PATIENT INFORMATION AND MEDICAL HISTORY FORM

PATIENT DEMOGRAPHICS

Preferred Called Name:_____ Age:_____

Last Name:_____ First Name:_____

Date of Birth:_____ Social Security Number:_____

CONTACT

Home:_____ Work:_____ Cell:_____

May we leave a detailed message? ☐ Yes ☐ No IF YES, please circle the preferred number.

Email:_____

May we email you for appointment reminder, confidential results, promos, etc? ☐ Yes ☐ No

Preferred appointment reminder: Email Text Message Phone[h] Phone[w] Phone[c]

ADDRESS

Address:_____

City:_____ State:_____ Zip:_____

EMPLOYMENT

Employer:_____ Occupation:_____

EMERGENCY CONTACT

Last Name:_____ First Name:_____

Phone number:_____ Relationship to Patient:_____

FINANCIALLY RESPONSIBLE PARTY (Complete if NOT self/patient is a MINOR/NOT the main policy holder)

Last Name:_____ First Name:_____

Relationship to patient:_____ Date of Birth_____ SSN:_____

Address:_____ Phone:_____

PRIMARY PHYSICIAN

Physician Name:_____ Physician Phone:_____

Physician Address:_____

PREFERRED PHARMACY

Pharmacy Name:_____ Address:_____

Phone:_____ Fax:_____

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER

NOTICE OF PRIVACY PRACTICES

EFFECTIVE: APRIL 14, 2003
REVISED: March 3, 2016

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

ABOUT THIS NOTICE:

Texas Tech University Health Sciences Center (TTUHSC) is dedicated to maintaining the privacy of your Protected Health Information (PHI). TTUHSC provides health care services and items through its Schools of Medicine, Nursing, Pharmacy and Allied Health Sciences. TTUHSC provides services at its main community hospitals, ambulatory care clinics, ambulatory surgical centers, pharmacies, research units and several community service outreach centers throughout West Texas. TTUHSC is required by law to maintain the privacy of your PHI and provide you with notice of its legal duties and privacy practices. This notice of privacy practices describes how TTUHSC may use or disclose your PHI. PHI includes any information that relates to (1) your past, present, or future physical or mental health or condition; (2) providing health care to you; and (3) the past, present, or future payment for your health care. For TTUHSC at Lubbock, University Medical Center (UMC), and UMC Physicians Network Services (PNS) participate in a clinically integrated health care setting which is considered an organized health care arrangement under HIPAA. This arrangement involves participation of three legally separate entities in the delivery of health care services in which no entity will be responsible for the medical judgment or patient care provided by the other entities in the arrangement. Each entity within this arrangement (TTUHSC, UMC, and PNS) will be able to access and use your PHI to carry out treatment, payment, or health care operations. The terms of this notice shall apply to TTUHSC's privacy practices until it is changed by TTUHSC.

YOUR PRIVACY RIGHTS:

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- **Get an electronic or paper copy of your medical record**. You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, within 14 days of your request. We may charge a reasonable, cost-based fee.
- **Ask us to correct your medical record.** You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- **Request confidential communication.** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- **Ask us to limit what we use and share.** You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- **Get a list of those with whom we've shared information.** You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide accounting once a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- **Get a copy of this privacy notice.** You can ask for a paper copy of this notice at any time, even if you have agreed to receive this notice electronically. We will provide you with a paper copy promptly.
- **Choose someone to act for you.** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- **File a complaint if you feel your rights are violated.** You may file a complaint in one of the following ways:
  - Contact the TTUHSC privacy official at the address indicated below
  - Use our confidential website at www.Ethicspoint.com
  - Contact The Office for Civil Rights:
    United States Department of Health and Human Services
    1301 Young Street, Suite 1169, Dallas, Texas 75202
    www.hhs.gov/ocr/privacy/hipaa/complaints/

  We will not retaliate or take action against you for filing a complaint.

YOUR CHOICES:

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

- **In these cases, you have both the right and choice to tell us to:**
  - Share information with your family, close friends, or others involved in your care.
  - Share information in a disaster relief situation.
  - Include your information in a hospital directory
  - If you are not able to tell us your preference, for example if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- **In these cases we never share your information unless you give us written permission:**
  - Marketing purposes
  - Sale of your information
  - Most sharing of psychotherapy notes

TTUHSC USES AND DISCLOSURES:

How do we typically use or share your health information? The following uses do **NOT** require your authorization, except where required by Texas Law.

- **Treat you**. We can use your health information and share it with other professionals who are treating you. For example: a doctor treating you for an injury asks another doctor about your overall health condition.
- **Run our organization.** We can use and share your health information to run our practice, improve your care, and contact you when necessary. For example, we use health information about you to manage your treatment and services.
- **Bill for your services**. We can use and share your health information to bill and get payment from health plans or other entities. For example, we give information about you to your health insurance plan so it will pay for your services.
- **In the case of fundraising.** We may use your PHI to contact you for fundraising efforts. We must include in any fundraising material you receive a description of how you may opt out of receiving future fundraising communications.
- **How else can we use or share your health information?** We are allowed or required to share your information in other ways-usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html
    - **Help with public health and safety issues.**
        - We can share health information about you for certain situations such as:
            - Preventing disease
            - Helping with product recalls
            - Reporting adverse reactions to medications
            - Reporting suspected abuse, neglect, or domestic violence
            - Preventing or reducing a serious threat to anyone's health or safety
    - **Conducting Research**. We can use or share your information for health research.
    - **Comply with the law.** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
    - **Respond to organ and tissue donation requests**. We can share health information about you with organ procurement organizations.
    - **Work with a medical examiner or funeral director.** We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
    - **Address workers' compensation, law enforcement, and other government request.**
        - We can use or share health information about you:
            - For workers' compensation claims
            - For law enforcement purposes or with a law enforcement official
            - With health oversight agencies for activities authorized by law
            - For special government functions such as military, national security, and presidential protective services
    - **Respond to lawsuits and legal actions.** We can use or share health information about you in response to a court or administrative order, or in response to a subpoena.

TTUHSC RESPONSIBILITIES:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

CHANGE IN NOTICE OF PRIVACY PRACTICES:

TTUHSC reserves the right to change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

QUESTIONS:

If you have any questions about this notice or would like additional information, please contact the privacy official at the address and telephone number listed below or you may visit our web site at www.ttuhsc.edu/hipaa

PRIVACY OFFICIAL CONTACT INFORMATION

REGIONAL PRIVACY OFFICER AT AMARILLO 1400 COULTER ROAD AMARILLO, TX 79106 (806) 414-9607	REGIONAL PRIVACY OFFICER AT LUBBOCK 3601 4TH STREET, STOP 8165 LUBBOCK, TX 79430 (806) 743-9541	REGIONAL PRIVACY OFFICER AT THE PERMIAN BASIN 800 WEST 4TH STREET ODESSA, TX 79763 (806) 743-9539

www.Ethicspoint.com

TTUHSC Provides For Program Accessibility To Members Of The Public. Those Who Need Materials In Braille, Large Print, Tape Format, Or Who Need An Interpreter Or Telecommunications Device For The Deaf Are Asked To Contact The Clinic Manager.

Texas Tech University
Health Sciences Center

Acknowledgement of Notice of Privacy Practice and Confirmation of Various Healthcare Communications

☐ I have received a copy of the Texas Tech University Health Sciences Center (TTUHSC) Notice of Privacy Practices (rev. 3/16) in **accordance with 45 CFR § 164.520.**

Consent to Email or Text Usage for Appointment Reminders and other Healthcare Communications:

☐ I consent to receive email and/or text messaging from TTUHSC to remind me of an appointment, for surveys about my experience with the healthcare team, or to provide general health reminders or information about new services.

The cell phone number and/or email I authorize for TTUHSC to use are listed below:

Email: _____

Cell phone number: _____

TTUHSC does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan.

By signing below, I acknowledge any options selected above, will remain in effect until further written notification by me.

Date	Print Your Name (Person signing consent form)	Signature (Patient or Other Legally Authorized Person)	
		Relationship to Patient	

Texas Tech University Health Sciences Center Ambulatory Clinics

Consent to Treatment/Health Care Agreement

CONSENT TO TREATMENT: I voluntarily consent to receive medical and health care services provided by Texas Tech University Health Sciences Center physicians, employees and such associates, assistants, and other health services may include diagnostic procedures, examinations, and treatment. I understand photographs, videotapes, digital and/or other images may be made/recorded for treatment, identification and payment purposes only. I understand that TTUHSC is a teaching institution. I acknowledge that no warranty or guarantee has been made to me as to result or cure.

I understand that this Consent to Treatment/Health Care Agreement will be valid and remain in effect as long as I attend or receive services from the TTUHSC Ambulatory Clinics, unless revoked by me in writing with such written notice provided to each clinic I attend or from which I receive services.

RELEASE OF MEDICAL INFORMATION: I understand that my prescriptions and prescription history will be sent, received and shared electronically with other healthcare providers and pharmacies. In addition, my medical records are available to other healthcare providers for treatment purposes through Health Information Exchanges (HIE). An HIE is an electronic system that stores your health information from multiple sources, not just TTUHSC, and may contain mental health and substance abuse information. Providers will attempt to exclude certain mental health and substance abuse records, but some portions of this information may be included. I may opt out of the HIE by completing an Opt-Out form. If I later change my mind, I may opt back in the same way.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: In consideration for receiving medical or health care services, I hereby assign to TTUHSC physicians and providers and/or the TTUHSC Medical Practice Income Plan my right, title, and interest in all insurance, Medicare/Medicaid, or other third-party payer benefits for medical or health care services otherwise payable to me. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third-party payer, up to the total amount of my medical and health care charges, to TTUHSC physicians and/or Medical Practice Income Plan. I certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare/Medicaid, is correct. **I agree to pay all charges for medical and health care services not covered by, or which exceed, the amount estimated to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third-party payer, and agree to make payment as requested by TTUHSC.**

ADVANCE DIRECTIVE:

Do you have a current, signed Advance Directive? ☐ YES ☐ NO

Has a signed copy been provided to TTUHSC? ☐ YES ☐ NO

By signing below, I agree I have read this form or it has been read to me and I understand what it is saying and agree to the terms.

Date	Print Name	Signature Patient/ legally authorized person

Witness/Translator	Relationship to Patient

Texas Tech University Health Sciences Center

Confidential Communication Request

Patient Name: _____

MRN: _____

DOB: _____

TTUHSC values the privacy of its patients and is committed to operating our practice in a manner that promotes patient confidentiality while providing high quality patient care. TTUHSC will accommodate reasonable requests.

If you need copies of medical records, you will need to complete a different authorization form. Please ask a staff member for the required form.

☐ Permission to give verbal protected health information (including appointment information) and leave messages with the following person(s): Example: family members, friends, personal caregivers, etc. You do not need to list any medical providers who are involved in your care. The patient and individuals listed below must provide at least one of the following: patient's address, patient's date of birth, last four digits of the patient's Social Security number.

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Please note that TTUHSC cannot leave specific test results or details of treatment plan on answering machines or voice mail due to our concern for your privacy.

Please complete the following questions for additional level of security which staff may ask if they have concerns on releasing your information. **Please provide at least one answer.**

1. What was your mother's maiden name? _____
2. What town were you born in? _____
3. What is your grandmother's name? _____
4. What is the name of your first pet? _____

Date

Print Your Name and Relationship to Patient (Person signing consent form)

Signature (Patient or Other Legally Authorized Person)

Relationship to Patient

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER

Informed Consent to Telemedicine/Telephone/Telepharmacy/Teletherapy Consultation

You are scheduled for a telemedicine/telephone/telepharmacy/teletherapy consultation. Prior to your visit, is important that you read and understand this document.

By signing this document, you are attesting that you understand:

1. The purpose is to assess and treat your medical condition.
2. This consult is done through a two-way communication whereby the physician or other health provider at TTUHSC can see your image on the screen and/or hear my voice. However, unlike a traditional medical consult, the physician or other health provider does not have the use of the other senses such as touch or smell; and it may not be equal to a face-to-face visit.
3. Since we are in different locations, we must rely on information provided by you. TTUHSC and affiliated telemedicine/telephone/telepharmacy/teletherapy consultants rely on your accurate and complete information to provide appropriate care.
4. You can ask questions and seek clarification of the procedures and telemedicine technology.
5. You can ask that the telemedicine exam and/or videoconference be stopped at any time.
6. You know there are potential risks with the use of this new technology. These include but are not limited to:
    - Interruption of the audio/video link.
    - Disconnection of the audio/video link
    - A picture that is not clear enough to meet the needs of the consultation
    - Electronic tampering.

    If any of these risks occur, the procedure might need to be stopped.
7. The consultation may be viewed, heard or videotaped by medical and non-medical persons for evaluation, informational, research, educational, quality, technical purposes, or as might be required by my health coverage plan.
8. You understand you can make a complaint of your provider to the appropriate licensing board.

If you have any questions or concerns about this document, please make sure to ask your nurse or healthcare provider.

Printed Name: _____

Signature: _____
(Patient/Parent/Guardian)

Date: _____

Texas Tech University Health Sciences Center
Consent and Release to Use Image or Information

I, (print name) _____
or my authorized legal representative, hereby give consent for Texas Tech University Health Sciences Center (TTUHSC) employees, students or agents to take and use information about me (including my medical history, if applicable), my name or image or likeness including, but not limited to, photographs, videotaped images, audio recordings, digital (collectively "Images"), or my data or presentation for the purposes checked below.

I AGREE TO USES DESIGNATED BELOW: ***(Not including uses for patient treatment or payment.)***	My Name	My Image(s)	My Information	My Data or Presentation
☑ For educational purposes **within** TTUHSC.	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No
~~☐ For educational purposes **outside** TTUHSC.~~	~~☐ Yes ☐ No~~	~~☐ Yes ☐ No~~	~~☐ Yes ☐ No~~	~~☐ Yes ☐ No~~
~~☐ For TTUHSC marketing or publicity. (This includes news and social media such as interviews, Facebook, websites, Twitter, YouTube, etc.)~~	~~☐ Yes ☐ No~~	~~☐ Yes ☐ No~~	~~☐ Yes ☐ No~~	~~☐ Yes ☐ No~~
~~☐ For publication in journals or on the Internet~~	~~☐ Yes ☐ No~~	~~☐ Yes ☐ No~~	~~☐ Yes ☐ No~~	~~☐ Yes ☐ No~~
~~☐ Other purpose(s):~~	~~☐ Yes ☐ No~~	~~☐ Yes ☐ No~~	~~☐ Yes ☐ No~~	~~☐ Yes ☐ No~~

I understand that TTUHSC and its regents, employees, agents, and personnel, acting on behalf of TTUHSC, shall not be held responsible for any use of my name, information and/or image(s), including any use whatsoever by any outside user or third parties, and I hereby release and hold harmless TTUHSC and its regents, employees, agents and personnel, acting on its behalf, from any and all liability for damages of whatever kind, character or nature which may at any time result from this Consent and Release authorizing use or dissemination in accordance with the above.

I understand that TTUHSC will own the Image(s) of me for the purposes stated above. I do hereby knowingly and voluntarily waive any and all other rights, compensation, royalties, or payment of any kind or character in connection with the use of my name, likeness and/or image(s) as authorized above.

This Consent and Release can be revoked or withdrawn at any time, but such withdrawal or revocation must be in writing and sent to the TTUHSC Institutional Privacy Officer. Any withdrawal of consent does not affect any information used or disclosed prior to receipt of the written notice of withdrawal.

By signing below, I represent that I have read and understand this "Consent and Release to Use Image or Information" and that it is binding on my heirs, executors and personal representatives. I am 18 years of age or older.

_____ _____
Signature of Person Named Above Date

_____ _____
OR Signature and Print Name of Authorized Legal Representative Date

For Office Use Only:	Completed by: _____	
Date of Event: _____ ☐ Speaker	MR#: _____ ☐ Patient	R# (Banner): _____ ☐ Faculty ☐ Staff ☐ Student

Psychiatric Intake Form

(All information on this form is strictly confidential)

Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will it will go quickly. You may need to ask family members about the family history. **Also, please print out and complete the following:** MDQ and Depression questionnaire. Thank you!

Today's date: _____
Name: _____ Date of Birth: _____
Home Phone: _____ May I leave messages on this phone? ☐ Y ☐ N
Work Phone: _____ May I leave a message on this phone? ☐ Y ☐ N
Cell Phone: _____ E-mail: _____
Street address: _____
City: _____ Zip code: _____
Emergency Contact: _____
Phone: _____ Relationship to you: _____
Marital status: S ☐ M ☐ D ☐ W ☐ Non-married committed relationship? ☐
Name all the people with whom you live and their relationship to you:
_____
_____
Occupation: _____
Employer: _____
Highest level of education: _____ Age: _____ Sex: M ☐ F ☐

Do you wish me to contact your referral person regarding today's visit? ☐ Y ☐ N
If yes, person's name, address and phone number: _____
_____
_____
List the problems for which you wish to be seen today:

1. _____
2. _____
3. _____

What are your three biggest stressors right now?

1. _____
2. _____
3. _____

What are your goals for treatment?
_____
_____

Psychiatric History

Do you have a history of mental health problems or hospitalizations? ☐ Y ☐ N

If so, please complete the following:

Diagnosis Dates treated By whom

_____
_____
_____
_____

Are you currently receiving professional counseling or any kind of psychotherapy?

☐ Y ☐ N If yes, by whom: _____ Phone: _____

If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can remember all the details, just write in what you do remember.)

Dates Dosage Helpful?

Prozac (fluoxetine) _____
Zoloft (sertraline) _____
Luvox (fluvoxamine) _____
Paxil (paroxetine) _____
Celexa (citalopram) _____
Lexapro (escitalopram) _____
Effexor (venlafaxine) _____
Cymbalta (duloxetine) _____
Wellbutrin (bupropion) _____
Desyrel (trazodone) _____
Remeron (mirtazapine) _____
Serzone (nefazodone) _____
Anafranil (clomipramine) _____
Pamelor (nortriptyline) _____
Tofranil (imipramine) _____
Elavil (amitriptyline) _____
Tegretol (carbamazepine) _____
Lithium _____
Depakote (valproate) _____
Lamictal (lamotrigine) _____
Seroquel (quetiapine) _____
Zyprexa (olanzapine) _____
Geodon (ziprasidone) _____
Abilify (aripiprazole) _____
Clozaril (clozapine) _____
Haldol (haloperidol) _____
Prolixin (fluphenazine) _____
Xanax (alprazolam) _____
Ativan (lorazepam) _____

Restoril (temazepam) _____
Klonopin (clonazepam) _____
Valium (diazepam) _____
Ambien (zolpidem) _____
Buspar (buspirone) _____
Adderall (amphetamine) _____
Concerta (methylphenidate) _____
Ritalin (methylphenidate) _____
Strattera (atomoxetine) _____

Suicide Risk Assessment

Have you ever had feelings so bad that you have thoughts that you didn't want to go on, or that you might want to kill, yourself? ☐ Y ☐ N
If YES, please answer the following... If no, please skip to family history.
Is this unhappy feeling so strong you wish you were dead? ☐ Y ☐ N
How often have you had these thoughts? _____
Has anything happened recently to make you feel this? _____
_____
On a scale of 1 to 10, how strong is your desire to kill yourself? _____
What would it take to move you one point down the scale? _____
_____
Have you ever thought about how you would kill yourself? _____
Is this method you would use readily available? _____
Have you planned a time for this? _____
Have you ever tried to kill or harm yourself before? _____
Did things change as a result of these attempts? _____
Is there anything that would stop you from killing yourself? _____
_____
If you could look into the future, what do you feel you could look forward to? _____
_____
Are you bothered by problems with sleep? ☐ Y ☐ N
Are you bothered by hearing or seeing things or by voices? ☐ Y ☐ N If yes, please complete the DES questionnaire.
Do you have difficulty with focusing or following through on task? ☐ Y ☐ N

Family Psychiatric History

Has anyone in your family been diagnosed with or treated for:

	Yes No		Yes No
Bipolar disorder	Select	Schizophrenia	Select
Depression	Select	Post-traumatic stress	Select
Anxiety	Select	Alcohol abuse	Select
Anger	Select	Other substance abuse	Select
Suicide	Select	Violence	Select
ADHD	Select		

If yes, who had what problem?

_____

_____

Has any family member been treated with a psychiatric medication? ☐Y ☐N If yes, what medications and how effective were they? _____

_____

_____

Medical Information Allergies: _____

Current prescription medications and how often you take them: (if none, write none)

_____

_____

Current over-the-counter medications or supplements: _____

_____

Current medical problems: _____

_____

Past medical problems, hospitalizations or surgeries: _____

_____

Do you have any concerns about your health you would like to discuss with me? ☐ Y ☐ N

On a 1 to 10 scale, with 10 being the most pain, what number would you rate your current physical pain now? _____ What number is it normally? _____

Name of your primary health care provider: _____

Phone: _____ Address: _____

Date and place of last physical exam: _____

Have you ever had an EKG? ☐ Y ☐ N Date: _____

For women only: Date of last menstrual period _____ Are you currently pregnant or do you think you might be pregnant? ☐Y ☐N

Are you planning to get pregnant in the near future? ☐Y ☐N

Birth control method _____

How many times have you been pregnant? _____ How many live births? _____

Do you have history of:

	Yes	No		Yes	No
Thyroid Disease			Depression		
Anemia			Bipolar Disorder		
Liver Disease			Psychosis		
Fibromyalgia			Anxiety		
Chronic Fatigue			Panic Attacks		
Heart Disease			Epilepsy/seizures		
Kidney Disease			Chronic Pain		

Diabetes _____ High Cholesterol _____

Asthma/respiratory problems _____ High blood pressure _____

Stomach or intestinal problems _____ Head trauma_____

Cancer _____

Is there a family history of anything **NOT** listed here? (Please explain):

_____

_____

When your mother was pregnant with you, were there any complications around the pregnancy or birth? _____

How many days a week do you exercise? _____ How many minutes w week do you exercise? _____ What kind of exercise do you get? _____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ☐ Y ☐ N

If yes, for which substances? _____

If yes, where and when were you treated? _____

_____

How many alcoholic drinks do you consume each week? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

Have you used any street drugs in the past 3 months? ☐ Y ☐ N

If yes, which ones? _____

Have you ever felt you ought to cut down on your drinking or drug use? ☐ Y ☐ N

Have people annoyed you by criticizing your drinking or drug use? ☐ Y ☐ N

Have you ever felt bad or guilty about your drinking or drug use? ☐ Y ☐ N

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ☐ Y ☐ N

Do you think you may have a problem with alcohol or drug use? ☐ Y ☐ N

Check if you have ever tried the following:

	Yes	No	If yes, when did you last use it?
Methamphetamine	☐	☐	_____
Cocaine	☐	☐	_____
Stimulants (pills)	☐	☐	_____
Heroin	☐	☐	_____
LSD or Hallucinogens	☐	☐	_____
Marijuana	☐	☐	_____
Pain killers (not prescribed)	☐	☐	_____
Methadone	☐	☐	_____
Tranquilizers/sleeping pills	☐	☐	_____

Ecstasy ☐ ☐ _____
Alcohol ☐ ☐ _____
Other_____
How many caffeinated beverages do you drink a day? _____

Tobacco History

Cigarettes: Now? ☐Y ☐N In the past? ☐Y ☐N When did you quit? _____
How many per day on average? _____ For how many years? _____
Pipe, cigars, or chewing tobacco: Now? ☐Y ☐N In the past? ☐Y ☐N
What kind? _____ How often per day average? _____ For how many years? _____

Social History

Family Background and Childhood History

Were you adopted? ☐Y ☐N Where were you raised? _____
Please list your brothers and sisters and their ages: _____
_____
What is your father's occupation? _____
What is your mother's occupation? _____
Did your parents' divorce? ☐Y ☐N If so, how old were you when they divorced? _____
If your parents divorced, who raised you? _____
Describe your father and your relationship with him:
_____
Describe your mother and your relationship with her:
_____
_____
How old were you when you left home? _____
Where you ever physically or sexually abused? _____
Is so, at what age(s)? _____
Has anyone in your immediate family died? _____
Who and when? _____

Educational History

Did you attend college? _____ Where? _____
What was your major? _____
What is your highest educational level or degree attained? _____

Occupational History

Are you currently: ☐Working ☐Not working
How long in present position? _____

What is you occupation? _____

Where do you work? _____

Have you ever served in the military? _____ If so, what branch and when? _____

_____

Have you ever been arrested? _____ Do you have pending legal problems? _____

Marital History and Current Family

Are you currently dating, sexually active, or in a relationship(s)? ☐Y ☐N

How would you identify your sexual orientation?

☐straight/heterosexual ☐lesbian/gay/homosexual ☐bisexual ☐transsexual

☐unsure/questioning ☐asexual ☐other ☐prefer not to answer

Do you have concerns related to your sexual orientation? ☐Y ☐N

Are you currently: ☐Married ☐Divorced ☐Single ☐Widowed ☐Non-married committed

For how long? _____

What is your significant other's occupation? _____

Describe your relationship with your spouse or significant other:

_____

Have you had any prior marriages? ☐Y ☐N If so, how many? _____

For how long? _____

Do you have children? ☐Y ☐N Ages: _____

Describe your relationship with your children: _____

List everyone who currently lives at home: _____

_____

Trauma History

Do you have history of trauma from childhood abuse, military, combat, workplace trauma, domestic violence, rape, or medical trauma? _____

If you have a history of trauma, please complete the PSTD questionnaire.

Spiritual Assessment:

Do you belong to a particular religion or spiritual group? ☐Y ☐N

If yes, what is the level of your involvement? _____

Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ☐more helpful ☐stressful

If you do not belong to a particular group, do you have any particular religious, spiritual beliefs or a philosophy of life that are particularly important to you?

☐Y ☐N

Do your beliefs or philosophy of life affect how you think or feel about your illness?

☐Y ☐N If so, how? _____

Are there parts of your belief which you are calling into question because of your illness and current situation? ☐ Y ☐ N

As you face this illness, what activities do you use to help cope, feel better, and heal?

_____

What would you like your health care team and me, as your provider, to know about your spiritual needs as we care for you during this illness? _____

_____

What can I, as your provider, do to support you in your spiritual coping with this illness?

_____

Treatment Goals Checklist

This information is being collected under the authority of the Health and Social Service Authority in order to provide services. It is protected by the privacy provisions of the Access to information and Protection of Privacy (ATIPP). If you have questions about the collection or use of the information, please contact the manager/supervisor at the program providing the service. (The receptionist can direct you to the manager or supervisor)

Client Name: _____ Date: _____

The following is a list of goals that people coming to treatment sometimes have. Please indicate which your present goals are by circling Yes and which are not your present goals by circling No.

1. To deal with my problem of alcohol and/or drug use and/or gambling.	☐ Yes	☐ No
2. To learn to manage stress appropriately.	☐ Yes	☐ No
3. To learn to stand up for myself better.	☐ Yes	☐ No
4. To be able to deal with my feelings and express them directly.	☐ Yes	☐ No
5. To improve my relationship with members of my family (spouse, children, parents, etc.).	☐ Yes	☐ No
6. To be able to get along better socially.	☐ Yes	☐ No
7. To improve my ability to find and keep a job.	☐ Yes	☐ No
8. To learn to use my leisure time better.	☐ Yes	☐ No
9. To improve my living arrangements.	☐ Yes	☐ No
10. To deal effectively with my financial problems.	☐ Yes	☐ No
11. To deal effectively with my legal problems.	☐ Yes	☐ No
12. To deal effectively with my medical problems.	☐ Yes	☐ No
13. To manage my emotional/mental health issues appropriately.	☐ Yes	☐ No
14. Other-Please specify _____	☐ Yes	☐ No

Summary

How many goals have you indicated? _____

Of the goals you indicated, which are the most important for you to solve at the moment?

My first most important goal is # _____

My second most important goal is # _____

My third most important goal is # _____