Patient Self-Report History

This form is to provide Dr. Sadak with necessary preliminary information in order to optimize your initial assessment. All information is considered confidential. Please answer as carefully and completely as possible.

Patient's Name: _____

Date: _____ Birth Date: _____Phone: _____

Email:_____

Mailing Address:_____

Referred By: _____

Primary Care Clinician Name: _____Phone:_____

Other Health Care Provider:
Specialty_____

Name_____ Phone: _____

Other Health Care Provider:
Specialty_____

Name_____ Phone _____

Emergency Contact

Name:_____Relationship:_____Phone:_____

Do you have Advanced Directive and Living Will? (documents that state your wishes for care if you are no longer able to speak for yourself?) □Yes □No

Who is your Power of Attorney for Medical Decisions?

Name:_____Relationship:_____Phone:_____

DO YOU HAVE a DNR (do not resuscitates order to withhold CPR)? □Yes □No

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About your current problems

Please describe the problems that have brought you here to receive care.

_____

_____

_____

_____

_____

FAMILY HISTORY:

Are your parents:

□ living

□ deceased, if yes whom_____ age at death_____

if yes whom_____ age at death_____

Do you have siblings? □Yes □No

If yes, how many?: _____ Ages: _____

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty		Family Member(s)
Dementia	yes/no	_____
Depression	yes/no	_____
Bipolar Disorder	yes/no	_____
Anxiety Disorders	yes/no	_____
Panic Attacks	yes/no	_____
Schizophrenia	yes/no	_____
Alcohol/Substance Abuse	yes/no	_____
Eating Disorders	yes/no	_____

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Learning Disabilities	yes/no	_____
Trauma History	yes/no	_____
Suicide Attempts	yes/no	_____

ABOUT YOU

LIVING ARRANGEMENTS/ HOME ENVIRONMENT

With whom do you currently live? _____

Are there any concerns about living arrangements? _____

EDUCATIONAL HISTORY

Highest level of education completed_____

OCCUPATIONAL HISTORY

Occupation (current or former): _____

If not currently working, date you last worked: _____

ETHNIC/ CULTURAL AFFILIATION

Describe any cultural or ethnic practices or beliefs that may affect or influence your treatment.

_____

_____

Were you reared outside the US? □Yes □No
If yes, where?_____

Primary language, if other than English? _____

RELIGION/SPIRITUALITY

What role, if any, do **religion** and/or **spirituality** play in your life?

_____

_____

Where did you grow up? _____

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Please share few words about your childhood: _____

_____

_____

_____

Do you have good family support? □Yes □No

From whom?_____

Your Marital Status:
□Never Married □Partnered □Married □Separated □Divorced □Widowed

Are you currently in a romantic relationship? □Yes □No

If yes, for how long?_____

If yes, on a scale of 1-10 (10=great), how would you rate the quality of your romantic relationship?
□1 □2 □3 □4 □5 □6 □7 □8 □9 □10

Do you have children? □Yes □No

If yes, how many?: _____ Ages: _____

Are you satisfied with your **social situation/interpersonal relationships**? □Yes □No

If no, explain why:_____

_____

What do you consider to be your **strengths**?_____

What do you **like most about yourself**?_____

What are effective **coping strategies** you use when stressed?_____

_____

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Do you have **financial concerns**? □Yes □No

If yes, please explain: _____

Do you have any **legal concerns**? □ No □ Yes

If yes, please explain:_____

_____

What are your **overall goals for therapy and psychiatric/memory medications**?

_____

What do you feel you need to **work on first**?_____

SLEEP

Hours per night you normally sleep _____

Are you having any problems with your **sleep**? □Yes □No If yes, check where applicable:

- □ Sleeping too little
- □ Sleeping too much
- □ Can't fall asleep
- □ Can't stay asleep

Do you snore? □Yes □No
Do you have Restless Leg Syndrome? □Yes □No

EXERCISE

Do you **exercise** regularly? □Yes □No

If yes, how many times per week do you exercise? _____

For how long? _____

If yes, what do you do?_____

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SUBSTANCE USE

Do you regularly use **alcohol**? □ Yes □ No

If yes, what is your drinking frequency?
□ once a month □ once a week □ daily □ daily, 3 or more □ intoxicated daily

How often do you engage in **recreational drug use**?
□ Daily □ Weekly □ Monthly □ Rarely □ Never

If you checked any box other than "never," which drugs do you use?

_____

Do you smoke? □Yes □No If yes, how many cigarettes per day?_____

If you smoked in the past:
When did you quit?_____ How much did you smoke?_____

Do you drink **caffeinated drinks**? □Yes □No

If yes, # of sodas per day_____ cups of coffee per day_____ Other _____

Are you having any difficulty with **appetite or eating habits**? □Yes □No

If yes, check where applicable:
□ Eating less □ Eating more □ Bingeing □ Purging (binging and throwing up)

Have you experienced **significant weight chan**ge in the last 2 months? □Yes □No

If yes how many pounds did you gain? _____ How many did you lose? _____

DIET

What is your typical breakfast?

Mid-Morning Snack?

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Lunch?

Mid-Afternoon Snack?

Dinner?

Evening Snack?

Comfort foods?

How many glasses of water or non- carbonated, not caffeinated fluids do you drink a day? ____

In the last year, have you experienced any significant life **changes or stressors**?

_____

_____

_____

_____

_____

_____

_____

YOUR HISTORY OF MENTAL HEALTH TREATMENT

Did you **previously participate in psychotherapy**? □Yes □No

If yes, when and for how long?_____

Did you have **Psychiatric Hospitalizations** □Yes □No

If yes, why? _____when (year (s))_____

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Have you been previously **prescribed psychiatric medication**? □Yes □No

If Yes, please list names, year, effect, why discontinued:

Medication Name	How long did you take it (from…to)	Was it effective?	Why did you discontinue?

Current Mental Health Symptoms:

Are you **experiencing**: ***Rating Scale 1-10 (10 =worst)**

	If YES, Please Select		Present or Past	
Memory Problems	yes	no	_____	_____
Depressed Mood or Sadness	yes	no	_____	_____
Irritability/Anger	yes	no	_____	_____
Mood Swings	yes	no	_____	_____
Rapid Speech	yes	no	_____	_____
Racing Thoughts	yes	no	_____	_____
Anxiety	yes	no	_____	_____
Constant Worry	yes	no	_____	_____
Panic Attacks	yes	no	_____	_____
Phobias	yes	no	_____	_____

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Sleep Disturbances	yes	no	_____	_____
Hallucinations	yes	no	_____	_____
Paranoia	yes	no	_____	_____
Poor Concentration	yes	no	_____	_____
Alcohol/Substance Abuse	yes	no	_____	_____
Frequent Body Complaints	yes	no	_____	_____
Eating Disorder	yes	no	_____	_____
Body Image Problems	yes	no	_____	_____
Repetitive Thoughts (e.g., Obsessions)	yes	no	_____	_____
Repetitive Behaviors (e.g., counting)	yes	no	_____	_____
Poor Impulse Control (e.g., ↑ spending)	yes	no	_____	_____
Self Mutilation	yes	no	_____	_____
Sexual Abuse	yes	no	_____	_____
Victim of Physical Abuse	yes	no	_____	_____
Victim of Emotional Abuse	yes	no	_____	_____

SELF HARM

Are you hopeful about your **future**? □Yes □No

Are you having **current suicidal thoughts or whish that you do not wake up**?
□ Frequently □ Sometimes □ Rarely □ Never

If yes, have you **recently** done anything to **hurt yourself**? □Yes □No

Have you had **suicidal thoughts in the past**?
□ Frequently □ Sometimes □ Rarely □ Never

If you checked any box other than "never", **when** did you last have these thoughts?

_____
Did you ever act on them? □Yes □No

Do you engage in any self-harm activities (ex. Cutting, excessive laxative use) □Yes □No

If yes what do you do _____

PHYSICAL HEALTH SCREENING:

How is your **physical health currently**?

□Poor □Unsatisfactory □Satisfactory □Good □Very good

Date of last physical examination _____

Did you have any abnormal lab results I the past 6 months? □Yes □No

If yes please list: _____

DID YOU EVER HAVE**:**

STOMACH or OTHER INTERNAL BLEEDING? □Yes □No If YES, what was the diagnosis and when did this happen?_____

ABNORMAL CARDIAC RHYTHM? □Yes □No If YES, what was the diagnosis and when did this happen? _____

ABNORMAL EKG (EX. QT PROLONGATION)? □Yes □No If YES, what was the diagnosis and when did this happen? _____

SIGNIFICANT BRAIN INFECTION (EX. MENINGITIS, ENCEPHALITIS?) □Yes □No If YES, what was the diagnosis and when did this happen?_____

STROKE OR A TIA (transient ischemic attack)? □Yes □No If YES, what was the diagnosis and when did this happen? _____

SEIZURES? □Yes □No If YES, what was the diagnosis and when did this happen?
_____

HEAD INJURY? □Yes □No If yes, when and what happened?_____

ARE YOU CONCERNED ABOUT YOUR MEMEORY? □Yes □No
If yes, what are your concerns? _____

Were you ever diagnosed with **memory problems eg. Mild Cognitive Impairment (MCI) or Dementia**? □Yes □No If yes, when? _____

What is the diagnosis? _____

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Please describe **your CURRENT memory symptoms**

_____

_____

_____

_____

Do you have difficulty finding words? (ex. you know what you want to say, but can find the right words) □Yes □No

Were you ever diagnosed with Sleep Apnea? □Yes □No

If yes, When _____ Do you use CPAP? □Yes □No

Did you ever have visual hallucinations of people or animals? □Yes □No
Do you ever act out your dreams, or have excessive movements when you sleep? □Yes □No

Do you have trouble distinguishing dreams from reality when you are transitioning from sleeping to waking up? □Yes □No

Do you have tremors? □Yes □No

Do you experience rigidity in your movements? □Yes □No

Do you have problems with your balance? □Yes □No

Do you experience frequent falls? □Yes □No

Do you feel unsteady when you walk? □Yes □No

Do you experience urinary incontinence? □Yes □No

Do you experience bowl incontinence? □Yes □No

Do you experience frequent nausea? □Yes □No

Do you experience dizziness? □Yes □No

Do you find that things you used to enjoy are less enjoyable now? □Yes □No

Does it take more effort to do things (ex. chores, socializing, hobbies)? □Yes □No

Are you more irritable and short tempered, compared to few years ago? □Yes □No

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PLEASE LIST ALL YOUR ALLERGIES

Medications	Environmental	Food

PLEASE LIST ALL PAST AND CURRENT MEDICAL PROBLEMS/SYMPTOMS

CURRENT Problem	PAST Problem	
		Shortness of Breath
		Coughing up blood
		Bleeding from any part of the body
		Chest pain/ palpitation
		MRSA Infection
		Stroke
		Sudden loss of Smell, Taste, Vision, Hearing, Sensation
		Convulsions/ Seizures
		Motor coordination/ paralysis
		Sexually transmitted disease
		Thyroid/ gland problems
		High blood pressure
		Diabetes
		Frequent severe headaches
		Frequent lingering cough
		Swelling of the hands & feet
		Night sweats/ fevers

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		Dizziness/ fainting spells
		Pain in back or extremities
		Jaundice/ hepatitis
		Increased thirst/ urination
		Abdominal pain
		Eating disorder
		Unintentional weight loss/gain
		Joint/ back problems
		Asthma
		Kidney disease/ stones
		Liver problems
		Cancer (within last 5 years)
		Arthritis
		Tuberculosis/ exposure
		Heart disease: eg. Myocardial Infarction, Congestive heart failure, fast or slow heart rate, rhythm abnormality
		Anemia
		Ulcers
		Skin problems
		Nutrition problems
		Hormone replacement
		Delirium
		Other:

Surgeries/ injuries (when? (year) reasons):

1. year_____ reason_____
2. year_____ reason_____
3. year_____ reason_____
4. year_____ reason_____
5. year_____ reason_____
6. year_____ reason_____
7. year_____ reason_____
8. year_____ reason_____

Hospitalizations (when? (year) and reasons):

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1. year_____ reason_____	7. year_____ reason_____
2. year_____ reason_____	8. year_____ reason_____
3. year_____ reason_____	9. year_____ reason_____
4. year_____ reason_____	10. year_____ reason_____
5. year_____ reason_____	11. year_____ reason_____
6. year_____ reason_____	12. year_____ reason_____

PLEASE LIST
Current / Recent Medications their dose and frequency:

Medication	Dose	How often, when taken?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		

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PLEASE LIST
Current / Recent SUPPLIMENTS/ VITAMINS their dose and frequency:

SUPPLIMENT	Dose	How often, when taken?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Is there anything that I did not ask about here that would be important for me to know about your mental/cognitive health?

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Financial Agreement and Insurance Information

Name_____ Date of Birth _____Today's Date_____

Agreement to Pay:

- I understand that I am financially responsible to Psychiatric Wellness and Dementia Care, LLC for services rendered.
- I agree to pay the co-pay, coinsurance, and any deductibles stipulated by my insurance plan.
- Payment is due at the time of my appointment unless other arrangements have been made.
- It is my responsibility to inform Psychiatric Wellness and Dementia Care, LLC of any changes that affect the billing or charges to my account. This includes changes in any of my third-party payors, income or family status.
- I understand that standard collection procedures will be followed if payment is not made.

Initial for above statements _____

Standard fees and charges (usually covered by insurance):

- $297 for 60-minute Evaluation session (All New Clients and family consultations)
- $197 per 50-minute follow-up medications management and therapy sessions
- $130 per 25-min follow-up brief therapy and medications management

Out-of-pocket, Not covered by insurance

- Telemedicine (via video-conferences) same rates as above
- Phone call, email, texts, filling out forms, care coordination (communication with hospitals and clinicians...) fees, prorated based on $130/hr (may be reduced or waived in cases of financial need)
- $25 medication refill without scheduled appointment fee
- $25 fee for not paying co-pays or patient-portion of the bill at the time of service
- $130 late cancellation or no-show fee

Insurance Information

Primary insurance Name: _____ Policy #: _____

Insured's Name _____ Insured's Date of Birth _____

Insured's Address _____

Insured's Phone Number_____

Insured's Relationship to client ☐Self ☐Spouse ☐Parent ☐Other

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Secondary Insurance Name:_____ Policy #:

_____

Insured's Name _____ Insured's Date of Birth _____

Insured's Address _____

Insured's Phone Number_____

Insured's Relationship to client ☐Self ☐Spouse ☐Parent ☐Other

I understand that having health insurance is not a guarantee that my condition is covered and that insurance payment will be made.

Initial for above statements _____

Assignment of Benefits: I authorize payment by my third-party payor (Insurance Company, Medicare/Medicaid, County, or other) to be paid directly to Psychiatric Wellness and Dementia Care, LLC for services rendered. I understand that I am financially responsible for charges applied to deductibles and for all charges limited by my third-party payor.

_____ _____

Signature of Individual Receiving Services/Legally Responsible Person Date

_____ _____

Staff Signature Date

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

HIPPA

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability and Accountability Act of 1996. Updated 9-23-13 version of the NOPP reflecting OMNIBUS rule and Updated on 2-20-14 reflecting new guidelines on HIPPA Privacy Rule and Sharing Information Related to Mental Health.

I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed by my health care provider Dr. Tatiana Sadak, Psychiatric Wellness and Dementia Care LLC about the *Notice of Privacy Act* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive the copy of the Notice of Privacy Act. I understand that my health care provider has the right to change the Notice of Privacy Policies and that I may contact this office listed above to obtain current copy of the Policies. I understand that I may request in writing, or may restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions. I was referred to the website http://www.hhs.gov/ocr/privacy/ for more information.

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Signature of the Patient: _____

Signature of Personal Representative: _____

Relationship to Patient if Personal Representative: _____

Date of signature: _____