomy
		Colectomy
		Coronary artery bypass graft
		Hysterectomy
		Hysterectomy total with removal of both tubes and ovaries
		Thyroidectomy
		Tubal ligation
		Anesthesia complications
		Cardiac stent
		Bariatric surgery

Other Surgical History:

_____

_____

Social History

Yes	No	Social History
		Current every day smoker
		Current some day smoker
		Former smoker
		Never smoked
		Smoker, current status unknown
		Unknown if ever smoked
		Other tobacco use
		Passive smoker
		Alcohol use
		Alcohol abuse
		Past alcohol abuse
		Current drug user
		Past drug use
		Substance abuse: amphetamines
		Substance abuse: cocaine
		Substance abuse: heroin
		Prescription drug abuse
		Exercise
		Follows a diet

Patient name:
DOB:

Yes	No	**Social History Continued**
		Caffeine
		Lives alone
		Children
		Employed
		Received disability payments
		Abused
		Sexually active
		Married
		Divorced
		Separated
		Single
		Widowed
		Siblings
		Military history
		Legal problems
		High school diploma
		Attending higher education college
		Received higher education college education
		Received higher education at technical college
		Received university education
		Received postgraduate education
		Received post doctorate education

Other:

_____

_____

Family History

Yes	No	Does anyone in your family have the following?
		Psychiatric condition
		Alcoholism
		Substance abuse
		ADD/ADHD
		Depression
		Postpartum depression
		Diabetes
		Heart disease (CAD)
		High cholesterol
		Hypertension

Yes	No	**Family History Continued**
		Stroke
		Epilepsy
		Thyroid disease
		Liver disease
		Kidney disease
		Cancer, other unspecified
		Huntington's disease
		Other inherited genetic or chromosomal disorder

Other:

_____

_____

General Symptoms

Yes	No	Do you experience any of the following?
		Insomnia
		Excessive day and night-time sleepiness
		Increased appetite
		Decreased appetite
		Recent weight change
		Weight gain
		Weight loss
		Pain
		Night sweats
		Fever
		Chills
		Dizziness
		Fatigue
		Weakness
		Activity level normal

Other:

_____

_____

Patient name:
DOB:

Neurological Symptoms

Yes	No	Do you experience any of the following?
		Headaches
		Migraines
		Seizures
		Fainting
		Lightheadedness
		Short term memory problems
		Long term memory problems
		Confusion/ disorientation
		Change in personality
		Change in vision
		Trouble hearing
		Trouble smelling
		Change in taste
		Speech changes
		Facial weakness/ numbness
		Drooling
		Weakness/ numbness in arm
		Weakness/ numbness in leg
		Loss of limb use
		Tremors
		Involuntary movements
		Trouble with coordination
		Difficulty walking
		Balance problems
		Losing control of urine or bowel

Other:
_____
_____

Psychiatric Symptoms

Yes	No	Do you experience any of the following?
		Depression
		Frequent crying
		Feeling hopeless
		Sadness
		Loss of interest
		Loss of initiative
		Trouble with focus, concentration, or decision-making
		Feeling angry
		Mania
		Excessive energy
		Anxiety
		Nervousness
		Panic attack
		Auditory hallucinations
		Visual hallucinations
		Delusions
		Suicidal thoughts
		Homicidal thoughts

Other:
_____
_____

Patient name:
DOB:

DATE

DRUG ALLERGIES (please indicate if you have none, don't leave blank)		
CURRENT MEDICATIONS PRESCRIBED: NAME AND DOSAGE	**DIRECTION: HOW IS IT TAKEN/ DIRECTION PER BOTTLE**	**PRESCRIBED BY**

WHAT PHARMACY DO YOU USE TO FILL PRESCRIPTIONS?

NAME AND PHONE NUMBER: