DESERT SPRING

BEHAVIORAL HEALTH

Mental Health/Psychiatric
Medication Management

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New Client Packet
April 2017

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BEHAVIORAL HEALTH

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General Information

- Lisa is in the office Monday thru Thursday, 8:30 A.M. to 4:00 P.M.

- Lisa is not in the office on Fridays.

- Your initial appointment will be one hour. Every subsequent visit will be scheduled for 30 minutes. If you are going through a life change, a crisis or simply feel that you need more than 30 minutes, please call and let us know so we can accommodate you. (As scheduling permits.)

- Typically, Lisa books appointments two weeks in advance. We suggest that you make your next appointment before you leave the office.

- We maintain a 24 hour cancelation policy. If you do not cancel your appointment within 24 hours of your appointment, or do not show up to your appointment, you will be charged a late cancelation fee that your insurance will NOT pay.

- If you keep your appointments, you will not run out of medication. If you do miss your next appointment, we can bridge your prescription until your next visit – depending on the medication and how you are doing.

- Please allow 2-3 business days for prescription refills.

- If you receive any controlled substances we cannot call in or e-scribe these prescriptions. In addition, you must be seen each time. A prescription will be written on paper for you to take to your pharmacy for refill.

- After-hours services are limited. If you are experiencing a medical crisis or having thoughts of harming yourself or others, please call 911 or go directly to the nearest emergency department.

- Emails are used to remind patients of their appointments, and maintain correspondence between you and our office. We ask that you please provide a current, active email address to best serve you.
- It is your repsonsibility to know your insurance coverage. We request that you give us any changes as soon as possible. We also advise that you know that co-pays, deductibles, co-insurance are due at the time of service.

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Patient Demographics and Insurance Information

First Name: MI: Last Name: Sex: DOB:

Age: Ethnicity: SS#: Marital Status: Years of Education:

Mailing Address: City: State: ZIP:

Physical Address: City: State: ZIP:

Cell Phone: Home Phone:

Note: Please initial by each phone number where we may leave a message.

Employer: Phone:

Address: City: State: ZIP:

Emergency Contact

Name: Phone 1: Phone 2:

Relationship: Address:

Contacts Employer: Phone:

Address:

Nearest Relative not living with you: Relation to you:

Phone: Address:

Primary Insurance Company: Policy ID#:

Phone:

Claims Address: City: State: ZIP:

Policyholder: DOB: Sex: Marital Status:

Relationship to Client: SS#: Phone:

Address: City: State: ZIP:

Employer: Phone:

Secondary Insurance Company: Policy ID#:

Phone:

Claims Address: City: State: ZIP:

Policyholder: DOB: Sex: Marital Status:

Relationship to Client: SS#: Phone:

Address: City: State: ZIP:

Employer: Phone:

Third-Party to be Billed:

Name to be Billed: Phone: Alt Phone:

Mailing Address: City: State: ZIP:

Number of Sessions/Visits Allowed:

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Patient Medication and Medical History

What brings you in?

Medical History

Primary Care Provider:
Date of Last Exam:
May we contact your provider to coordinate care if needed?
Phone:
Height: ft in
Weight:
General Health concerns:
Do you smoke?
Is there a history of smoking?

Current Medications

Medication 1: Dose: Frequency per day:
Medication 2: Dose: Frequency per day:
Medication 3: Dose: Frequency per day:
Medication 4: Dose: Frequency per day:
Medication 5: Dose: Frequency per day:
Medication 6: Dose: Frequency per day:
Medication 7: Dose: Frequency per day:
Medication 8: Dose: Frequency per day:

Medication Allergies

Medication 1: Reaction 1:
Medication 2: Reaction 2:
Medication 3: Reaction 3:
Medication 4: Reaction 4:
Medication 5: Reaction 5:
Medication 6: Reaction 6:

Past Psychiatric Medications Tried

Did the medicaion help or cause problems

Medication 1: Response 1:
Medication 2: Response 2:
Medication 3: Response 3:
Medication 4: Response 4:
Medication 5: Response 5:
Medication 6: Response 6:
Medication 7: Response 7:
Medication 8: Response 8:

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Patient Medication and Medical History cont.

Past Major Surgeries or Medical Events

Procedure or Event 1:

Procedure or Event 2:

Procedure or Event 3:

Procedure or Event 4:

Procedure or Event 5:

Procedure or Event 6:

Current Medical Problems you are being treated for at this time

Problem (ex: high blood pressure)

Please list treating provider if other than Primary Care Provider

Problem 1:

Provider 1:

Problem 2:

Provider 2:

Problem 3:

Provider 3:

Problem 4:

Provider 4:

Problem 5:

Provider 5:

Problem 6:

Provider 6:

Problem 7:

Provider 7:

Problem 8:

Provider 8:

Family Medical and Psychiatric History

Please list any serious medical conditions such as heart disease, cancer, diabetes, hypertension, auto-immunedisorders or other conditions in the family.

Father:

Mother:

Other 1:

Other 2:

Other 3:

Please list any mental health disorders such as depression, anxiety, bipolar disorder, schizophrenia or other conditions in the family.

Father:

Mother:

Other 1:

Other 2:

Other 3:

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Patient History

Psychiatric History

Past Mental Health Diagnosis:	When did you start getting treatment for this disorder?	Who was the treating provider for this disorder?

Past Psychiatric Hospitalizations

Date:	Reason:	Length of stay:	Location:

History of Suicide Attempts

Date:	Age:	Brief description of attempt and surrounding circumstances

Are you currently having thoughts of ending your life or feeling it would be better if you were not here?

Do you have a plan in mind?

Do you think there is any risk of acting on it?

Self Harm Behaviors

Please list any past self harm behaviors that were not suicidal in nature (ex: cutting)

Date:	Age:	Behavior:	Date of last engagement:

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Patient History cont.

Substance Use

Substance: (ex: alcohol, street drugs, prescription med abuse)	Dates Used: (Age, how long. Note if use is current)	Did you have treatment?: (If so, where and what type)

Social History

Place of Birth:

Were your parents married?

Number of Siblings:

Name in Birth Order:
ex: 1 name, 2 name,

Describe the quality of your childhood or any problems.

Please briefly describe any history of abuse, neglect or trauma? (Emotional, physical, sexual)

How did you do in school as a child?

Highest level of education:

Religious Preference:

Current marital status:

Current employment status:

Military Service:

List any current legal problems:

Other information you feel is important: