Gordon Behavioral Sciences, P.C.

Frank G. Pratt, Jr., M.D
Psychiatrist

Patient Registration

Patient Name ____
Last *First* *Middle Initial*

Mailing Address ____

City ____________________ **State** _______ **ZIP**_______________

Home Phone ___________________ **Work Phone** _________________________

Cell Phone ____________________ **Friend or Family Member**_____________
someone to call to get a message to you if you can't be reached

Date of Birth ____________ **Sex** ________ **Age** ________ **Race** ____________

Social Security Number ______________________ **Are you retired?** Yes ___ No ___

Employer Name/Address _______________________________________

In case of an emergency, who should be notified?

Name _______________________________ **Phone Number** ________________

Relationship to Patient ____

If the patient is a minor <u>or</u> if someone other than patient is responsible for payment, please fill in everything below. The person responsible for the bill <u>must</u> sign below.

Guarantor Name ____
Last *First* *Middle Initial*

Date of Birth ____________ **Social Security Number** ______________________

Relationship to Patient: ____

I hereby accept responsibility for all charges to the account of this patient

Guarantor's Signature: ____

<u>Insurance Information</u> *We must have a copy of your card.*

Medicare # ____________________ Medicaid# ____________________

Insured Name *person responsible for bill, if not same as above.*

Name ______________________________ Employer ____________________

SSN ________________________________ Date of Birth ________________________

Phone Number ______________________ Do you have insurance? ___ Yes ___ No

---

Primary Insurance Information

Insurance Company ____

Insurance Address ____

Insurance Phone Number ____

Policy Number ______________________ Group Number ____________________

Policy Holder ________________________ Relationship to patient ______________

Secondary Insurance Information

Insurance Company ____

Insurance Address ____

Insurance Phone Number ____

Policy Number ______________________ Group Number ____________________

Policy Holder ________________________ Relationship to patient ______________

<u>NOTE: PAYMENT IS EXPECTED AT THE TIME OF SERVICE</u>

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDIATE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. I UNDERSTAND THAT GORDON BEHAVIORAL SCIECNES P.C. MAY USE THE SERVICES OF A COLLECTION AGENCY TO COLLECT DELINQUENT FEES FROM ME. I AUTHORIZE THE RELEASE OF MEDICAL AND GOVERNMENT BENEFITS TO GORDON BEHAVIORAL SCIENCES, P.C. THAT PROVIDE SERVICES TO ME.

____ ________________________

Signature Parent's signature if patient is under 18 ***Date***

Revised 07/19/19

Release and Assignment Form

1. I authorize the release by Frank G. Pratt, Jr., MD./ Gordon Behavioral Sciences, PC. of my medical records and information necessary to process my medical insurance claims.

2. I authorize and request payment of medical benefits directly to Frank G. Pratt, Jr., M.D., my physician.

3. I authorize Frank G. Pratt, Jr., M.D., my physician, to release my medical records and related information to any physician, hospital, or other medical treatment facility to which I may be referred to for medical care and treatment.

4. If the payment of any medical care is to be made by anyone besides myself, or if **I am a participant in a managed care organization,** I authorize the release by Frank G. Pratt, Jr., M.D., my physician, of pertinent information in my medical files or related information to such parties, including records, files and information related to psychiatric and psychological care, drug and alcohol abuse, child or adult abuse or neglect, and confidential HI V/AIDS information, **in order that Frank G. Pratt, Jr., M.D., my attending physician, may comply with the disclosure requirements of such plan, or for any reason requiring release of my medical tiles and records as contained in the Agreement between my insurance company and my attending physician.**

5. I am personally responsible for the payment to Frank G. Pratt, Jr., M.D./Gordon Behavioral Sciences, PC. for all charges that occur as a result of my medical treatment. I understand that Dr. Pratt's services may not be covered by insurance company. I have received a copy of Dr. Pratt's fee schedule, and understand that I will be subject to any future fee changes. I understand that I will be responsible for **100%** of these fees if my insurance coverage is denied.

6. Some services may require prior authorization.

7. If I am a Medicare enrollee, I authorize the holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for processing any of my Medicare related claims. I request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand that regulations pertaining to Medicare assignment of benefits apply.

8. I agree that this authorization will cover all medical services rendered until such authorization is revoked in writing by me. A photocopy of this form may be used in lieu of the original.

9. I authorize any and all pharmacies and pharmacists to release to Frank G. Pratt, Jr., M.D., my attending physician, all information concerning my pharmaceutical records.

10. I authorize Frank G. Pratt, Jr., M.D. to furnish any medical or pertinent financial information regarding my care to,________________________, my personal representative, who may be contacted at ________________________________ phone number (optional.)

11. In the event Dr. Pratt is unable to reach me, he may leave a message on my answering machine Circle one: yes no

12. I consent to the review of my medical record for the purposes of clinical research. I understand that any information collected is confidential and that my identity is protected Circle one: yes no

13. The undersigned patient hereby agrees and consents to such diagnostic procedures and the administration of such medical and or psychological treatment as the above-referenced attending physician may perform or request. Consent is also given for such other Gordon Behavioral Sciences, P.C. employees and personnel as maybe determined by the attending physician to provide such diagnostic procedures and treatment to the undersigned patient.

____ ______________________________

Signed Patient or Legal Representative *Date*

TREATMENT AGREEMENT

Both I the patient and my physician and his staff have a common treatment goal to improve my ability to function and/or work. In consideration of that goal I may be treated with potent medications. Some of them may be amphetamines, narcotics, tranquilizers and/ or barbiturates. Many of these medications are considered controlled substance medication, and their use is closely controlled and monitored by local, state and federal agencies. Prescribed medications are highly effective when taken as directed under medical supervision, but they also have a potential for misuse and abuse. I understand that medication alone, or in combination with alcohol, may impair my ability to think and perform tasks such as driving.

1. I realize that there are many problems inherent in the use of controlled substances, including the possibility of tolerance the loss of effect of the current dose, dependence abstinence syndrome might occur if the opioid is withdrawn, addiction loss of control in regard to the drug, with compulsive use and preoccupation with acquisition, and side effects such as skin rash, constipation, sexual dysfunction, sleep disturbance, sweating, altered mental status, sedation and difficulty breathing. I understand that to stop taking medications abruptly may be dangerous and lead to withdrawal symptoms. If medications need to be discontinued, I will do so gradually and only under medical supervision.
2. I recognize that opioids may be prescribed with the intent of improving my productivity and daily level of functioning. If they are prescribed, I may be asked to provide my physician with proof of same in the form of a statement of employment, school attendance, or volunteer work, or to obtain two sworn statements from responsible adults, only one of which can be a family member, who will identify the ways in which I am more productive and functional as a result of taking opioids.
3. I will obtain medications prescribed by Dr. Pratt from only one pharmacy, listed below:.

______________________	______________________
Pharmacy	**Phone**

4. I will inform my physician of all medications I am taking, because I realize that dangerous drug interactions can occur, I will bring back all unused opioids in the original bottle. If I suspect that 1 am pregnant, I will call Dr. Pratt immediately.
5. I agree to abstain from the use of all illegal drugs. I agree to not take prescription medications unless I have a legal, unexpired prescription. I agree to never, under any circumstances, share any medication that is prescribed to me with anyone else. I give permission to Dr. Pratt to perform random and unannounced urine drug screens. I acknowledge that the presence of any non-prescribed or illicit drug in a drug screen, and/or other indication of illegal drug use will be grounds for permanent termination of my patient/physician relationship with Dr. Pratt.
6. I waive my right of privacy with regard to this treatment agreement so that my physician can contact any health care provider, pharmacy, legal authority, or family member to obtain or provide information about patient care.
7. I am responsible for my controlled substance medications. If the medications or the prescriptions are lost, misplaced, stolen, or disappear for any reason, they will not be replaced. I will keep track of the amount of the medications left and plan ahead for refill of my prescriptions in a timely manner so I will not run out of medications. Generally, controlled substances may be obtained only through a scheduled visit with my physician. They may be prescribed without a visit on rare occasions.
   - A. A 48 hour advance notice is usually needed for refills of prescriptions.
   - B. Requests for refills must be telephoned to the pharmacy with the exception of Schedule II medications, which must be requested from 10:00 A.M. to 3:00 P.M. Monday through Friday. Refills will not be made at night, on holidays, or on weekends.
   - C. Schedule II prescriptions cannot be called in and must be picked up or sent through the mail.
   - D. I understand that Dr. Pratt cannot send prescriptions to pharmacies via. electronic prescribing (“E-Prescribing”).
8. I agree to help myself by trying to change my behavior towards a healthier lifestyle, including stopping smoking, use of alcohol only in moderation as permitted by my physician, diet and weight control, and exercise. I agree to abstain from all illegal drug use. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.
9. I acknowledge that threats of legal action to coerce any physician to prescribe controlled substances is considered by law to be extortion, and is punishable as same.
10. I understand that as a physician, Dr. Pratt is a mandated reporter for suspected child abuse under Georgia Law OCGA 19-7-5. I also understand that Mandate. Mandated reporting laws also require Dr. Pratt to report suspected abuse of and elderly or disabled individual.
11. I acknowledge that my violation of the spirit and terms of this agreement may result in termination of the doctor/patient relationship.

______________________	______________________	______________
Patient	**Witness**	**Date**

Our HIPPA notice is posted on the wall in our waiting room.
Please let a staff member know if you want a hard copy.

CONTRACT FOR CONTROLLED SUBSTANCE MEDICATION PRESCRIPTION

Both I the patient and Frank G. Pratt, Jr., M.D. and Gordon Behavioral Sciences, P.C. staff have a common treatment goal to improve my ability to function and/or work. In consideration of that goal I am being treated with potent medications. Some of them may be amphetamines, narcotics, tranquilizers and/or barbiturates. These medications are considered controlled substance medication, and their use is closely controlled and monitored by local, state and federal agencies. These medications are highly effective when taken as directed under medical supervision, but they also have a potential for misuse and abuse.

I have been fully informed by my physician and staff about psychological dependence and about possible physical addiction to controlled substances. If this happens, I will follow my physician's guidance and participate in any treatment program prescribed which may include detoxification, psychological counseling and medical treatment.

I understand that medication alone or in combination with alcohol may impair my ability to think and perform tasks such as driving. I agree not to drive any motor vehicle if impaired by any medication.

I therefore agree to abide by the following conditions:

1. I will follow the treatment plan to which my physician and I agree. I will take the medications as directed, no more and no less. If I use up my medication sooner than prescribed, I understand that it will not be replaced.
2. I will not ask for or accept controlled substance medications or non-controlled psychotropic prescriptions from any other individual or physician while I am receiving such medications from Dr. Pratt. If requested, I agree to sign a release of information form to obtain pharmacy records documenting prescriptions I have received.
3. I know that some patients may develop tolerance the need to increase the dose of the medication to achieve the same effect. I also understand that if as a result of other treatment modalities or the natural course of my disease process. my symptoms decrease, my medication doses will have to be adjusted as deemed appropriate by my physician. I will not adjust the medications myself unless instructed beforehand during an office visit.
4. I understand that to stop taking the medications abruptly may be dangerous and lead to withdrawal symptoms. If medications need to be discontinued, I will do so gradually and only under medical supervision.
5. I am responsible for my controlled substance medications. If the medications or the prescriptions are lost, misplaced, stolen, or disappear for any reason, they will not be replaced.
6. I am responsible for keeping track of the amount of the medications left and planning ahead for refill of my prescriptions in a timely manner so I will not run out of medications.
7. I agree to help myself by trying to change my behavior towards a healthier lifestyle including stopping smoking, use of alcohol only in moderation as permitted by my physician, diet and weight control and exercise. I agree to abstain from all illegal drug use. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.

I understand that if I violate any of the above conditions, my controlled substance prescriptions and/or treatment at the office of Dr. Pratt may be ended immediately, If the violation involves obtaining controlled substances from another individual as described above, the incident may also be reported to my primary physician, local medical facilities, pharmacies and other authorities.

Patient	**Witness**	**Date**

New Patient Consent to the Use and Disclosure of Health Information

for Treatment, Payment, or Healthcare Operations

I, ______________________, understand that as part of my health care, Gordon Behavioral Sciences, P.C. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I know how to obtain Dr. Pratt's *Notice of Information Practices*, which provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Gordon Behavioral Sciences, P.C. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Gordon Behavioral Sciences, P.C. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Gordon Behavioral Sciences, P.C. change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

____

____

____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

____

Patient's Signature

____

Date

FOR OFFICE USE ONLY

[ ] Consent received by ____________________________ on ___________________.

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on ________________________.

Revised July, 2019

Notice of Health Information Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

Dr. Pratt and staff are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Dr. Pratt, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating heath professionals,
- A source of information for public health officials charged with improving community health,
- A tool with which we can assess and improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of this office, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

We are required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclosure your health information after we have received a written revocation of such an authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact the practice's Privacy Officer,
Frank G. Pratt, III at (770) 387-3535.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

***Business associates*:** There are some services provided in our organization through contacts with business associates. Examples include, but are not necessarily limited to physician services in the emergency department and radiology, laboratory tests, and our transcription company. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

***Notification*:** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

***Communication with family*:** Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

***Appointments*:** We may contact you to provide appointment reminders

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: ______________________________ DATE: ______________

Over the last *2 weeks,* how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL:

10. If you checked off *any problems,* how *difficult* 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	________

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GORDON BEHAVIORAL SCIENCES, P.C.

PATIENT HISTORY FORM

Date: ______/______/______

NAME ______________________________ Birthdate: _____/_____/_____
Last First M.I.

Age:__________ Sex: ☐ F ☐ M

How did you hear about this clinic?

Describe briefly your present symptoms:

Please list the names of other practitioners you have seen for this problem:

Psychiatric Hospitalizations (include where, when, & for what reason):

Have you ever had ECT? Have you had psychotherapy?

CURRENT MEDICATIONS

Drug allergies: ☐ No ☐ Yes To what?

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	Dose (include strength & number of pills per day)	How long have you been taking this?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Physician initials _______

Please circle ALL of the past psychiatric medications that you have taken in the past.

- Abilify (aripiprazole)
- Abilify Maintena (aripiprazole, injection)
- alprazolam
- Alventa XL (venlafaxine)
- amitriptyline
- aripiprazole
- asenapine
- Ativan (lorazepam)
- Brintellix (AKA Trintellix) / vortioxetine
- buspirone
- Camcolit (lithium)
- chlordiazepoxide
- chlorpromazine
- Cipramil (citalopram)
- clozapine
- Clozaril (clozapine)
- Cymbalta (duloxetine)
- Denzapine (clozapine)
- Depakote (valproate)
- Depefex XL (venlafaxine)
- Diazepam (Valium)
- Dolmatil (sulpiride)
- duloxetine
- Ebesque (quetiapine)
- Efexor XL (venlafaxine)
- escitalopram
- Faverin (fluvoxamine)
- Fluanxol (flupentixol)
- Fluoxetine (Prozac)
- flupentixol
- Haldol (haloperidol)
- Haldol decanoate (injection; haloperidol)

- haloperidol
- haloperidol (injection)
- Invega (paliperidone)
- Lamictal (lamotrigine)
- lamotrigine
- Latuda (lurasidone)
- Librium (chlordiazepoxide)
- Liskonum (lithium)
- lithium
- loprazolam
- lorazepam
- melatonin
- nortriptyline
- olanzapine (Zyprexa)
- olanzapine (Zyprexa, injection)
- phenelzine
- Phenergan (promethazine)
- promazine
- Prozac (fluoxetine)
- quetiapine (Seroquel)
- Risperdal (risperidone)
- Risperdal Consta (injection; risperidone)
- risperidone
- Seroquel (quetiapine)
- Sertraline (Zoloft)
- Sominex (promethazine)
- Tegretol (carbamazepine)
- Temazepam (Restoril)
- tranylcypromine
- trazodone

- trifluoperazine
- Trimipramine
- Trintellix / vortioxetine
- venlafaxine (Effexor)
- vortioxetine
- Xanax (alprazolam)
- Zolpidem (Ambien)
- Zyprexa (olanzapine)

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) ____________
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other medical conditions (please list):

____

____

PERSONAL HISTORY

Were there problems with your birth? (specify)

Where were your born & raised?

What is your highest education? ❑High school ❑Some college ❑College graduate ❑Advanced degree

Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered/significant other

What is your current or past occupation?

Are you currently working? : ❑ Yes ❑ No Hours/week ______ If not, are you ❑ retired ❑ disabled ❑ sick leave?

Do you receive disability or SSI? ❑ Yes ❑ No If yes, for what disability & how long? ____________________

Have you ever had legal problems? (specify)

Religion:

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age (s)	Health & Psychiatric	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				

EXTENDED FAMILY PSYCHIATRIC PROBLEMS PAST & PRESENT:

Maternal Relatives:

Paternal Relatives:

Physician initials ______

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss; how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

Women Only:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

OTHER PROBLEMS:

WOMENS REPRODUCTIVE HISTORY:

Age of first period:

Pregnancies:

Miscarriages:

Abortions:

Have you reached menopause? Y / N At what age?

Do you have regular periods? Y / N

Physician initials ______