New Patient Information Form

Please Print or Type

_____ signatures checked

PATIENT INFORMATION

Last Name:_____ **First Name:**_____ **Middle Name:**_____

Suffix: JR SR III IV or _____ **Nickname:**_____ **Date of Birth:**____/____/____

Is the patient a minor (under 18 y.o)? Yes* No Parent/Guardian Name_____ _____

*If Yes, please provide Parent/Guardian info Parent/Guardian Phone_____ Email_____

Gender: Male Female **Marital Status:** Divorced Married Separated Single Widowed

SSN:_____-_____-_____ **Spouse Name and Contact#:**_____

Street Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Email*:_____ **Home#:** (_____)_____-_____ **Mobile#:**(_____)_____-_____

Work#:(_____)_____-_____ **Other#:**(_____)_____-_____

REFERRAL INFORMATION

Source of referral: Internet Insurance Plan Friend Psychotherapist M.D.
Other (specify) _____

If MD, specify:_____ Referred phone#:_____

Primary Care Physician:_____ PCP phone#:_____

PATIENT STUDENT / EMPLOYMENT DETAILS

Student Status: Full-time Part-time Not a student **School/College Name:**_____

Occupation:_____

Employment Status: Full-time Part-time Not Employed Self Employed On active military duty Unknown

Employer Name: _____ **Employer Work#:** (_____)_____-_____

Employer Address:_____ **City, State and Zip:**_____

EMERGENCY CONTACT

Contact Name: _____ **Relationship:**_____

Phone#: (_____)_____-_____ **Mobile#:**(_____)_____-_____

PREFERRED LAB AND PHARMACY

Lab: Quest Diagnostics Labcorp Other:_____

Local Pharmacy: Costco CVS Publix Sam's Club Target Walgreens WinnDixie Other:_____

Pharmacy Store#, Address or phone#:_____

Mail Order Pharmacy: CVS Caremark Express Scripts OptumRx PrimeMail Other:_____

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INSURANCE / FINANCIAL RESPONSIBILITY

Primary Payer: Self pay Aetna BCBS Cigna Golden Rule Magellan Medicare Tricare United Healthcare/UBH ValueOptions Other:_____

Insurance ID#:_____ **Group#**_____ **COPAY (if known):**_____

Subscriber's Full Name:_____

Subscriber's Birthdate:_____ **Subscriber's SS#:**_____

Secondary Payer (if any): Self pay Aetna AARP by UHC Bankers Life BCBS Cigna Golden Rule Magellan Medicare 2nd Tricare United Healthcare/UBH ValueOptions Other:_____

Insurance ID#:_____ **Group#**_____ **COPAY (if known):**_____

INSURANCE & MEDICARE ASSIGNMENT AND SELF PAY AGREEMENT AUTHORIZATION TO RELEASE

I certify that I have insurance coverage with the primary insurance company, if applicable; and the secondary insurance payer, if applicable, listed above. I assign directly to Center of Revitalizing Psychiatry, P.C. all insurance payments, if any, otherwise payable to me for services rendered. I understand I am financially responsible for deductible, co-payments, co-insurance amounts, non-covered charges, and any and all balances not covered under a contractual agreement between Center of Revitalizing Psychiatry and my insurance or other third party payer. I understand that is my responsibility to update the Center of Revitalizing Psychiatry regarding any changes in my coverage or my benefits. I authorize the use of my signature for all insurance submissions. I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made on my behalf to Center of Revitalizing Psychiatry for any services furnished to me by that provider. I agree that my signature remains valid until I am an active patient of the practice or until I notify the office in writing, of my intent to leave the practice.
If Self Pay, I understand it is my responsibility to pay for services rendered at time of visit.

I understand and agree that Center of Revitalizing Psychiatry may use my health care information to the above named insurance payer(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I understand that if an authorization is needed from my insurance plan, it is my responsibility to obtain such authorization and provide this to Center of Revitalizing Psychiatry.

Signature of Patient, Parent or Personal Representative:_____

Print name of Patient, Parent or Personal Representative:_____

Relationship of Patient: Self Parent POA/Caregiver **Date:**_____

FOR PATIENTS ENTITLED TO MEDICARE BENEFITS

I certify that the information given by me in applying for payment under the XVIII of the Social Security Act is correct. I authorize any 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 for information needed for this or a related Medicare claim. I request the payment of authorized benefit made on my behalf. I assign the benefits payable of physician services to the physician or organization furnishing the services, or authorize such physician or organization to submit a claim to Medicare payment to me.

_____ _____
Signature Date

New Patient Information Form

Please Print or Type

PATIENT CONSENT FOR RELEASE OF INFORMATION

_____ _____

Patient Name Date of Birth

Authorization for release to individuals *(please select)*:

____I authorize Center of Revitalizing Psychiatry to release the following information to the name/s I have provided below:

Name:	Appointment info	Medication info	Billing info
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

OR

____I DO NOT authorize Center of Revitalizing Psychiatry to release any information to **anyone** at this time. (Check yes if this applies)

_____ _____

Patient Signature Date

Authorization for release to PCP *(please select)*:

____I **authorize** the Center of Revitalizing Psychiatry to make the disclosure of the following information: dates of service, diagnosis, medications prescribed to my **primary care physician**:

Physician name: _____

Phone No: _____

OR

____I **DO NOT authorize** the Center of Revitalizing Psychiatry to make the disclosure of the following information: dates of service, diagnosis, medications prescribed to my **primary care physician**.

_____ _____

Patient Signature Date

Authorization for practitioner coordination:

Should it be necessary for the practitioners at Center of Revitalizing Psychiatry, P.C. to consult with one another regarding my care, I give permission for such.

_____ _____

Patient Signature Date

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1966 (P.L. 104-191), 42 U.S.C. Section 132d, et Seq., and regulation promulgated there under, as amended from time to time (collectively referred to as HIPAA"). This authorization affects your rights in the privacy of your personal behavioral health information. Please read it carefully before signing.

I understand that the information in my health record may include information relating to sexually transmitted disease acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Center of Revitalizing Psychiatry, P.C. will not condition treatment on your providing authorization for the requested use or disclosure. You may refuse to sign this authorization. You have the right to revoke this authorization, in writing, at any time, except to the extent that Center of Revitalizing Psychiatry, P.C. has taken action in reliance on it.

By signing this authorization I acknowledge and agree that any information used or disclosed pursuant could be at risk of re-disclosure by the recipient and no longer protected under HIPAA. This authorization will be valid for the duration of me remaining an active patient of Center of Revitalizing Psychiatry or until I renounce my signature by notifying the Center of Revitalizing Psychiatry in writing.

This information has been disclosed to you from record protected by 42 CR Part 2. The Federal Rules prohibit you from making any further disclosure unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFT Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose.

PATIENT CONSENT FOR EVALUATION OR TREATMENT
CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
CONSENT FOR OFFICE POLICIES AND PROCEDURES

Medical / Psychiatric care and treatment at Center of Revitalizing Psychiatry, P.C. may be provided by Physicians, Advanced Registered Nurse Practitioners (ARNP), Licensed Clinical Social Workers (LCSW), Licensed Mental Health Counselors (LMHC), or other recognized behavioral health practitioners by local state law. I hereby authorize Center of Revitalizing Psychiatry, P.C. to evaluate, diagnose, and render appropriate treatment to the patient designated below. This consent is knowingly and freely given. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Center of Medicare and Medicaid services, my Medigap insurer, or my private health insurance company and their agents any information needed to determine these benefits for related services.

I hereby give my consent for **Center of Revitalizing Psychiatry, P.C. and their Business Associate's** (such as, but not limited to, medical billing company, EHR vendor, collection agency, automated appointment reminder vendor, dictation service, and electronic prescription vendor) to use and disclose **protected health information** (**PHI**) about me to carry out treatment, payment and **health care operations (HCO)**. You can ask for a copy of the Notice of Privacy Practices provided by **Center of Revitalizing Psychiatry, P.C.** which describes such uses and disclosure in detail.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Center of Revitalizing Psychiatry, P.C.** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Privacy Officer at 2033 Wood Street, Ste 220, Sarasota, FL 34237.** You can also pick up a copy in our office.
With this consent, **Center of Revitalizing Psychiatry, P.C** may communicate to me in reference to any items that assist the practice in carrying out HCO, such as, but not limited to, appointment reminders, billing statements, insurance issues and any messages pertaining to my clinical care, including laboratory test results, among others by use of phone calls to my home, mobile or other alternative location and speak or leave a message; SMS/Text message, Email, and/or postal delivery.

It is further understood that all information given by the patient or family member to a treating clinician is ***confidential*** and will not be released, except under special circumstances, without patient consent or consent of legal guardian. The following is a list of exceptions to the law: disclosure of child abuse, disclosure of your intention to harm another person, your inability or refusal to keep yourself from self-harm, and disclosure of abuse to vulnerable adults. You can authorize us to release information relating to your treatment to another person, provider or company by signing a Release of Information (ROI) form provided by our office.

A client may be terminated from **Center of Revitalizing Psychiatry, P.C.** non-voluntarily, if the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at **Center of Revitalizing Psychiatry, P.C.** and/or the client refuses to comply with treatment recommendations, or does not make a payment or payment arrangements in a timely manner. The client may appeal this decision with **Center of Revitalizing Psychiatry, P.C.** or request to re-apply for services at a later date.

By signing this form, I am consenting to allow Center of Revitalizing Psychiatry, P.C. to use and disclose my PHI to carry out HCO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Center of Revitalizing Psychiatry, P.C may decline to provide treatment to me.

I understand and agree with all the preceding information unless otherwise indicated in writing. I agree and accept the terms of all these documents. Copies of these documents are available at your request in our office or by downloading from our website, www.revitalizingpsychiatry.com.

X_____ _____

Signature of Patient, Parent, Guardian or Personal Representative **Date**

_____

Print name of Patient, Parent, Guardian or Personal Representative

This document is due in its entirety before your first visit.

New Patient Information Form

Please Print or Type

CRP OFFICE POLICIES

Your signature at the end of this document will indicate that you have read, understand, and agree to the policies outlined below.

- Appointments are to be made and kept in a timely manner, the **patient is responsible** of keeping track of his/her scheduled appointments:
    - If you cannot keep your scheduled appointment, please give the **office at least 48 hours** notice (this is in addition to weekends and holidays) for all appointments **to avoid a cancellation or a late reschedule fee of $100.**
    - Please call to confirm **ALL** scheduled appointments
    - If you fail to keep your scheduled appointment or if you are late to your scheduled appointment, you **will be charged a no show fee**.
    - If you **no show to 2 appointments** in a row or **cancel 3 appointments late** you will be **discharged** from our office.
    - Our office collects a deposit prior to the first appointment. Once this appointment takes place, and the claim has been processed, the deposit will be returned upon request. Otherwise, it will stay as credit on the patient's account to be applied for future patient responsibility charges.
- Please be advised that **all deductible, coinsurance, and co-payment fees** are expected to be paid **before** your visit.
    - Please contact your insurance company to verify your outpatient mental health benefits and facility mental health benefits. The information we obtain on your behalf is not guaranteed to be accurate by your insurance company.
    - For all payments, we accept Visa, Master Card, Discover or Cash; **we do not accept personal checks**.
    - If the outstanding balance **is not paid in 30 days** from your first statement date, you will be charged a **$25 late fee** and the outstanding amount will be submitted to a collections agency for collection.
- Please **do not use cell phones in our office**; it interferes with our work and patient privacy.
- In certain circumstances, phone conversations may be necessary with your clinician between appointments, there may be an additional fee for this service.
- Forms and letters furnished on your behalf may have fees associated with them, and we reserve the right to charge $0.25/page fee for processing of medical records.
- If you miss/reschedule your appointment or lose your prescription, there will be a $25.00 refill fee and we will only fill the prescription until your next appointment.
- It is the **patient's responsibility** to notify our office of any changes to your personal information (address, phone number, email, etc) or your insurance coverage. Please make sure that we always have your most **up-to-date personal information and insurance card** to file the claims to the correct company.

I understand that if my insurance does not pay for my visit, **I agree to take responsibility for it** and pay the Center of Revitalizing Psychiatry directly.

I have read and understand the information listed above and agree to comply with its contents. I accept financial responsibility for serviced rendered.

Signature _____ Date _____

New Patient Information Form

Please Print or Type

CENTER OF REVITALIZING PSYCHIATRY CREDIT CARD POLICY

Your signature at the end of this document will indicate that you have read, understand, and agree to the policies outlined below.

As of September 1, 2014, the Center of Revitalizing Psychiatry requires a valid credit card be kept on file.

This policy is designed to:

- Help you avoid all billing related fees
- Streamline the billing process in our office and eliminate the expenses related to handling overdue accounts.
- Focus our time and energy on your medical care.

How the policy works:

1. At the time of registration or check-in, you will be asked for your credit card to be electronically stored in our password protected software. This can be **a real Credit Card,** or **an HSA card.**
2. As before, we will bill your insurance carrier as a courtesy for all charges related to your visit.
3. When your appointment is confirmed via text, email or phone your credit card will be charged for your co-pay or deductible. After receiving the explanation of benefits (EOB) from your insurance, we will bill the credit card on file for any additional patient responsibility assigned by your insurance carrier. You are responsible to update our office if your phone number changes. If we cannot reach you or if your phone number is disconnected we reserve the right to bill your credit card for your balance.
4. If you fail to keep an appointment or cancel an appointment late, we will we will charge your credit card $100.00 the same day or within 3 days as the missed appointment.
5. If your appointment is at a time where our receptionists are not in the office to collect your payment, we will charge this card on file.
6. If we attempt to use your card and it is declined or has expired we will contact you and you will be responsible for updating our records with a new credit card and for the balance on your account.

Please remember that this policy does not restrict your right to appeal any charge made to your credit card. Should you feel that we have charged your card in error, you may contact our billing office. If a mistake has been made we will reverse the charges.

I have reviewed a copy of the Center of Revitalizing Psychiatry's billing policy and agree to provide my credit card information to the Center of Revitalizing Psychiatry for the sole purpose of payment for my medical care. Your signature will authorize the card to be used only when a balance becomes due. **Please INITIAL** _____

This is not a receipt. This is a contract agreeing to pay for services once patient liability has been determined.
The terms of this contract are outlined below.

I agree to allow the practice to charge my credit card during the effective period for the balance due, as determined by the final adjudication of all claims included under this contract. I agree to the final adjudication amount as defined by my insurance company, with exceptions as noted below. I also agree to allow the practice to charge my credit card for missed appointments and late cancellations, as per the practice policies. I agree to these charges under the following conditions:

- The charges will take place upon receipt, or within a few days, of the final explanation of benefits from my insurance company.
- The amount charged to my card will not exceed $1,000
- I will receive a bill for any balance greater than $1,000 for which I will send prompt payment to the office.
- Upon request I will receive a receipt for any amount charged to my card once the transaction has been executed.
- I will comply with this policy in order to remain an active patient at the Center of Revitalizing Psychiatry

Patient Name: _____

_____ _____ _____

Name as it appears on your credit card. Card Type (Visa, Mastercard, AE only)* Last 4 digits of card*

**(the card on file maybe updated by the patient at any time, this agreement still fully applies to ANY credit card on file)*

Your signature below will indicate that you have read, understand, and agree to the policies outlined above. Signature will remain valid for the duration of you being seen at our practice, or until you renounce it in writing.

Cardholder/Guarantor Signature:_____ Date: _____

I agree to pay the above total amount according to the card issuer agreement.

New Patient Information Form

Please Print or Type

POLICY FOR PATIENTS WITH OUTSTANDING BALANCES

Center of Revitalizing Psychiatry strives to maintain your mental health in stable condition regardless of your financial situation.

Therefore, in order for us to help you, we need you to understand our policy regarding patients' past due balances. Please read the following and feel free to ask any questions before signing this addendum.

If you have any past due balance and would like to schedule your next appointment, please note:

1. In order to continue to be treated in our Center, the patient must either pay the outstanding balance or establish a payment plan with the office manager and initiate a first payment.

2. We **will not** be able to schedule any appointments until the patient does so.

3. However, **to prevent any interruption of medication management**, we will schedule the patient's next appointment with the medical provider. If the patient fails to start paying the balance before the scheduled appointment, the doctor will meet with him/her and provide him/her with no more than a 30-day prescription, and refer the patient outside of our Center.

4. A late fee of $25 will be applied to any balance that is 30 days past due. A 24% fee of the owed amount may be added if the account is sent to collection services.

5. When any balance is 90 days past due with out a payment arrangement, the Center reserves the right to send the case to a collection agency.

Our office staff is fully committed to working with our clients who may fall into financial hardship at times, and will diligently work to maintain the doctor – patient relationship and continuity of care.

When your balance is kept up to date, it allows us to continue to provide services that you and others need, and for that, we are very grateful.

I have read and agree with this policy:

Signature: _____ Date: _____

Signature will remain valid for the duration of you being seen at our practice, or until you renounce it in writing.

Name (please print): _____

APPOINTMENT REMINDERS

As a courtesy, we can send you appointment reminders via email, phone, or text message. Please choose **ONE** option below and provide the number or email:

- Voice Call to: (check **ONE**) Home Mobile Work Other - ____ / ____ / ____
- SMS/Text to Mobile/Cell - ____ / ____ / ____
- Email - _____

You agree and acknowledge that email, calls, texts, voicemails and any form of messaging to your home, mobile, work or other contact will pertain to information regarding your appointments in our office. If your appointment is not confirmed via your first option, our office may try to call to confirm a second time, as a courtesy.

Signature: _____ Date: _____

This document is due in its entirety before your first visit.

AGREEMENT FOR CONTROLLED PRESCRIPTION MEDICATION MAINTENANCE

The purpose of this agreement is to give you information about the medication you may be prescribed to assure that you and your physician comply with all state and federal regulations concerning the prescribing of controlled substances. The physician's role is for you to have the best quality of life possible given the nature of your condition. The success of treatment depends on mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits of using these medications.

1. You should use only (1) physician to prescribe and monitor all opioid, sedative, and hypnotics.

2. You should use only one (1) pharmacy to obtain any of the above-mentioned medications.

Pharmacy: _____ Phone: _____

3. You should inform your physician of all medications that you are taking since some can interact with other prescribed medications or over the counter medications.
4. You will need to be seen on a regular basis and prescriptions will be given to last from appointment to appointment.
5. Prescriptions will only be given during an office visit or during regular office hours. There will be no refills given during the evening or on weekends.
6. The patient will keep an open mind and be willing to work with the provider including:
   a. Negotiate with the provider to arrive at an acceptable plan of treatment.
   b. Be open to trying alternative treatment strategies.
   c. Follow the treatment provider's instructions precisely.
7. You will be responsible for keeping your medications in a safe and secure place. You are expected to protect your medication from loss or theft. Stolen medications should be reported to the police and to your physician immediately! If your medications are lost, misplaced or stolen, your physician may choose to not replace the medication.
8. You may not give or sell your medications to any other person under any circumstances. If you do, you may endanger that person's health. It is also against the law.
9. Any evidence or drug hoarding, acquisition or any other medications in the same category as the medications that you are prescribed (which includes emergency rooms and hospitals and walk in clinics), and uncontrolled drug escalation, loss of prescriptions or failure to follow the agreement may result in termination of the provider/patient relationship.
10. You should not use any illicit substances, such as cocaine, marijuana, etc. while taking these medications. This may result in a change to your treatment plan, including safe discontinuation of your medication where applicable or complete termination or provider/patient relationship.
11. The use of alcohol is contraindicated with many controlled medications.
12. You may be advised not to drive any type of automobile, vehicle, machinery or any potentially hazardous device while taking narcotics, hypnotics or sedatives. The use of these medications can decrease mental function.
13. You agree and understand that your provider reserves the right to perform random and unannounced urine drug testing. If requested to give a urine sample, you agree to cooperate. If you decide not to comply, your treatment plan may change, including safe discontinuation of your medication and/or termination of the provider/patient relationship. The presence of non-prescription drug(s) or illicit drug(s) can be grounds for termination of the provider/patient relationship. Urine drug testing is done for your benefit as a diagnostic tool and in accordance with state legal and regulatory materials on the use of controlled substances.
14. You agree to allow your provider to contact any health care professional, family member, pharmacy, legal or regulatory agency to obtain or provide information about your care or actions, if the provider feels that it is necessary.
15. If you miss or cancel your medication refill appointment, then you will be unable to get your refills in a timely manner and you may run out. Please avoid this situation as it could cause you to run out of your medications. It is your responsibility to know when your appointment is and to keep it. The reminder calls are only courtesy reminders.

I have read, understand, and agree with the above contract.

X_____ _____

Signature of Patient, Parent, Guardian or Personal Representative **Date**

New Patient Information Form

Please Print or Type

HEALTH SCREENING INFORMATION

The following information is provided by: ☐ Patient ☐ Parent ☐ Family member ☐ Other:_____

1. Chief Complaint: What is the reason for your visit?

☐ Addiction	☐ Depression	☐ Helpless	☐ Mania	☐ Paranoia
☐ ADHD	☐ Energy level decreased	☐ Hopeless	☐ Medication Effects	☐ Phobia
☐ Anger/Temper	☐ Grief	☐ Impulsivity	☐ Memory problem	☐ Self-injury
☐ Anxiety	☐ Guilt	☐ Irritability	☐ Obsession	☐ Suicidal Thoughts
☐ Concentration is poor	☐ Hallucinations	☐ Isolation	☐ Panic Attacks	☐ Tearfulness
☐ Confusion				☐ Worthlessness

☐ Other, please explain:

_____

_____

_____

2. Psychiatric History:

Have you ever been treated for Mental Health issues? ☐ YES ☐ NO

If YES, then answer the Treatment History tables below. If NO, then skip to next question on Stressors.

INPATIENT TREATMENT HISTORY IN HOSPITAL or PARTIAL HOSPITALIZATION:

Facility Name	Dates of Treatment	Reason or Explanation of this treatment

OUTPATIENT TREATMENT HISTORY:

Psychiatrist / ARNP / Therapist or Other Mental Health Provider Name	Dates of Treatment	Reason or Explanation of this treatment

STRESSORS:

☐ Disability	☐ Financial Problems	☐ Peer/ Friendship	☐ Support System
☐ Education Problems	☐ Health Problems		☐ Work Issues
☐ Family	☐ Housing Problems		
☐ Other:_____	☐ Marriage		

3. Substance Abuse History:

Have you ever been treated for alcohol or drug use or abuse? YES NO
If YES, then complete the Treatment History table below. If NO, continue to next question.

INPATIENT SUBSTANCE ABUSE TREATMENT HISTORY:

Facility Name	Dates of Treatment	Reason or Explanation of this treatment

Complete the table below regarding the following substances:

Substance	Have you ever tried before?	Age Started	Last used on this approx. date	Frequency of use	Lost Control?	Comments
Alcohol	Yes No					
Caffeine (coffee,tea,cola's)	Yes No					
Cigarettes, cigars or tobacco	Yes No					
Cocaine	Yes No					
Hallucinogens (LCD, mushrooms, Mescaline)	Yes No					
Heroin	Yes No					
IV Drug use	Yes No					
Marijuana	Yes No					
Pain Pills	Yes No					
Other:	Yes No					

Periods of Abstinence:_____

Have you experienced any of the following withdrawal symptoms and on what substance(s)?

Withdrawal Symptom	Have you experienced?	What Substance(s)?
Anxiety	Yes No	
D.T's (delirium tremens)	Yes No	
Seizures	Yes No	
Sweating	Yes No	
Tremors	Yes No	
Tachycardia	Yes No	
Other:	Yes No	

SMOKING STATUS:

- Current every day smoker
- Current some day smoker
- Former smoker
- Current smoker
- Never smoker
- Unknown current smoker
- Unknown if ever smoked

New Patient Information Form

Please Print or Type

4. Medical History:

Please check beside any illness you have now or have had in the past.

Arthritis	Chronic Pain	High Blood Pressure	Stomach Problems
Blood Disorders	Diabetes	Liver Disease	Stroke
Bowel Problems	Glaucoma/Vision Problems	Lung Disease/Breathing Problems	Thyroid Disease
Cancer	Heart Attack	Migraines	Ulcer
Chest Pain	Hepatitis	Seizures / Epilepsy	

Other, please explain:_____

SURGICAL PROCEDURES:

Type of Procedure	Date Occurred

SERIOUS INJURIES OR ACCIDENTS:

Type of Injury/Accident	Date Occurred

ALLERGIES:

Food / Medication Allergy	Type of Reaction

CURRENT MEDICATIONS:

Current Medications	Dose	Frequency	Last dose taken

Have you ever discontinued or altered the prescribed dose of your medication without the recommendation of your treating physician? YES NO

If YES, please explain:_____

FOR WOMEN ONLY:

Date of last menstrual period:_____.

Are you currently pregnant or do you think you might be pregnant? YES NO

Are you planning to get pregnant in the near future? YES NO

Birth control method:_____

New Patient Information Form

Please Print or Type

5. Family History

Has anyone in your family ever been treated for any of the following? (please check all that apply and when appropriate indicate paternal or maternal.

Illness	Father	Mother	Aunt	Uncle	Brother	Sister	Children	Grandparent
ADHD								
Alzheimer's Disease								
Anxiety / Panic Attacks								
Bipolar Disorder								
Depression								
Heart Disease								
Schizophrenia								
Seizures								
Stroke								
Substance Abuse								
Suicide Attempts								

NUTRITIONAL ASSESSMENT:

Height:_____ Current Weight:_____

Without wanting to, have you lost / gained more than 10 pounds within the last 6 months? YES NO

If YES, Amount Weight Lost:_____ Amount Weight Gained:_____

Sleep Patterns: Hours each night: _____ Awakens Frequently Difficulty returning to sleep Difficulty falling asleep

FUNCTIONAL ASSESSMENT:

Have you experienced a recent loss of independence in caring for yourself? YES No

If YES, please explain:_____

Comments—In your own words, please describe why you have sought services with us?

_____

_____

_____

_____

Any other additional information you care to share with us?

_____

_____

_____

>>>Please bring this completed new patient paperwork with you at your first appointment or fax**/send to us before your first appointment. Also, remember to bring your photo ID and insurance cards, if applicable. Thank you.**