therapeutic solutions
Behavioral Health Services

Welcome to Therapeutic 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.

CONSENT FOR SERVICES – THE RIGHT TO CONSENT

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

1) an explanation of their diagnosis; information about their recommended treatment, including the possible risks and expected benefits;
2) any alternatives to the recommended treatment, along with the risks and benefits of such alternatives; and
3) give or refuse to give consent for treatment.

By signing this form, I am voluntarily agreeing to receive mental health services from Therapeutic 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.**

CONSENT FOR DRUG AND ALCOHOL TESTING

It is the policy of Therapeutic Solutions that when you enter into services, we have the right to require you to submit to a urinalysis. The testing will be upon admittance and at your doctor's discretion. It may or may not be required during your program attendance.

When you sign the document below you are voluntarily giving the staff of Therapeutic Solutions, P.C., the following permission:

I, _____, hereby give my permission for drug and alcohol testing at a designated lab throughout my treatment at Therapeutic Solutions, P.C.

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 Therapeutic Solutions, P.C. The purpose of this test is to help measure and formulate your needs and treatment strategy. Thank you for your cooperation.

Therapeutic Solutions would also like to notify you that the urine analysis will be sent to an outside source for processing. You have the right to choose any clinical laboratory for purposes of medical testing. Please inform the staff immediately if you choose to use another clinical laboratory for your testing. Billing for this service will be sent to you directly.

☐ **I have read and have understood the information above regarding Consent for Drug and Alcohol Testing.**

SIGNATURE

Patient's Name: _____ Birth Date: _____

Patient's Signature: _____ Date: _____

If a minor, guardian/parent:

Please print name: _____ Relationship: _____

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 which 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**.

****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 in regard to 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.

If there are questions regarding your account, please contact our billing department at (530) 899-3150.

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 (530) 899-3150 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 appointment**. **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. 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.

☐ **I have read and have understood the information above regarding Patient Financial Responsibilities.**

SIGNATURE

Patient's Name: _____ Birth Date: _____

Patient's Signature: _____ Date: _____

If a minor, guardian/parent:

Please print name: _____ Relationship: _____

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES: ACKNOWLEDGMENT OF RECIEPT

By signing this form, you acknowledge receipt of the "Notice of Privacy Practices" of Therapeutic 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 (530) 899-3150.

If you have any questions about our "Notice of Privacy Practices," please contact us at (530) 899-3150.

☐ **I acknowledge receipt of the "Notice of Privacy Practices" of Therapeutic Solutions, P.C.**

SIGNATURE

Patient's Name: _____ Birth Date: _____

Patient's Signature: _____ Date: _____

If a minor, guardian/parent:

Please print name: _____ Relationship: _____

Signature: _____ Date: _____

PATIENT RIGHTS

Mental health patients have the same legal rights guaranteed to everyone by the Constitution and other laws. As citizens, patients do not lose their rights by being hospitalized or receiving services. Under California law, the following rights may never be denied (Cal. Welf. & Inst. Code § 5325.1):

YOU HAVE THE RIGHT:

- to treatment services which promote the potential of the person to function independently; treatment should be provided in ways that are least restrictive of the personal liberty of the individual
- to dignity, privacy, and human care
- to be free from harm, including unnecessary or excessive physical restraint, isolation, medication, abuse, or neglect; medication may not be used as punishment, for the convenience of staff, as a substitute for, or in quantities that interfere with the treatment program
- to prompt medical care and treatment
- to religious freedom and practice
- to participate in appropriate programs of publicly supported education
- to social interaction
- to physical exercise and recreational opportunities
- to be free from hazardous procedures
- to see and receive the services of a local Patients' Rights Advocate, contact (530) 343-1731 or the State of California Patient Advocate Office at (916) 324-6407
- to 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.

All patients have the following treatment rights:

- to give or withhold informed consent to medical and psychiatric treatment, including the right to refuse antipsychotic medication, unless specific emergency criteria are met or there has been a judicial determination of incapacity (Cal. Welf. & Inst. Code § 5150, 5325.2)
- to participate in the development of individualized treatment and services planning (Cal. Welf. & Inst. Code § 5600.03)
- to refuse psychosurgery (Cal. Welf. & Inst. Code § 5326.6)
- to confidentiality (Cal. Welf. & Inst. Code § 5328)
- to inspect and copy the medical record, unless specific criteria are met (Cal. Health & Safety Code § 1795)
- to have family/friends notified of certain treatment information with patient's permission (Cal. Welf. & Inst. Code § 5328.1)
- to an aftercare plan (Cal. Welf. & Inst. Code § 5622)
- to confidentiality as provided for in Title 42, Code of Federal Regulations, Part 2
- to be accorded dignity in contact with staff, volunteers, board members and other persons
- to be accorded safe, healthful and comfortable accommodations to meet his or her needs
- to be free from verbal, emotional, physical abuse and/or inappropriate sexual behavior
- to be informed by the program of the procedures to file a grievance or appeal discharge
- to be free from discrimination based on ethnic group identification, religion, age, sex, color, or disability to be accorded access to his or her file

SIGNATURE

Patient's Name: _____ Birth Date: _____

Patient's Signature: _____ Date: _____

If a minor, guardian/parent:

Please print name: _____ Relationship: _____

Signature: _____ Date: _____

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION (PERSONAL)

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

Name _____

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 Therapeutic Solutions office, or I may submit my revocation to Therapeutic Solutions at this address: 3255 Esplanade, Chico, CA 95973. 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 530-899-3150.

SIGNATURE

Patient's Name: _____ Birth Date: _____

Patient's Signature: _____ Date: _____

If a minor, guardian/parent:

Please print name: _____ Relationship: _____

Signature: _____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS

NAME: _____

I hereby authorize Therapeutic Solutions and/or the undersigned Psychiatrist and/or Nurse Practitioner to release information acquired in the course of my examination or treatment, for the purpose of processing and payment of claims.

I hereby assign and authorize my insurance benefits that are payable to me to instead be paid directly to Therapeutic Solutions, and/or physician(s). The amount is not to exceed the balance due toward programs and physician's regular charges for this period of treatment. I understand I may be financially responsible to Therapeutic Solutions and physician(s) for charges not covered by this authorization.

SIGNATURE

Patient's Name: _____ Birth Date: _____

Patient's Signature: _____ Date: _____

If a minor, guardian/parent:

Please print name: _____ Relationship: _____

Signature: _____ Date: _____

NOTIFICATION OF NON-ACCEPTANCE OF MEDI-CAL

By signing this form, you acknowledge that you have been informed that Therapeutic Solutions **does not** accept:

- Anthem Blue Cross Medi-Cal
- Partnership Health Plan Managed Care Medi-Cal
- California Health and Wellness Medi-Cal
- CMSP Medi-Cal

Therefore, I understand that I am financially responsible for the balance.

If you have another insurance which covers this service, we will be happy to bill that insurance company.

The balance for services rendered is payable at the time of each session.

If you have any questions, please contact us at (530) 899-3150.

SIGNATURE

Patient's Name: _____ Birth Date: _____

Patient's Signature: _____ Date: _____

If a minor, guardian/parent:

Please print name: _____ Relationship: _____

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 LAST 4 WEEKS, HOW MUCH HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING:	**NOT BOTHERED**	**BOTHERED A LITTLE**	**BOTHERED A LOT**
Stomach pain		❍	❍	❍
Back pain		❍	❍	❍
Pain in your arms, legs, or joints (knees, hips, etc.)		❍	❍	❍
Menstrual cramps or other problems with your periods		❍	❍	❍
Pain or problems during sexual intercourse		❍	❍	❍
Headaches		❍	❍	❍
Chest pain		❍	❍	❍
Dizziness		❍	❍	❍
Fainting spells		❍	❍	❍
Feeling your heart pound or race		❍	❍	❍
Shortness of breath		❍	❍	❍
Constipation, loose bowels, or diarrhea		❍	❍	❍
Nausea, gas, or indigestion		❍	❍	❍
	OVER THE LAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING:	**NOT AT ALL**	**SEVERAL DAYS**	**MORE THAN HALF THE DAYS**	**NEARLY EVERY DAY**
Little to no interest or pleasure in doing things		❍	❍	❍	❍
Feeling down, depressed, or hopeless		❍	❍	❍	❍
Trouble falling asleep or staying asleep		❍	❍	❍	❍
Sleeping too much		❍	❍	❍	❍
Feeling tired or having little energy		❍	❍	❍	❍
Poor appetite or overeating		❍	❍	❍	❍
Feeling bad about yourself		❍	❍	❍	❍
Trouble concentrating on things such as reading, watching television		❍	❍	❍	❍
Moving or speaking slowly that other people have noticed		❍	❍	❍	❍
Being so fidgety or restless that other people have noticed		❍	❍	❍	❍
Thoughts that you would be better off dead or hurting yourself		❍	❍	❍	❍
Persistently elevated, expansive mood		❍	❍	❍	❍
Inflated self-esteem		❍	❍	❍	❍
Pressure to keep talking		❍	❍	❍	❍
Racing thoughts		❍	❍	❍	❍
Easily distractible		❍	❍	❍	❍
Impulsiveness (buying sprees, sexual indiscretions, or foolish investments)		❍	❍	❍	❍
Gambling		❍	❍	❍	❍

	QUESTIONS ABOUT ANXIETY	YES	NO
	In the last 4 weeks, have you had an anxiety attack—suddenly feeling fear or panic?	❍	❍
	Has this ever happened before?	❍	❍
	Do some of these attacks come suddenly out of the blue—in situations where you don't expect to be nervous or uncomfortable?	❍	❍
	Do these attacks bother you a lot or are you worried about having another attack?	❍	❍
	THINK ABOUT YOUR LAST ANXIETY ATTACK:	**YES**	**NO**
	Were you short of breath?	❍	❍
	Did your heart race, pound, or skip?	❍	❍
	Did you have chest pain or pressure in your chest?	❍	❍
	Did you sweat profusely?	❍	❍
	Did you feel as if you were choking?	❍	❍
	Did you have hot flashes or chills?	❍	❍
	Did you have nausea, an upset stomach, or the feeling that you were going to have diarrhea?	❍	❍
	Did you feel dizzy, unsteady, or faint?	❍	❍
	Did you tremble or shake?	❍	❍
	Were you afraid you were dying?	❍	❍

	OVER THE LAST 4 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS:	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS
	Feeling nervous, on edge, or worried a lot about a lot of different things	❍	❍	❍
	Feeling restless so that it is hard to sit still	❍	❍	❍
	Getting tired very easily	❍	❍	❍
	Muscle tension, aches, or soreness	❍	❍	❍
	Trouble falling asleep or staying asleep	❍	❍	❍
	Trouble concentrating on things, such as reading a book or watching TV	❍	❍	❍
	Obsessions (fear of contamination, intrusive thoughts of harm, need for order or symmetry)	❍	❍	❍
	Becoming easily annoyed or irritated	❍	❍	❍
	Compulsions (checking doors often, washing hands excessively, etc.)	❍	❍	❍
	Social Anxiety (center of attention, avoiding social situations)	❍	❍	❍

	QUESTIONS ABOUT YOUR EATING HABITS	YES	NO
	Do you often feel that you cannot control what or how much you eat?	❍	❍
	Do you often eat within a 2 hour period what most people would regard as an unusually large amount of food?	❍	❍
	Has this been as often, on average, as twice a week for the last 3 months?	❍	❍
	Do you fear gaining weight or feeling fat?	❍	❍
	Do you frequently diet or restrict caloric intake?	❍	❍
	Do you frequently exercise excessively to lose weight?	❍	❍

	IN THE LAST 3 MONTHS, HAVE YOU OFTEN DONE ANY OF THE FOLLOWING TO AVOID GAINING WEIGHT:	YES	NO
	Made yourself throw up	❍	❍
	Taken more than twice the recommended dose of laxatives	❍	❍
	Fasted for over 24 hours	❍	❍
	Exercised for more than an hour, specifically to avoid gaining weight after binge eating	❍	❍
	If you checked "YES" to any of these ways of avoiding gaining weight, were any as often, on average, as twice a week?	❍	❍
	QUESTIONS ABOUT ALCOHOL	**YES**	**NO**
	Do you ever drink alcohol (including beer or wine)?	❍	❍
	HAVE ANY OF THE FOLLOWING HAPPENED TO YOU MORE THAN ONCE IN THE LAST 6 MONTHS:	**YES**	**NO**
	You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health.	❍	❍
	You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities.	❍	❍
	You missed or were late for work, school, or other activities because you were drinking or hung over.	❍	❍
	You had a problem getting along with other people while you were drinking.	❍	❍
	You drove a car after having several drinks or after drinking too much.	❍	❍

IF YOU CHECKED OFF ANY OF THESE PROBLEMS, HOW DIFFICULT HAVE THEY 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**
❍	❍	❍	❍

	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?	❍	❍

	QUESTIONS ABOUT SUICIDE AND SELF HARM	YES	NO
Have you attempted suicide in the past?		❍	❍
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 of hurting yourself?		❍	❍
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.)		❍	❍
	WERE YOU EVER A VICTIM OF:	**YES**	**NO**
Childhood physical abuse		❍	❍
Childhood sexual abuse (molestation)		❍	❍
Childhood neglect		❍	❍

PRIOR PSYCHATRIC HOSPITALIZATIONS			
Name of Hospital	**City/State**	**Dates of Service/Duration**	**Reason For Hospitalization**

PREVIOUS AND CURRENT PSYCHIATRIC/COUNSELING CARE			
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			
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					
Navane/Thiothixene					
Prolixin/Fluphenazine					
Risperdal/Risperidone					
Saphris					
Seroquel/Quetiapine					
Stelazine/Trifluoperazine					
Symbyax					
Trilafon/Perphenazine					
Vraylar					
Zyprexa/Olanzapine					
ANTIDEPRESSANTS					
Anafranil/Clomipramine					
Asendin/Amoxapine					
Brintellix/Vortioxetine					
Celexa/Citalopram					
Cymbalta/Duloxetine					
Deplin					
Desyrel/Trazodone					
Effexor/Venlafaxine					
Elavil/Endep/Amitriptyline					
Lexapro/Escitalopram					
Luvox/Fluvoxamine					
Nardil/Phenelzine					
Norpramin/Desipramine					
Pamelor/Aventyl/Nortriptyline					
Paxil/Pexeva/Paroxetine					
Pristiq					
Prozac/Sarafem/Fluoxetine					
Remeron/Mirtazapine					
Serzone/Nefazodone					
Sinequan/Adapin/Doxepin					
Tofranil/Imipramine					
Trintellix					
Viibryd					
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					
Focalin/Dexmethylphenidate					
Metadate/Methylin/ Methylphendiate					
Ritalin					
Strattera/Atomoxetine					
OTHERS					
Aricept/Donepezil					
Artane/Trihexyphenidyl					
Cogentin/Benztropine					
Exelon/Rivastigmine					
Lyrica/Pregabalin					
Namenda/Memantine					
Provigil/Modafinil					
Reminyl/Galantamine					
Suboxone					

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

PHARMACY PLAN	
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 (i.e., Mother, Father, Sibling, Child, Grandparent, Uncle, Aunt, etc.)	**Diagnosis**	**Type of Problem**