WCS Policies

Informed Consent for Services

We are grateful to have the opportunity to work with you. Please read this document carefully, as it contains important information about our healthcare services and business policies. Before signing, please feel free to ask any questions.

Services

Wilson Clinical Services, PLLC. provides various psychiatric healthcare services, including prescription medication, psychotherapy, neuropsychological, and psychological examinations. We can prescribe medication if you and your provider agree this is a necessary and appropriate treatment. All treatment requires an active effort on your part. After your initial consultation, we will offer you some impressions of what our work may entail, along with treatment recommendations. You should assess this information and your initial impressions to decide whether you feel comfortable working with us. If you have questions regarding our clinical procedures at any time, please feel free to bring them to our attention.

Confidentiality

Trust and safety are paramount in the treatment of your mental health. Therefore, we take confidentiality very seriously. Moreover, federal law prohibits us from releasing information about our work without your written permission. However, there are a few exceptions:

- If we believe you could harm yourself or others
- If we suspect child or elder abuse
- If a court subpoenas your records
- If an on-call provider in this office needs information to treat you appropriately in the absence of your primary provider

Please refer to the *Notice of Privacy Practices* or the *Consent for Telemedicine* for more information.

Emergencies

During business hours, please get in touch with our office at (253) 200-0234 or frontdesk@WilsonClinical.com. After business hours and on weekends, please call 911, or seek immediate care at your nearest emergency department. The emergency department staff can involve the on-call provider as needed.

Prescription Refills

If you begin taking a medication, you must be safely monitored for its effectiveness and side effects. You will be given ample medication and refills until your next appointment. You are responsible for scheduling follow-up appointments before you run out of your prescription. In return, you will find that we are conscientious about the cost of medical care and do not request unnecessary visits. If we refill a medication between visits, it is usually our policy to prescribe only enough medicine until the next visit. If our initial appointment is performed via telepsychiatry, you must complete and sign all intake forms before any medication is prescribed.

Contacting You

It is your responsibility to keep your contact information up to date. We cannot be your treatment provider if we cannot contact you or your PCP. If your information changes, please contact our office at (253) 200-0234 or frontdesk@WilsonClinical.com and update our staff as soon as possible.

Contacting Us

We encourage you to contact us if you have questions or concerns about your treatment. You may call during office hours and leave a non-confidential message with our office staff, or you may call and leave a confidential voicemail with your provider. We will not interrupt appointments to take calls except in absolute emergencies. We will make every effort to return calls as soon as possible. You may email, but please understand that we may not respond in a timely way.

Payment

Payment is expected at each session, and your card on file will be charged. We will strive to complete all work during our scheduled sessions. However, we may charge on a prorated basis for other professional services you may require, such as report writing, email correspondence, telephone conversations, prior authorizations, and consultations with other professionals that you have requested. Our office accepts cash, check, credit card, and many HSA cards for your convenience.

Cancellations & Missed Appointments

Cancellations must be made by calling the office at least 48 business hours before your appointment. ***Failure to do so will result in a full charge for the missed appointment.*** Repeated no-shows or late cancellations will be carefully discussed and may be cause to discontinue treatment. Missed appointments must be rescheduled in a timely way for us to continue our treatment effectively.

Insurance

We accept most insurance plans. If you are insured under a plan we do not work with, we can provide you with the necessary information to file your claim with your insurance company. It is your responsibility to understand what your insurance company will cover for the cost of the appointment.

We greatly appreciate the opportunity to be of service to you. If you have any questions, concerns, or suggestions regarding our practice, please discuss them with us. We are always eager to hear your comments and will gladly answer any questions. Your signature below indicates that you have read the above and consent to the terms of this contract.

I, First Name Last Name, *have read and understood the office policies regarding financial arrangements, fees, and charges for missed appointments or late cancellations. I voluntarily consent to treatment and understand that informed consent ends with the termination of the professional relationship. I may terminate this relationship at any time.*

Patient Name

Patient Signature (or signature of person authorized to sign for the patient)

If authorized signer, relationship to patient:

Date

Identity Verification

Patient Name

ID or Driver's License

Please take a picture of the front and back of a government-issued ID.

ID Card Photo Upload

Picture of Yourself

Please take a picture of yourself. This is best done using your phone. This allows us to verify that you and the person on your ID are the same!

Selfie Upload

New Patient Form (*Please note, if you already completed the "Book An Appointment" initial form, you may skip this form / step)

Name

Preferred Name

Patient Status

☐ Deaf ☐ Hard of Hearing ☐ CODA ☐ DeafBlind

☐ Low Vision / Blind ☐ Hearing ☐ Other

Social Security Number

Sex

☐ Male ☐ Female ☐ Other

Age

Explain

Date of Birth

Address/City/State/Zip

Cell Phone or Text Number

My we leave a message or text?

☐ Yes ☐ No

Home Phone or VP

May we leave a message?

☐ Yes ☐ No

Email Address

Emergency Contact

Primary Care Provider (PCP)

Approximate Last Date of Service w/ PCP

Reason for Visit with PCP:

Reason for Referral (What Services Are You Seeking with Us?):

Preferred Pharmacy

Insurance

Insurance Information

We accept many insurance plans. In the event we do not accept your insurance plan, we can provide you with the necessary information to file your claim with your insurance company. It is your responsibility to understand what your insurance company will cover for the cost of the appointment.

Primary Insurance Policy Holder

☐ Self ☐ Spouse ☐ Father

☐ Mother ☐ Family ☐ Other

First Name of Primary Insured

Last Name of Primary Insured

Upload Primary Insurance Card

Do you have Secondary Insurance? (If yes, please complete insurance information below)

☐ Yes ☐ No

Secondary Insurance Policy Holder
☐ Self ☐ Spouse ☐ Father
☐ Mother ☐ Family ☐ Other

First Name of Secondary Insured

Last Name of Secondary Insured

Insurance ID #

Insurance Company Name

Group Name

Group Number

Birthdate of Secondary Insured

Secondary Insured Relationship to Patient

Upload Insurance

Secondary Insurance Policy Holder
☐ Self ☐ Spouse ☐ Father
☐ Mother ☐ Family ☐ Other

First Name of Secondary Insured

Last Name of Secondary Insured

Upload Secondary Insurance Card

Privacy Practices

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

Our commitment to your privacy

As part of providing professional care to you, we will do all we can to maintain the privacy of what is called your “protected health information” (PHI). We are also required by law to keep your PHI private. These laws are complicated, and we must give you this important information. This page is a shorter description of what we do to maintain your privacy. Please ask any staff member for a copy if you want to read the more detailed version. If you have any questions about our practices, please get in touch with our compliance officer, whose email information is listed at the bottom of this page.

How we use and disclose your protected health information (PHI) with your consent

We will use the information we collect about you mainly to provide you with treatment; to arrange payment for our services; and for some other business activities called, in the law, “health care operations.” We will ask you to sign a separate consent form to show that you understand how we handle your information. We will not treat you if you disagree and won’t sign this consent form. If we want to use, send, share, or release your PHI for other purposes, we will discuss this with you so you fully understand it and ask you to sign a release-of-information form to allow this.

Disclosing your health information without your consent

There are some times when the laws require us to share your information without getting your consent. They are described in the longer version of our Notice of Privacy Practices, but here are the most common situations:

1. When there is a serious threat to your or another person’s health or safety or the public. We will only share information with people who can help prevent or reduce the danger.

2. When we are required to do so by lawsuits and other legal or court proceedings.

3. When a law enforcement official requires us to do so.

4. For workers' compensation and similar programs, if you seek these benefits.

Your rights to your health information

1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home rather than at work to schedule or cancel an appointment. We will try our best to do as you ask.

2. You can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.

3. You have the right to look at the health information we have about you, such as your medical chart, case file, and billing records. You can get a copy of these records, and we can charge you for them. Please talk to our compliance officer to arrange how to see your records.

4. If you believe that the information in our records is incorrect or missing something important, you can ask us to add to your records to correct the situation. You have to make this request in writing and send it to our compliance officer.

5. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our compliance officer and the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the healthcare we provide to you in any way.

6. You have the right to a copy of this notice.

Also, you may have other rights granted to you by the laws of your state, which may be the same as or different from the abovementioned rights. Our compliance officer will be happy to discuss these situations or answer any questions now or as they arise. The email to the compliance officer is: frontdesk@WilsonClinical.com

Name

Patient Signature (or signature of person authorized to sign for the patient)

If authorized signer, relationship to patient:

Date

Telemedicine Consent

Introduction

Telemedicine or telepsychiatry involves using electronic communications to enable healthcare providers at different locations to share individual patient healthcare or medical information to improve patient care. Providers may include primary care practitioners, specialists, or subspecialists. The information may be used for diagnosis, therapy, follow-up, or education and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data. They will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to healthcare by enabling a patient to remain in his/her provider's office (or at a remote site) while the provider obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient healthcare evaluation and management.
- Obtaining the expertise of a distant specialist.

Possible Risks:

As with any medical or healthcare procedure, there are potential risks associated with telemedicine or telepsychiatry. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate medical or healthcare decision-making by the provider or consultant.
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions, allergic reactions, or other judgment errors.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine and telepsychiatry, and that no information obtained in the use of telemedicine or telepsychiatry which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine or telepsychiatry in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded during a telemedicine or telepsychiatry interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical or healthcare may be available to me, and I may choose one or more of these at any time. My provider has explained the alternatives to my satisfaction.
5. I understand that telemedicine or telepsychiatry may involve electronic communication of my personal medical information to other medical practitioners or healthcare providers who may be located in other areas, including out of state.
6. I understand that I must inform my provider of electronic interactions regarding my care that I may have with other healthcare providers.

7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Patient Consent To The Use of Telemedicine or Telepsychiatry

I, , have read and understand the information provided above regarding telemedicine or telepsychiatry, have discussed it with my provider or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I agree to hold harmless any provider or employee associated with Wilson Clinical Services, PLLC. from any liability that may result from using telemedicine or telepsychiatry. I hereby give my informed consent for using telemedicine or telepsychiatry in my medical or general healthcare.

Name

Signature of Patient (or person authorized to sign for patient):

If authorized signer, relationship to patient:

Date

Credit Card Authorization

CREDIT CARD AUTHORIZATION FORM

A credit card is required before initiating healthcare services with Wilson Clinical Services, PLLC. Your credit card information will be stored and protected under the strictest security procedures as it is with your healthcare information.

Card Holder First Name

Card Holder Last Name

Credit Card Type

☐ MasterCard ☐ Visa ☐ AMEX ☐ Discover

☐ Other

Account Number

Text Field

Expiry Date

Security Code

Email of card holder

Credit Card Photo Upload (this is required in addition to the CC information inputted)

BILLING INFORMATION

Billing Address

City, State, Zip

I, **first name & last name**, authorize the use of my credit card on file for the charges related to services provided by Wilson Clinical Services, PLLC. I understand the amount charged to my credit card will be reflected on my credit card statement within seven days of authorization. The amount charged is based on services requested by me.

Patient Name

Signature

Date

Release - PCP

In certain cases, we may need to collaborate with your primary care provider (PCP) for your care. To allow that collaboration, we will need your express permission. Your permission is required for us to provide services to you.

Primary Care Provider's (PCP's) Information

PCP First Name **PCP Last Name** **Provider Type** **PCP Phone**

PCP Fax Number **PCP's Email (if unknown, type "N/A")**

Authorization

Patient First Name **Patient Last Name**

Patient/Representative Signature

Date

If Individual is unable to sign this Authorization, please complete the information below:

Name of Guardian **Legal Relationship** **Date**

Release - Therapist

The philosophy of WCS is to collaborate closely with other providers you work with, especially your therapist or counselor. To allow that collaboration, we will need your express permission. If you have a therapist or counselor with whom you'd like us to communicate, please please answer "yes" and sign below.

Do you have a therapist or counselor with whom you would like us to communicate?

- ☐ Yes
- ☐ No

Patient Name

Signature

Date

Medical History Questionnaire

Can you please share what you are seeking care for?*

- ☐ **Depression**
- ☐ **Anxiety**
- ☐ **OCD**
- ☐ **ADHD/ADD**
- ☐ **Autism**
- ☐ **Bipolar Disorder**
- ☐ **Eating Disorder**
- ☐ **Schizophrenia**
- ☐ **Neuropsychological or Psychological Exam**

Other

What healthcare goals do you hope to achieve in seeing one of our providers?

Please indicate your height

Please indicate your weight

If you know your most recent blood pressure reading, please indicate:

Current Healthcare Providers*

Please list any other healthcare providers you see (e.g., specialists, OBGYN, physical therapists, chiropractor):

Psychiatric History*

Have you had any past psychiatric treatment or diagnoses?

- ☐ Yes
- ☐ No

If yes, name & last visit:

Text Field

Please list past psychiatric diagnoses (e.g., anxiety, depression, bipolar, ADHD):

Have you ever seen a therapist before?

☐ Yes ☐ No

***If yes, name & last visit:**

Are you CURRENTLY having thoughts of harming yourself?

☐ Yes ☐ No

If yes, do you feel the need to go to the ER or a hospital?

☐ Yes ☐ No

If no, are you going to be able to keep yourself safe?

☐ Yes ☐ No

Are you CURRENTLY having thoughts of harming others?

☐ Yes ☐ No

Have you taken psychiatric medication in the past? Please describe your experience. (Name of medication, dosage, length of time taken, outcomes and/or side effects)

Current Medication(s) (please list ALL medications you are taking)*

A.

Medication Concerns? ☐ Yes ☐ No **Medication helpful?** ☐ Yes ☐ No

Concerns

B.

Medication Concerns? ☐ Yes ☐ No **Medication helpful?** ☐ Yes ☐ No

Concerns

C.

Medication Concerns? ☐ Yes ☐ No **Medication helpful?** ☐ Yes ☐ No

Concerns

Please list all other medications or supplements not noted above (please Include over-the-counter vitamins, herbs, pain relievers):

Have you been hospitalized or have been in a day treatment program?

☐ Yes ☐ No

If yes, how many times?

☐ 1-2 times ☐ 3-4 times ☐ 5+ times

1. Hospital Name/Location (City)/ Dates of Stay/ Reason for Hospitalization

2. Hospital Name/Location (City)/ Dates of Stay/ Reason for Hospitalization

Reason and dates of hospitalization:

Have you been treated for alcohol or drug abuse in the past?

☐ Yes ☐ No

If yes, where were you treated and when?

If yes, what substance?

Was program completed?

☐ Yes ☐ No

Please indicate whether treatment was for alcohol, substance abuse, or both.

Have you abused any alcohol, illegal drugs or marijuana, in the past three months?

☐ Yes ☐ No

If yes, which ones?

If yes, how often?

☐ 1-3 times ☐ 4-8 times ☐ 8+ times

Every

☐ Day ☐ Week ☐ Month ☐ Year

Have you been treated at a methadone clinic or received Suboxone treatment in the last two years?

☐ Yes ☐ No

If yes, when was your last visit?

Please provide any additional comments or notes regarding substance use:

Family Medical & Psychiatric History*

Please list any medical and psychiatric conditions that run in your family. (Examples: depression, diabetes)

Has anyone in your family been diagnosed with bipolar disorder, psychosis, substance use disorder, or had a psychiatric hospitalization?

☐ Yes ☐ No

Has anyone in your family attempted or committed suicide?

☐ Yes ☐ No

Allergies

Please list each allergy and what occurs (rash, hives, trouble breathing, etc.):

Medical History* (please indicate if you have had any of the following diagnoses):

ADD/ADHD ☐ Yes ☐ No

Radiation Treatment ☐ Yes ☐ No

Chronic Sinus Problems ☐ Yes ☐ No

Rapid Weight Gain/loss ☐ Yes ☐ No

Heart Attack ☐ Yes ☐ No

Cochlear Implant ☐ Yes ☐ No

Congenital Heart Defect ☐ Yes ☐ No

Convulsions/ Seizures ☐ Yes ☐ No

Cortisone Treatments ☐ Yes ☐ No

Heart Pacemaker ☐ Yes ☐ No

Skin Rash ☐ Yes ☐ No

Arthritis/Rheumatism ☐ Yes ☐ No

Artificial Heart Valves ☐ Yes ☐ No

Smoking ☐ Yes ☐ No

Crohn's Disease ☐ Yes ☐ No

Asthma ☐ Yes ☐ No

High Cholesterol ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

Back Problems ☐ Yes ☐ No

Kidney Disease ☐ Yes ☐ No

Chronic Fatigue Syndrome ☐ Yes ☐ No

Adenoids Removed ☐ Yes ☐ No

Circulatory Problems ☐ Yes ☐ No

Rheumatic Fever ☐ Yes ☐ No

Heart Disease ☐ Yes ☐ No

Allergies/Hayfever ☐ Yes ☐ No

Anaphylaxis ☐ Yes ☐ No

Anemia ☐ Yes ☐ No

Shortness Of Breath ☐ Yes ☐ No

Cosmetic Surgery ☐ Yes ☐ No

Angina Pectoris ☐ Yes ☐ No

Herpes ☐ Yes ☐ No

Cough Up Blood ☐ Yes ☐ No

Artificial Joint (Hip/Knee) ☐ Yes ☐ No

Depression ☐ Yes ☐ No

Anxiety ☐ Yes ☐ No

Irritable Bowel Syndrome ☐ Yes ☐ No

Dizziness/fainting ☐ Yes ☐ No

Drug Addiction ☐ Yes ☐ No

Swelling Of Feet/Ankles ☐ Yes ☐ No

Gout ☐ Yes ☐ No

Headaches ☐ Yes ☐ No

AIDS/HIV Positive ☐ Yes ☐ No

Alcoholism ☐ Yes ☐ No

Rheumatic Heart Disease ☐ Yes ☐ No

Scarlet Fever ☐ Yes ☐ No

Heart Murmur ☐ Yes ☐ No

Shingles ☐ Yes ☐ No

Heart Surgery ☐ Yes ☐ No

Hemophilia ☐ Yes ☐ No

Cough Persistent ☐ Yes ☐ No

Sleep Apnea ☐ Yes ☐ No

Hepatitis ☐ Yes ☐ No

High Blood Pressure ☐ Yes ☐ No

Snoring ☐ Yes ☐ No

Stroke ☐ Yes ☐ No

Surgical Implant ☐ Yes ☐ No

Jaw Pain ☐ Yes ☐ No

Blood Disease ☐ Yes ☐ No

Blood Transfusion ☐ Yes ☐ No

Systemic Lupus Eryth
☐ Yes ☐ No

Latex Allergy ☐ Yes ☐ No

Emphysema/COPD ☐ Yes ☐ No

Thyroid Disease ☐ Yes ☐ No

Liver Disease ☐ Yes ☐ No

Epilepsy ☐ Yes ☐ No

Bipolar Disorder ☐ Yes ☐ No

Fen-Fen Use ☐ Yes ☐ No

Bruises Easily ☐ Yes ☐ No

Tobacco Use ☐ Yes ☐ No

Tonsilitis ☐ Yes ☐ No

Low Blood Pressure ☐ Yes ☐ No

Cancer ☐ Yes ☐ No

Mitral Valve Prolapse ☐ Yes ☐ No

Fever Blisters ☐ Yes ☐ No

Tonsils Removed ☐ Yes ☐ No

Fibromyalgia ☐ Yes ☐ No

Cerebral Palsy ☐ Yes ☐ No

Multiple Sclerosis ☐ Yes ☐ No

Chemotherapy ☐ Yes ☐ No

Gall Bladder Problems
☐ Yes ☐ No

Tuberculosis ☐ Yes ☐ No

Ulcerative Colitis ☐ Yes ☐ No

Glaucoma ☐ Yes ☐ No

Osteoporosis ☐ Yes ☐ No

Psychiatric Care ☐ Yes ☐ No

Venereal Disease ☐ Yes ☐ No

Chronic Ear Problems
☐ Yes ☐ No

Any Drug Or Food Allergies?
☐ Yes ☐ No

Any Other Medical Conditions Not Listed Above?

Are You Being Treated For Cancer Of Any Kind? ☐ Yes ☐ No

Women: Are You Pregnant?
☐ Yes ☐ No

Nursing? ☐ Yes ☐ No

Taking Birth Control Pills?
☐ Yes ☐ No

Do You Or Have You Used Prescribed Medical Marijuana? ☐ Yes ☐ No

If Yes, Please Indicate The Condition Being Treated.

Do You Or Have You Used Marijuana Recreationally? ☐ Yes ☐ No

I, , have reviewed the information on this medical history form and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate and healthful treatment. If there is any change in my medical status, I will inform the doctor. I authorize the insurance company indicated on this form to pay to the doctor all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Patient Name

Signature

Date

Current Symptoms

Please tell us any physical symptoms you are having at the time of your appointment with us.

GENERAL

☐ None ☐ Fatigue ☐ Lethargy ☐ Sleepiness ☐ Fever / Chills ☐ Recent weight gain ☐ Recent weight loss ☐ Decreased appetite ☐ Increased appetite ☐ Pain

SKIN

☐ None ☐ Rash ☐ Swelling ☐ Itching / Dryness ☐ Acne ☐ Hair / Nail concerns ☐ Other

HEAD

☐ None ☐ Headache / Migraine ☐ Head injury ☐ Lightheadedness ☐ Dizziness ☐ Other

EYES

☐ None ☐ Vision impairment ☐ Other

EARS

☐ None ☐ Hearing loss ☐ Ringing in the ears ☐ Dizziness ☐ Other

NOSE

☐ None ☐ Sinus congestion ☐ Bleeding ☐ Other

MOUTH / THROAT

☐ None ☐ Dry mouth ☐ Sore throat ☐ Hoarseness ☐ Dental concerns ☐ Difficulty swallowing ☐ Other

NECK

☐ None ☐ Lump / Goiter ☐ Swelling ☐ Stiffness ☐ Pain ☐ Other

BREASTS

☐ None ☐ Lump ☐ Pain ☐ Discharge ☐ Breast feeding ☐ Other

CARDIOVASCULAR

☐ None ☐ Chest pain ☐ Chest tightness ☐ Palpitations ☐ Heart racing ☐ Swelling / Edema in the legs ☐ Other

RESPIRATORY

☐ None ☐ Shortness of breath ☐ Cough ☐ Mucus ☐ Wheezing ☐ Other

GASTROINTESTINAL

☐ None ☐ Abdominal pain ☐ Heartburn ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Mucus in stool ☐ Blood in stool ☐ Incontinence ☐ Food allergies ☐ Other

URINARY

☐ None ☐ Pain ☐ Bladder problems ☐ Blood in urine ☐ Other

MALE REPRODUCTIVE

☐ None ☐ Libido concerns ☐ Erectile dysfunction ☐ Difficulty achieving orgasm ☐ Testicular or penile concerns ☐ Hormones ☐ Other

FEMALE REPRODUCTIVE

☐ None ☐ Libido concerns ☐ Difficulty achieving orgasm ☐ Vaginal discharge ☐ Sores ☐ Pain with intercourse ☐ Perimenopausal ☐ Postmenopausal ☐ Oral conctraceptive ☐ Other hormones ☐ IUD ☐ Pregnancies ☐ Menstruation ☐ Other

HEMATOLOGIC / LYMPHATIC

☐ None ☐ Shortness of breath ☐ Excess bruising ☐ Excess bleeding ☐ Enlarged, warm, or tender lymph nodes ☐ Other

MUSCULOSKELETAL

☐ None ☐ Muscle pain ☐ Joint pain ☐ Back pain ☐ Limited range of motion ☐ Weakness ☐ Other

NEUROLOGICAL

☐ None ☐ Numbness ☐ Tingling ☐ Nerve pain ☐ Fainting ☐ Seizures ☐ Blackouts ☐ Tremors ☐ Other

ENDOCRINE

☐ None ☐ Changes in urination ☐ Changes in thirst ☐ Changes in hunger ☐ Changes in sweating ☐ Changes in cold tolerance ☐ Changes in heat tolerance ☐ Other

ALLERGIC / IMMUNE SYSTEM

☐ None ☐ Seasonal allergies ☐ Frequent illnesses ☐ Arthritis ☐ Other

Consent to Obtain Medication Hx

Importance of Medication History

Obtaining your medication history is very important in helping healthcare providers treat you properly and in avoiding potentially dangerous drug interactions. Please note that some pharmacies do not make drug history available. Your drug history may not include drugs purchased without using your health insurance as well as over-the-counter drugs, supplements, or herbal remedies that patients take on their own.

Patient medication history is a list of prescription medicines that our practice providers or other providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history. The medication history may include sensitive information including, but not limited to, medications related to mental health conditions, sexually transmitted diseases, substance (drug and alcohol) abuse, and HIV/AIDS.

Consent

By signing this consent form, you are giving your healthcare provider permission to collect information about your medication history, and it gives permission to your pharmacy and health insurer to disclose your medication history. This includes specific consent to release sensitive health information listed in the first paragraph. This consent will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing, but if you do, it will not affect any actions taken before receiving the revocation.

Name

Signature

Date

ISI

ISI

Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Difficulty falling asleep

- [ ] None
- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Very Severe

- [ ] **Lifetime**
- [ ] **Lifetime**
- [ ] **Lifetime**
- [ ] **Lifetime**
- [ ] **Lifetime**

Difficulty staying asleep

- [ ] None
- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Very Severe

- [ ] **Lifetime**
- [ ] **Lifetime**
- [ ] **Lifetime**
- [ ] **Lifetime**
- [ ] **Lifetime**

Problems waking up too early

- [ ] None
- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Very Severe

- [ ] **Lifetime**
- [ ] **Lifetime**
- [ ] **Lifetime**
- [ ] **Lifetime**
- [ ] **Lifetime**

How SATISFIED / DISSATISFIED are you with your CURRENT sleep pattern?

- [ ] Very Satisfied
- [ ] Satisfied
- [ ] Moderately Satisfied
- [ ] Dissatisfied
- [ ] Very Dissatisfied

- [ ] **Lifetime**
- [ ] **Lifetime**
- [ ] **Lifetime**
- [ ] **Lifetime**
- [ ] **Lifetime**

How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

☐ Not at all Noticeable ☐ A Little ☐ Somewhat ☐ Much ☐ Very Much Noticeable

☐ **Lifetime**
☐ **Lifetime**
☐ **Lifetime**
☐ **Lifetime**
☐ **Lifetime**

How WORRIED / DISTRESSED are you about your current sleep problem?

☐ Not at all Worried ☐ A Little ☐ Somewhat ☐ Much ☐ Very Much Worried

☐ **Lifetime**
☐ **Lifetime**
☐ **Lifetime**
☐ **Lifetime**
☐ **Lifetime**

To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g., daytime fatigue, mood, ability to function at work / daily chores, concentration, memory, mood, etc.) CURRENTLY?

☐ Not at all Interfering ☐ A Little ☐ Somewhat ☐ Much ☐ Very Much Interfering

☐ **Lifetime**
☐ **Lifetime**
☐ **Lifetime**
☐ **Lifetime**
☐ **Lifetime**

ISI Total

Mood Disorder Screening

MOOD DISORDER SCREENING

Instructions: Please answer each question to the best of your ability.

1. Has there ever been a period of time when you were not your usual self and...

	Yes	No
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
...you were so irritable that you shouted at people or started fights or arguments?	○	○
...you felt much more self-confident than usual?	○	○
...you got much less sleep than usual and found you didn't really miss it?	○	○
...you were much more talkative or spoke much faster than usual?	○	○
...thoughts raced through your head or you couldn't slow your mind down?	○	○
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
...you had much more energy than usual?	○	○
...you were much more active or did many more things than usual?	○	○
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
...you were much more interested in sex than usual?	○	○
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○	○
...spending money got you or your family into trouble?	○	○

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?

☐ Yes ☐ No

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? Please select one response only.

☐ No Problem ☐ Minor Problem ☐ Moderate Problem ☐ Serious Problem

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?

☐ Yes ☐ No

5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder? ☐ Yes ☐ No

Score (based on algorithm):

GAD-7

Instructions: Over the last 2 weeks, how often have you been bothered by any of the following problems?

Rating Scale

	(0) Not at all	(1) Several Days	(2) More than Half the Days	(3) Nearly Everyday
1. Feeling nervous, anxious or on edge?	○	○	○	○
2. Not being able to stop or control worrying?	○	○	○	○
3. Worrying too much about different things?	○	○	○	○
4. Trouble relaxing?	○	○	○	○
5. Being so restless that it is hard to sit still?	○	○	○	○
6. Becoming easily annoyed or irritable?	○	○	○	○
7. Feeling afraid as if something awful might happen?	○	○	○	○

Score

PHQ-9

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	0 - Not at all	1 - Several days	2 - More than half the days	3 - Nearly every day
1. Little interest or pleasure in doing things	○	○	○	○
2. Feeling down, depressed or hopeless	○	○	○	○
3. Trouble falling or staying asleep, or sleeping too much	○	○	○	○
4. Feeling tired or having little energy	○	○	○	○
5. Poor appetite or overreacting	○	○	○	○
6. Feeling bad about yourself... or that you are a failure or have let yourself or your family down	○	○	○	○
7. Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
8. Moving or speaking so slowly that other people could	○	○	○	○
9. Thoughts that you would be better off dead, or of hurting yourself	○	○	○	○

Score _____