CRUZ CLINIC and
INTEGRATIVE PSYCHOLOGY

CONSENT TO SERVICES

Patient:_____ Date of Birth:_____

(Please initial to verify understanding)
___ I acknowledge that I have received Cruz Clinic's pamphlet, "Important Information for Patients," in which is described the policies and procedures of Cruz Clinic/Integrative Psychology regarding confidentiality of patient records, emergencies, fee payment requirements, canceled and missed appointments, termination and discharge from treatment, and my rights and responsibilities as a recipient of services.

___I understand that my records, or the records of my dependent, at Cruz Clinic are confidential. These records can be released only as allowed by law under the statutes of the State of Michigan and Federal guidelines, or as allowed by my signature on a release form, with the exceptions written below and in other patient information I have received.

____I acknowledge that I have been given the opportunity to review the Notice of Privacy Practices for Cruz Clinic (HIPPA) pertaining to my right to privacy and the confidentiality of my protected health information. I understand that upon my request, a copy will be provided to me. I further understand that at any time I may contact the Cruz Clinic/Integrative Psychology Administrator in reference to any concern or question I may have regarding the notice or my rights.

___I understand that the services I, or my dependent, will receive at Cruz Clinic/Integrative Psychology is based on currently accepted practice in the fields of mental health and/or substance abuse treatment. I also understand that the outcome of treatment cannot be guaranteed and that services continue only with my voluntary consent. I have been provided with the name and credentials of the clinician who will provide services to me, or my dependent. I understand that all providers are either fully licensed or under the supervision of a fully licensed professional.

___Also, I understand that in order for Cruz Clinic/Integrative Psychology to provide care to me or my dependent, I may be asked to consult with a psychiatrist when this is considered necessary by a clinical staff member. I too may ask to consult with a psychiatrist on staff at Cruz Clinic/Integrative Psychology, if I consider this necessary. Further, I may request that I be referred to another organization for services.

___If services are paid either in part or in full for by a third-party payor such as an insurance company, I understand that the funding source or its agent has the right to examine my records at any time. I hereby authorize the examination of my or my dependent's patient records sources as required for reimbursement and/or clarification of services. I also understand that it may be necessary to release information regarding me, or my dependent, to a Case Manager or insurance verifier from my third-party payor in order for Cruz Clinic to obtain authorization to provide services. I give permission for this release. I also give my permission for Cruz Clinic/Integrative Psychology to release information acquired to process billing claims for services provided to me, or my dependent by the third-party payor reimbursing for these services.

___I understand that fees for services are to be paid at the time of the appointment, unless other arrangements have been made. If my third-party payor does not cover any fees or any portion of fees for the services I, or my dependent have received, I accept responsibility for them. If maximum third-party benefits have been reached, I understand that I am responsible for any fees for services subsequently rendered.

___I understand that it is my responsibility to know my insurance policy benefits. I realize that Cruz Clinic/Integrative Psychology has contacted my insurance company to receive my benefit information, yet sometimes the insurance companies do not give clinics accurate information. Payment is subject to the terms of your insurance policy and can only be determined at the time the claims are processed. Therefore, I realize it may be in my best interest to contact my insurance company myself to verify this information. If Cruz Clinic was quoted incorrect information, resulting in lesser benefit coverage, I understand that I am responsible for the difference. Many clients have found it helpful to ask the following question to my carrier:

Is out-patient mental health a covered benefit?
If covered, are there a certain number of visits allotted and or any parameters regarding the duration of therapy allowed?
Will therapy charges be applied to my deductible?
Are there any co-pays that I will be responsible for?
Do I need pre-authorization?

___I understand that I will be charged for missed appointments and late cancellations with less than 24 hours notice. I am aware that because third-party payors, such as insurance companies, will not pay for missed appointments or late

(Please continue on reverse side)

cancellations, any appointment that is missed or canceled without my giving 24 hours notice will be billed directly to me. I understand that I may be billed for these appointments at Cruz Clinic/Integrative Psychology's usual and customary fee. Payment for a missed or late canceled appointment is due within two weeks of the appointment. If treatment or diagnostic evaluation is terminated by my choice or because of violation of program rules, I agree to pay all outstanding fees existing at the time of termination. Cruz Clinic/Integrative Psychology utilizes an automated system which makes reminder calls the day prior to your appointment. I understand that this automated call is strictly a courtesy call, and I further understand that I am still responsible for a No Show/Late Cancel fee if I do not receive this call.

___ Yes, I would like to be included in this reminder call service at the following number _____.
___ No, I would prefer not to get a reminder call.

___I agree to inform Cruz Clinic/Integrative Psychology of any changes in my health insurance benefits and to assign insurance benefits to Cruz Clinic/Integrative Psychology. I understand and hereby agree that accounts more than 90 days delinquent, excluding those where payment is made directly to Cruz Clinic by a third-payor (e.g., and insurance company), may be subject to collection action.

___If I have been referred to Cruz Clinic/Integrative Psychology by a court, agency, Employee Assistance Program, physician, attorney, hospital, or another mental health or substance abuse treatment practitioner or program, Cruz Clinic/Integrative Psychology may want to acknowledge the referral by another professional. In order for this to occur, my consent is necessary. I hereby give consent to this limited release of information. Further, unless specified herein or by statute, the release of any further information to anyone required my written permission.

___I recognize that if I, or my dependent, have been ordered by a court to seek services at Cruz Clinic/Integrative Psychology the court will require one or more reports. My separate, written consent is required for this to occur. I understand that Cruz Clinic/Integrative Psychology shall not be obligated to send or release a copy or original of any report or any clinical records concerning me or my dependent to anyone until the balance on my or my dependent's account is paid in full.

___I understand and accept that it may be necessary for Cruz Clinic/Integrative Psychology to reach me by mail or by telephone during, or after, my or my dependent's treatment with Cruz Clinic for confirming or scheduling appointments, billing and payment issues, completing forms, conducting surveys and any necessary follow-up.

My signature below acknowledges that I am voluntarily authorizing diagnostic and treatment services at Cruz Clinic/Integrative Psychology for myself, or my dependent. I recognize that I may refuse any aspect of treatment. I also accept that such a refusal may result in termination of services by Cruz Clinic/Integrative Psychology. If termination of services does occur, I understand that I have the right of appeal. Further, I have read, understand and accept what is written in this "Consent To Services" and the "Important Information for Patients" pamphlet. I also understand that I may request a copy of this "Consent To Services" form.

_____		_____
Signature of Patient	Date	Witness
_____		_____
Signature of Parent/Guardian	Date	Witness

Patient Name _____
Patient I.D. _____

CRUZ CLINIC
Psychiatric & Psychological Care

Missed Appointment Policy

_____ _____

Patient Name (Please Print) Patient Date of Birth (mm/dd/yyyy)

We strive to create as many appointments as possible for our providers so that we can provide all the services needed by our patients. We need the help of our patients to make our system work. We know and understand how busy everyone's lives are and we know plans change. We would like the courtesy of a call if an appointment cannot be kept.

It is our policy that any scheduled appointment be canceled with at least 24 hours notice to the appointment time, except in case of an unforeseen emergency.

If an appointment is canceled, we will do our best to give our patient the next available appointment time for the type of visit required.

If you fail to keep an appointment or cancel on time, there will be a charge of **$75**. Three missed appointments may cause dismissal from our practice.

Please understand this policy will not affect those patients that keep their appointments. In an office with many missed appointments, we are trying to accommodate those patients that need to be seen in our office. We look forward to your anticipated understanding and cooperation.

_____ _____

Patient Signature Date

_____ _____

Legal Guardian Signature Date

_____ _____

Witness Signature Date

Cruz Clinic
Integrative Psychology of Ann Arbor

Release of Information

Patient Name _____ Date of Birth _____

The following individuals may contact Cruz Clinic for the following reasons:

NAME	PHONE
_____	_____
_____	_____

Please check all that apply

____ Call to schedule/cancel/change an appointment

____ Inquire about or inform the clinic about patient's insurance/or patient liability

____ Other _____

_____

_____

This authorization will not expire unless requested by patient.

_____ _____
Patient Signature Date

_____ _____
Witness/Cruz Clinic Employee Date

Cruz Clinic
17177 N Laurel Park Dr, Ste 131
Livonia, MI 48152
Ph: (734) 462-3210 Fax: (734) 462-1024

PAYMENT INFORMATION SHEET – SELF-PAY

Date_____

Patient Name_____ DOB_____

On _____ (Date) _____ (name of staff member) quoted you the below self-pay rates for services at Cruz Clinic.

I understand that the fee for services at Cruz Clinic are as follows:

PRESCRIBER

$195	Intake
$80	15-29 min (99212/99213)
$95	30-45 min (99214/99215)

THERAPIST

$195	Intake
$80	30 min session
$120	45 min session
$150	60 min session
$30	Group session
$250	Testing per hour

_____ _____
Signature of Patient Date

_____ _____
Witness – Cruz Clinic Staff Date

Cruz Clinic/Integrative Psychology - Coordination of Care

FOR YOUR INFORMATION ONLY - NOT A REQUEST FOR MEDICAL RECORDS

Patient Name: _____ Date of birth: _____

Behavioral Health Provider/Primary Care Physician Communication Form

Patient Consent to Exchange Information (to be completed by patient)

I, _____, **authorize / do not authorize** (CIRCLE ONE)
Cruz Clinic to send this coordination of care form to my primary care physician.

Primary Care Doctor Name _____
Primary Care Doctor Address _____
Primary Care Doctor Phone _____
Primary Care Doctor FAX _____

_____Patients please initial if you prefer no coordination of care and received "Be Your Own Health Manager" information sheet.

To exchange information regarding my mental health/substance abuse treatment and medical healthcare coverage for coordination of care purposes as may be necessary for the administration and provision of my health care coverage. The information exchanged may include information on mental health care or substance care and or treatment such as diagnosis and treatment plan. I understand that this authorization shall remain in effect for the course of this treatment. I understand that I may revoke this authorization at any time by written notice to the above behavioral health provider. I also understand that it is my responsibility to notify my behavioral health provider if I choose to change my Primary Care Physician. I also understand that most health care insurance (under the new health care act) require coordination of care with your PCP prior to paying for services rendered.

_____ _____
Patient Signature Date

_____ _____
Signature of Parent/ Guardian (If patient is a minor) Date

_____ _____
Signature of Witness Date

Provider Information (To be completed by Behavioral Health Provider)

(Provider Name) _____ at Cruz Clinic
17177 N. Laurel Park Drive, Ste 131, Livonia, MI. 48152 Phone 734-462-3210 Fax 734-462-1024
DSM V Diagnosis code & name:_____

Symptoms:_____
Treatment Type _____ Frequency _____ Length of TX_____
Medication (s) Prescribed: _____
___ screening tools attached (check here)
___ psychosocial assessment attached (check here)
Comments: _____

For Urgent or emergency situation, please call the primary care physicians In addition to sending form

Conclusion of mental health/ Substance treatment
_____ Date of last session _____ treatment completed? Yes _____ No_____
_____ Notification of prescription or change in medications (see comments)
_____Summary of care attached (check here)
_____ Comments: _____

_____ _____ _____
Provider's Signature Credentials (MD, PA ,NP, or Therapist) Date

A COPY OF THIS FORM MUST BE SENT TO THE PRIMARY CARE PHYSICAIN, RETAINING THE ORGINAL IN THE PATIENT CHART. IF THE FORM IS SENT BY FAX, ATTACH CONFIRMATIONN THAT THE FAX WAS SENT.
DATE SENT _____ SENT BY INTIALS_____ FAX OR MAIL

Please File in Patient's Chart

Cruz Clinic/Integrative Psychology
Credit Card Authorization Form

_____ _____/_____/_____
Patient Name Patient Date of Birth

□ Visa □ MasterCard □ Discover □ American Express

_____
Cardholder Name

_____
Cardholder Address

_____
City State Zip

_____
Credit Card Number

_____
Expiration Date Security Code

I AUTHORIZE CRUZ CLINIC TO CHARGE MY CREDIT CARD FOR PAYMENT/S TO BE PROCESSED:

□ AT EACH TIME OF SERVICE □ TOTAL BALANCE ON LAST DAY OF MONTH

□ PER PAYMENT AGREEMENT $_____

PLEASE READ AND INTIAL BELOW:

_____HAVING READ THIS FORM, MY SIGNATURE BELOW ACKNOWLEDGES THAT I VOLUNTARILY GIVE MY AUTHORATION AND CONSENT TO PROVIDING THE REQUESTED INFORMATION FOR MY CREDIT CARD TO BE CHARGED ACCORDINGLY FOR THE CONDITIONS LISTED ON THIS FORM.

_____I UNDERSTAND THAT THIS FORM IS VALID UNTIL_____ (DATE/YEAR) UNLESS I CANCEL THROUGH WRITTEN NOTICE TO CRUZ CLINIC.

_____OTHER THEN THE CONDITIONS MENTIONED IN THIS FORM, UNDER NO CIRCUMSTANCES WILL CRUZ CLINIC CHARGE YOUR CREDIT CARD FOR ANYTHING OTHER THEN WHAT IS LISTED ON THIS FORM.
IN CONJUNCTION WITH HIPAA REGULATIONS, ALL CREDIT CARD INFORMATION WILL BE CONFIDENTIALLY KEPT AND ONLY AUTHORIZED STAFF WILL BE ABLE TO ACCESS THIS INFORMATION.

_____ _____/_____/_____
Patient signature or authorized person Date

_____ _____/_____/_____
Witness signature Date

RECIEPTS CAN BE MAIL TO: □ ADDRESS IN ACCOUNT ☐ THE CARDHOLDER'S ADDRESS

N:forms/ patient forms/ Credit card auth form

Cruz Clinic
Integrative Psychology of Ann Arbor
TELEMEDICINE SERVICES CONSENT FORM

Name: _____ DOB: _____

Informed Consent for Telemedicine Services

•I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider used to deliver services to an individual when he/she is located at a different location or site than I am.

•I understand that the telemedicine visit will be done through a two-way video link-up. The healthcare provider will be able to see my image on the screen and hear my voice. I will be able to hear and see the healthcare provider.

•I understand that the laws that protect privacy and the confidentiality of medical information including (HIPAA) also apply to telemedicine.

•I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.

•I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without effecting my right to future care or treatment.

•I understand that by signing this form that I am consenting to receive health care services via telemedicine.

Signature of Client/Patient _____ Date _____

Printed Name _____

Phone # _____

E-mail Address _____

Witness _____ Date _____

PATIENT NAME: _____ DATE: _____

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?		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 fidgety 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 in some way	0	1	2	3
		PHQ9 total score:			

Q6 CORE10	I made plans to end my life in the last 2 weeks	NO	YES

GAD-7

Over the last 2 weeks, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3
		GAD7 total score:			

Cruz Clinic
Integrative Psychology of Ann Arbor

Adult Psychosocial Questionnaire
(Ages 18+)

Cruz Clinic and Integrative Psychology are dedicated to providing the best mental health services to all our clients. Please take a moment to carefully complete ALL parts of this form. Per state and federal guidelines, Cruz Clinic will always maintain your confidentiality and will not share your information with anyone outside of the practice.

Today's Date:_____/_____/_____ DOB: _____/_____/_____ Age:_____

Legal Name: _____ **SSN:** ____/____/____
Last First MI
Guardian name: _____

Name you want the clinic to use: _____

Pronouns: [ ] She/her/hers [ ] They/them [ ] He/him/his [ ] Other: _____

Place of Birth:_____ Primary language:_____

TYPE	PHONE NUMBER	LEAVE A MESSAGE
Home	( ) -	YES/NO
Cell	( ) -	YES/NO
Work	( ) -	YES/NO
Other	( ) -	YES/NO

Please explain "other" phone- _____

EMERGENCY CONTACT

Name:_ _____ Relationship:_____ _____
Address:_____ Phone:_____-_____-_____

REFERRAL REASON

What brings you to treatment?
_____
_____

What would you like to accomplish by coming to therapy?
_____
_____

Did anyone refer you to our office [ ] YES [ ] NO
If Yes, Who?_____

RISK ASSESSMENT & PROTECTIVE FACTORS

Are you **CURRENTLY** experiencing any of the following symptoms? **[ ] None**		
[ ] Suicidal thoughts/expression	[ ] Homicidal thoughts	[ ] Physical violence
If you checked any of the above boxes, please explain:		

Have you **EVER** experienced any of the following symptoms? **[ ] None**		
[ ] Suicidal thoughts/expression	[ ] Homicidal thoughts	[ ] Physical violence
If you checked any of the above boxes, please explain:		

In the past month did you…			
1	Think you would be better off dead or wish you were dead?	***NO***	***YES***
2	Want to harm yourself?	***NO***	***YES***
3	Think about suicide?	***NO***	***YES***
4	Have a suicide plan?	***NO***	***YES***
5	Attempted suicide?	***NO***	***YES***
6	In your lifetime, did you ever make a suicide attempt?	***NO***	***YES***

If you had any thoughts of hurting yourself, what factors would prevent you from acting on these thoughts? Please check all that apply: [ ] None			
[ ] Religion	[ ] Family	[ ] Pet(s)	[ ] Friends
[ ] Belief things will get better	[ ] Believe that suicide is wrong	[ ] Other:	

Do you have family/friends you can talk to? [ ] Yes [ ] No

Name three things that are very important to you (such as friends, family, spirituality, pets)
1.
2.
3.

Do you believe you have conflict resolution/problem solving skills and non-violent dispute resolution skills?	
YES	NO

Client Name: _____

DOB: _____

EMPLOYMENT & EDUCATION

Employment

Please indicate your employment status (check all that apply)
[ ] Full-time Employed [ ] Part-time Employed [ ] Unemployed [ ] Retired

Employer: _____ Job Title:_____
Do you have more than one job? [ ] YES, how many:_____ [ ] NO

What are your means of support?
[ ] work [ ] parents [ ] unemployment [ ] spouse [ ] other_____
[ ] I would like to discuss employment issues with my clinician

Current Education

Please indicate your current education enrollment
[ ] Full-time Student [ ] Part-time Student [ ] Not Enrolled [ ] Not a Student
Please indicate the type of school you attend
[ ] University [ ] College [ ] Vocational/Trade [ ] Other:_____
Name of school:_____ Degree type/field_____

Education History

Please indicate your highest level of education
[ ] Some High School [ ] High School Diploma [ ] GED [ ] Some College/Trade School
[ ] Associates Degree [ ] Bachelor's Degree [ ] Master's Degree [ ] Doctoral Degree

Did you attend: [ ] Infant day care [ ] Pre-school [ ] Kindergarten

Official School Classifications & Learning Disabilities:
[ ] LD or ADHD [ ] EI [ ] DHI [ ] ASD [ ] Visually Impaired [ ] Hearing Impaired
[ ] Dyslexia [ ] Other:_____

Type of K12 Educational Placement: [ ] General Education [ ] Special Education [ ] Honors (T&G) [ ] Home study

FAMILY HISTORY

Residence

[ ] Live with parents [ ] Live with partner [ ] Live with spouse [ ] Live alone [ ] Other:_____

Martial Status

[ ] Married [ ] Partnered [ ] Separated [ ] Divorced [ ] Widowed [ ] Other:_____
If spouse/partner is deceased, age at death _____

Parent Information

Name of parent #1: _____ Gender:_____ Level of Education: _____
Age of parent #1 _____If deceased, age at death _____

Name of parent #2: _____ Gender:_____ Level of Education: _____
Age of parent #2 _____If deceased, age at death _____

Biological parents are: ( ) Married ( ) Separated ( ) Divorced ( ) Other: _____

Primary Parental figures: _____

Family Composition

Family Member	Name	Relationship Type	Issues *(if any)*
Partner/Spouse		[ ] Good [ ] Fair [ ] Poor	
Child #1		[ ] Good [ ] Fair [ ] Poor	
Child #2		[ ] Good [ ] Fair [ ] Poor	
Child #3		[ ] Good [ ] Fair [ ] Poor	
Parent #1		[ ] Good [ ] Fair [ ] Poor	
Parent #2		[ ] Good [ ] Fair [ ] Poor	
Step-Parent #1		[ ] Good [ ] Fair [ ] Poor	
Step-Parent #2		[ ] Good [ ] Fair [ ] Poor	
Sibling #1		[ ] Good [ ] Fair [ ] Poor	
Sibling #2		[ ] Good [ ] Fair [ ] Poor	
Sibling #3		[ ] Good [ ] Fair [ ] Poor	
Other		[ ] Good [ ] Fair [ ] Poor	

Is your parent, child, or sibling deceased? [ ] YES [ ] NO
If Yes, Who?_____

Family History

Please indicate **any family history** of the following:
[ ] Substance Abuse: indicate who: _____
[ ] Mental Illness: indicate who: _____
[ ] Suicide: indicate who: _____
[ ] Autism: indicate who: _____
[ ] Developmental Disability: indicate who: _____
[ ] ADD/ADHD: indicate who: _____

Social History

Please indicate if you have the following concerns:
[ ] Peer Relationships [ ] Sexual Concerns [ ] Marital/Significant Other [ ] Job [ ] Money
[ ] Hobbies/Interest [ ] Relationship with family [ ] Custody [ ] School [ ] Other: _____

Leisure Time

How do you spend your leisure time?
[ ] Alone [ ] Mostly Alone [ ] With others [ ] About equal, ½ alone, ½ with others

Please list hobbies leisure interests, activities, and talents
_____
_____

DEMOGRAPHIC INFORMATION

Religion

[ ] Catholic [ ] Christian [ ] Muslim [ ] Protestant [ ] Mormon [ ] Jewish [ ] Atheist [ ] Agnostic
[ ] Spiritual but not religious [ ] No affiliation [ ] Other: _____
How **important** are your Religious/Spiritual Beliefs? [ ] Very [ ] Somewhat [ ] Not at all
Would you like to talk about their religious/spiritual beliefs? [ ] YES [ ] NO

Race/Ethnicity

[ ] Black/AA [ ] White [ ] American Indian or Alaska Native [ ] Asian [ ] Native Hawaiian [ ] Mixed
[ ] Other _____
Are you Hispanic? [ ] YES [ ] NO Would you like to talk about any racial/cultural issues? [ ] YES [ ] NO

Sexual Orientation

[ ]Heterosexual [ ] Lesbian [ ] Gay [ ] Bisexual [ ] Pansexual [ ] Asexual [ ] Queer [ ] Questioning
[ ] Other _____
Would you like to talk about your sexual orientation with your therapist? [ ]YES [ ]NO

Gender Identity

[ ] Female [ ] Male [ ] Transgender [ ] Gender non-conforming/non-binary [ ] Other: _____
Would you like to talk about your gender identity with your therapist? [ ]YES [ ]NO

BEHAVIORAL HEALTH TREATMENT HISTORY

Have you ever worked with a behavioral health care provider? [ ] YES [ ] NO

[ ] Inpatient Date: _____
If YES, for **Inpatient**, Name of Facility:_____
Length of Stay:_____ Number of admissions:_____
Reason: _____

[ ] Outpatient Date: _____
If YES for **Outpatient**, Name of Facility:_____
Name of Therapist:_____
Type of therapist? [ ] Psychiatrist [ ] Psychologist [ ] Social Worker [ ] Counselor [ ] Other: _____
Reason: _____

CURRENT & GENERAL PHYSICAL HEALTH STATUS

Please describe you general health:

[ ] Excellent [ ] Good [ ] Fair [ ] Poor [ ] Very Poor

Please indicate all the physical conditions your child is experiencing			
[ ] Thyroid Problems	[ ] Attention Problems	[ ] Ulcer	[ ] Colitis
[ ] Diabetes	[ ] Mental Health Issues	[ ] Low Blood Sugar	[ ] Seizures
[ ] High Blood Pressure	[ ] Trouble Sleeping	[ ] Vitamin D Deficiency	[ ] Other

Do you have any other health conditions? [ ] YES [ ] NO
If YES, please explain:_____

Have you been exposed to any communicable diseases in the past 3 months? [ ] YES [ ] NO
If YES, please explain:_____

Primary Care Physician

Name: _____ Office Name: _____
Office Address: _____
Office Phone: _____ Office Fax: _____

Reproductive Health

Would you like to speak about reproductive health matters? [ ] YES [ ] NO

Pain Status

Are you currently experiencing pain? [ ] YES [ ] NO
If YES, please explain: _____
Please indicate the severity of your pain: **Mild** 1 2 3 4 5 6 7 8 9 10 **Extreme**

Medical

Do you need a physical exam? [ ] YES [ ] NO
When was the last time you had a physical exam? _____
If it has been more than 12 months since your previous physical exam, you will need to see a primary care doctor.

If it has been more than 12 months since my last visit:
[ ] I will schedule an appointment with my primary care doctor.
[ ] I would like to be referred to a primary care doctor.
[ ] I refuse to see a primary care doctor.

Have you suffered from any recent or childhood illnesses/disorders, disabilities/handicaps, operations, and/or hospitalizations. [ ] YES [ ] NO
If YES, please explain and include dates and ages:
_____
_____
Have you had any serious accidents/injuries? [ ] YES [ ] NO
If YES, please explain _____

Head Injuries: [ ] None [ ] Yes, **without** loss of consciousness [ ] Yes, **with** loss of consciousness
Please explain: _____

Convulsions: [ ] YES [ ] with fever [ ] without fever} [ ] NO
Please explain: _____

Do you have any disabilities or special needs that we should be aware of? [ ] YES [ ] NO
if YES, please explain:
_____

Sleep

Do you have difficulty sleeping? [ ] YES [ ] NO
If YES, please explain:
_____
How long do you typically sleep? _____ What time do you go to sleep _____ and wake up: _____?
My overall quality of sleep is: [ ] Excellent [ ] Good [ ] Fair [ ] Poor [ ] Very Poor

Dental Screening

Do you have any dental concerns (cavities, broken teeth, etc.) [ ] YES [ ] NO
If yes, please explain: _____

Nutritional Screening

Have you [ ] Gained weight or [ ] Lost weight in the last 30-60 days? [ ] YES [ ] NO
If YES, how much and why? _____
_____

Your Height: _____foot ____inches Your Weight: _____lb

Do you believe you have a: [ ] low nutritional risk [ ] medium nutritional risk [ ] high nutritional risk

Do you have any diet or nutritional concerns that may be an indication of an eating problem such as binging, inducing vomiting, extreme dieting, etc.? [ ] YES [ ] NO
If YES, please explain:_____

Food Allergies

Do you have any **food** allergies? [ ] YES [ ] NO
If YES please list allergies and allergic reaction:
_____
_____

Non-Food Allergies

Do you have any **non-food** allergies? [ ] YES [ ] NO
If YES please list allergies and allergic reaction:
_____
_____

Medication Allergies

Do you have any **medication** allergies? [ ] YES [ ] NO

Medication Name	Reaction

Current Medications

Do you currently take any medications: [ ] YES [ ] NO
If YES, please list all the medications your child is **currently** taking or have taken in the **last year** (prescription and over the counter):

Medication Name	Dosage	How is it taken?	Start Date	Reason	Prescribing Doctor/Location	Works Well (Yes/No)

What medications do you know you must continue to take? _____

Past Psychotropic Medications

Do you currently take any medications: [ ] YES [ ] NO

If YES, please list all the medications your child is **currently** taking or have taken in the **last year** (prescription and over the counter):

Medication Name	Dosage	How is it taken?	Start Date	Reason	Prescribing Doctor/Location	Works Well (Yes/No)

Supplements

Supplement Name	Dosage	How is it taken?	Start Date	Reason

SUBSTANCE USE

Do you use nicotine? [ ] YES [ ] NO

If YES, [ ] Cigarettes/Cigars/Pipe [ ] Chewing tobacco [ ] E-cigarettes [ ] Vape

Amount per day: _____

How long have you used? _____

Any related health issues? [ ] YES [ ]NO if YES, please explain: _____

Do you use cannabis? [ ] YES [ ] NO

If YES, in what form? _____

How often do you use? _____

How much do you use? _____

Do you consume alcohol? [ ] YES [ ] NO

How often do you consume? _____ How long? _____

How much do you usually drink in one sitting?_____

Any related health issues? [ ] YES [ ]NO if YES, please explain: _____

If any Recovery, Longest length of sobriety: _____

Do you use illegal drugs? [ ] YES [ ] NO

If YES, please list all illegal drugs you use:_____

_____

How often do you use? _____

How much do you use? _____

Would you like to discuss your substance use with your provider? [ ] YES [ ] NO

ABUSE

Have you ever experienced any of the following? (check all that apply) [ ] YES [ ] NO				
[ ] Physical	[ ] Sexual	[ ] Emotional	[ ] Abandonment/Neglect	[ ] Other
If YES, please explain:				
Duration of abuse:				
Was the abuse reported to the authorities? [ ] YES [ ] NO If yes please explain:				
Have you ever physically, emotionally, or sexually abused anyone? [ ] YES [ ] NO If yes, please explain: Was it reported to the authorities? [ ] YES [ ] NO				
Have you ever witnessed any of the following? (please check all that apply) [ ] Physical abuse [ ] Emotional abuse [ ] Sexual abuse [ ] Other: If yes, please explain:				

STRENGTHS /WEAKNESSES

What are your main strengths and abilities?

_____

_____

What are your main weaknesses?

_____

_____

FINANCES

Do you currently have financial problems? [ ] YES [ ] NO

If YES, please explain:

_____

_____

LEGAL HISTORY

Are you currently facing any pending legal charges/convictions? [ ] YES [ ] NO

If YES, please explain: _____

Have you ever been arrested or spent time in jail? [ ] YES [ ] NO

If YES, please explain: _____

Do you currently have a probation officer? [ ] YES [ ] NO

If YES, Name of probation officer:_____Phone Number: _____

Military History:

Were you ever in the following organizations?

( ) Army ( ) Navy ( ) Air force ( ) Marines ( ) Coast Guard ( ) Merchant Marines ( ) None

Duty Status: _____ Discharge Type: _____ Highest Rank: _____

DEVELOPMENTAL HISTORY

Pregnancy

Duration of pregnancy: _____ months/weeks Length of delivery: _____hours/days [ ] unknown

Substance Use	**Delivery**
Did your birthparent consume any of the following during pregnancy? (check all that apply) [ ] unknown [ ] Smoking [ ]Alcohol [ ] Drugs [ ] Other If YES, please explain:	What type of **delivery** were you? [ ] unknown [ ] Cesarean Section [ ] Vaginal Birth Weight ____lb Any complication during delivery: [ ] YES [ ] NO If Yes, please explain:
Complications while Pregnant	**Developmental Milestones**
Any known complications while your birthparent was pregnant with you? [ ] unknown [ ] YES [ ] NO If Yes, please explain:	Please indicate and describe if you had any problems with **motor skills, language, or social attachment**. [ ] unknown [ ] YES [ ] NO If yes, please explain:

I have completed these questions to the best of my knowledge, and I am aware that I can discuss any concerns with my clinician.

_____ _____

Signature of Client Date

STOP HERE

- -
- -
- -

Client Name: _____

DOB: _____

(For the clinician only) I have reviewed and addressed all issues cited on this form with the client and/or guardian.

_____ _____

Signature of Clinician Date
MD/PA/Therapist/Nurse Practitioner

Client Name: _____

DOB: _____

PLEASE CHECK ALL MEDICATIONS THAT YOU RECALL TAKING AT ANY TIME IN THE PAST

Antidepressants

- ☐ Adapin/Sinequan (doxepin 3 & 6mg)
- ☐ Anafranil (clomipramine)
- ☐ Aplenzin
- ☐ Brintellix/Trintellix (vortioxetine)
- ☐ Buspar (buspirone)
- ☐ Celexa (citalopram)
- ☐ Cymbalta (duloxetine)
- ☐ Effexor/XR (venlafaxine)
- ☐ Elavil (amitriptyline)
- ☐ Fetzima (levomilnacipran)
- ☐ Lexapro (escitalopram)
- ☐ Luvox/CR (fluvoxamine)
- ☐ Norpramin (desipramine)
- ☐ Pamelor (nortriptyline)
- ☐ Paxil/CR (paroxetine)
- ☐ Pristiq (desvenlafaxine)
- ☐ Prozac (fluoxetine)
- ☐ Remeron (mirtazapine)
- ☐ Symbyax (fluoxetine/olanzapine)
- ☐ Trofranil (imipramine)
- ☐ Viibryd (vilazodone)
- ☐ Welbutrin/SR/XL (bupropion)
- ☐ Zoloft (sertraline)

Psychotropics

- ☐ Abilify (aripiprazole)
- ☐ Clozaril (clozapine)
- ☐ Fanapt (iloperidone)
- ☐ Geodon (ziprasidone)
- ☐ Haldol (haloperidol)
- ☐ Invega (paliperidone)
- ☐ Latuda (lurasidone)
- ☐ Rexulti (brexpiprazole)
- ☐ Risperdal (risperidone)
- ☐ Saphris (asenapine)
- ☐ Seroquel/XR (quetiapine)
- ☐ Thorazine (chlorpromazine)
- ☐ Triavil (Elavil/Trilafon)
- ☐ Trilafon (perphenazine)
- ☐ Vraylar (cariprazine)
- ☐ Zyprexa/Zydis (olanzapine)

Mood Stabilizers/Antiepileptics

- ☐ Depakote/ER (valproate)
- ☐ Dilantin (phenytoin)
- ☐ Keppra (levetiracetam)
- ☐ Lamictal (lamotrigine)
- ☐ Lyrica (lamotrigine)
- ☐ Neurontin/Horizant (gabapentin)
- ☐ Tegretol (carbamazepine)
- ☐ Topamax/Trokendi (topiramate)
- ☐ Trileptal (oxcarbazepine)

- ☐ **Lithium (Eskalith/Lithobid)**

Antihistamines

- ☐ Benadryl (diphenhydramine)
- ☐ Periactin (cyproheptadine)
- ☐ Vistaril/Atarax (hydroxyzine)

Beta Blocker

- ☐ Inderal (propranolol)

Alcohol Dependence

- ☐ Anabuse (disulfiram)
- ☐ Campral (acamprosate)
- ☐ Revia/Vivitrol (naltrexone)

Sedative-Hypnotics and Sleep Aid

- ☐ Ambien/CR (zolpidem)
- ☐ Belsomra (suvorexant)
- ☐ Dalmane (flurazepam)
- ☐ Halcion (triazolam)
- ☐ Intermezzo/Edular/ZolpiMist Spray (Zolpidem)
- ☐ Lunesta (eszopiclone)
- ☐ Rozerem (remelteon)
- ☐ Restoril (temazepam)
- ☐ Silenor (doxepin 3 & 6 mg)
- ☐ Sonata (Zaleplon)

Anxiolytics

- ☐ Ativan (lorazepam)
- ☐ Klonopin (clonazepam)
- ☐ Librium (chloridiazepoxide)
- ☐ Valium (diazepam)
- ☐ Xanax/XR (alprazolam)
- ☐ Trazodone

Stimulants

- ☐ Adderall/XR (mixed amphetamine salts)
- ☐ Aptensio XR (methylphenidate)
- ☐ Concerta (methyphenidate ER)
- ☐ Daytrana Patch (methyphenidate)
- ☐ Dextroamphetamine tablets (immediate release)
- ☐ Dexadrine Spansule/XR (dextroamphetamine)
- ☐ Evekeo (amphetamine salts)
- ☐ Focalin/XR (dexmethylphenidate)
- ☐ Metadate CD (methylphenidate)
- ☐ Quillivant (liquid methyphenidate)
- ☐ Ritalin/SR/LA (methylphenidate)
- ☐ Vyvanse (lisdexamphetamine)
- ☐ Zenzedi (dextroamphetamine sulfate)

Dopamine Agonists

- ☐ Mirapex (pramipexole)

Alpha 1A Antagonist

- ☐ Minipress (prazosin)

Alpha 2A Agonist

- ☐ Catapres (clonidine)
- ☐ Catapres TTS (clonidine patch)
- ☐ Kapvay (clonidine extended release)
- ☐ Intuniv (guanfacine extended release)
- ☐ Tenex (guanfacine)

Wake Promoting Agents

- ☐ Provigil (modafinil)

Supplements

- ☐ Axona (caprylidene)
- ☐ Cerefolin NAC or N-acetylcysteine
- ☐ Deplin/Enlyte/Enbrace/Bellevue S8/MethylPro
- ☐ Melatonin
- ☐ Sam-e
- ☐ St. John's Wort

IF PREVIOUSLY TAKEN, WHAT WAS THE REASON FOR DISCONTUNING MEDICATION?

PLEASE EXPLAIN ON FOLLOWING PAGE. ⟶

MEDICATIONS DISCONTINUED	REASON FOR DISCONTINUING