PATIENT INFORMATION SHEET

Patient's Name _____ Date of Birth _____

Address _____ City, State & Zip _____

Patient's SS # _____ Cell Phone # _____ Home_____

Sex: M F Race:_____, Declined Ethnicity: Hispanic, Non- Hispanic or Declined

Preferred Gender Identity: M F Other:_____

Marital Status: Married _____ Single_____ Divorced _____ Widowed_____

Primary Language _____ Religion _____ Email _____

Would you like to sign for our patient portal? Y N

Appointment reminder: No Reminder Email Voice call Text

Preferred Communication: Email Portal Mail Cell Home Work Text

Primary Language _____ Religion _____

Employer _____ Work Phone # _____

Employer Address _____

Work Status: Full Time _____ Part Time _____ Retired _____ Unemployed _____

Primary Care Physician _____ Location: _____

Name of Pharmacy and location _____

Name of Primary Insurance Card Holder _____

Name of Insurance _____ ID # _____

Group # _____ (Card Holder) DOB _____ SSN _____

Name of Secondary Insurance Card Holder _____

Name of Insurance _____ ID # _____

Group # _____ (Card Holder) DOB _____ SSN _____

Emergency Contact _____ Relationship to Patient _____

Phone # _____ Address _____

How did you hear about this clinic/physician? _____

If Minor- Information of Parent or Guardian

Name (Mom) _____ Primary Phone # _____

Address _____ City, State & Zip _____

Date of Birth _____ Social Security # _____

Employer Name & Address _____

Name (Dad) _____ Primary Phone # _____

Address _____ City, State & Zip _____

Date of Birth _____ Social Security # _____

Employer Name & Address _____

Signed _____ Date _____

CLINIC POLICY

PLEASE READ CAREFULLY AND KEEP FOR FUTURE REFERENCE

1. We accept assignment with most insurance companies including Medicare, and Medicaid. We file your insurance as a courtesy, therefore payment for services rendered is **the responsibility of the patient should your insurance decline payment.**

2. **It is the responsibility of the patient to ensure prior authorization is obtained if your insurance requires it.** Please contact our office if you need assistance with this. **YOUR CHARGE WILL APPLY TO YOUR MENTAL HEALTH BENEFITS AND NOT MEDICAL BENEFITS. All deductibles and/or co-pays will be collected at the time service is rendered.**

3. Professional fees are listed on the following page for your information.

EMERGENCY CARE POLICY

WRHS Behavioral Health Clinic is open Monday thru Friday from 8 a.m. to 5 p.m. We are closed on weekends and most holidays. Please call our office for non emergency issues during our business hours. **If you have an emergency, please go directly to the nearest emergency room or call 911.**

Our office does not provide coverage for provider absences due to illness, vacation or personal emergency. Every effort will be made to keep you informed/notified of schedule changes in a timely manner.

NO SHOW POLICY

There will be a $50 administrative fee assessed to you for no shows within 24 hours of your appointment time. We reserve this time specifically for you and we will be unable to offer this time to someone else in a timely manner. Repeated no shows may result in termination and referral of your provider/patient relationship.

CONSENT FOR TREATMENT
ACKNOWLEDGEMENT OF RECEIPT OF OFFICE POLICIES

I understand and agree to the following as evidenced by my initials:

1. _____ Clinic Policy

2. _____ Emergency Care Policy

3. _____ No Show Policy

By my signature below, I hereby authorize treatment from WRHS Behavioral Health Clinic and its providers. I acknowledge that I have received a copy of the White River Health Systems Notice of Privacy Practices.

_____

(Name) (Date)

Consent to treat: I voluntarily consent to receive medical and health care services - these services may include diagnostic procedures, examinations, blood work and treatment.

Authorization to release insurance information: I hereby authorize release of medical information to give my insurance company or company's any insurance information they require concerning my case.
Authorization for Assignment of medical payments: I hereby authorize payment of any medical benefits to WRHS Behavioral Health Clinic.
The undersigned herby authorizes White River Medical Center and the attending or consulting physician to photograph or permit other person to photograph while under the care of the above medical organization, and agree that they may use or permit other persons to use the negative, prints, digital, and/or video prepared there for such purposes and in such a manner as may be deemed necessary to provide medical care. _____
Use of picture declined _____
Authorization to Access Rx History Information: I hereby authorize WRHS Behavioral Health Clinic to access my historical prescription drug information
___ Yes ___ Declined
I have received a copy of the notice of privacy practices written acknowledgement form.

_____ _____ Date:_____
Signature of Patient or Personal Representative Relationship to Patient (parent, spouse, self)

Patient Name:_____

Contact Preferences

Please fill in circle for preferred contact method

- O Home Phone ( ) _____
- O Cell Phone ( ) _____
- O Work Phone ( ) _____
- O E-Mail ( ) _____

Please indicate by check mark your approval to leave the following information on voicemail:

- O Appointment Date and Time Reminder
- O Lab/Test Results/ Medication Changes
- O DO NOT LEAVE MESSAGES OF ANY KIND

The following people are allowed to receive information regarding my care and/or have my permission to consent for care of my child.

_____
Name and Relationship to Patient

_____
Name and Relationship to Patient

_____
Name and Relationship to Patient

_____
Name and Relationship to Patient

For Office Use Only

_____ _____ _____
Witness MRN Date of Signing

WRHS BEHAVIORAL HEALTH CLINIC
2230 HARRISON STREET
BATESVILLE, AR 72501
(870) 698-2100

INTAKE DATA (PLEASE COMPLETE ALL PAGES)

Name:_____ DOB:_____
Home phone number: _____ Work: _____
Can we contact you at home if needed? _____ Yes _____ No
Can we leave a message for you if someone else picks up the phone, or if there is an answering machine? _____ Yes _____ No
Can we contact you at work? _____ Yes _____ No
Can we leave a message for you at work? _____ Yes _____ No
Who referred you to the clinic? _____
Name of Primary Care Physician:_____
What are your reasons for making an appointment (WE DO NOT SEE COURT ORDER PATIENTS)? _____

_____

_____

Do you have thoughts of self harm/suicide or thoughts of harming someone else? _____
Have you ever taken any action on these thoughts?_____
If yes, please explain_____

Past Medical History (please circle all that apply):

AIDS/HIV	Heart Disease
Allergies	Huntington's Disease
Arteriosclerosis (artery disease)	Hypertension
Arthritis	Kidney Disease
Blood Disorder	Loss of Consciousness
Brain Disease or infection	Lung (respiratory) disease
Cancer or chemotherapy	Meningitis
Chronic Pain	Multiple Sclerosis
Concussion	Obesity
Dementia	Parkinson's Disease
Diabetes	Seizure Disorder
Head Injury	

Other Past Medical History Not Listed Above:_____

_____

DRUG ALLERGIES_____

_____

Currently prescribed and medications (list name and dosage):

_____

_____

_____

_____

_____

Current over the counter medications, vitamins or health food supplements you take (list name and dosage): _____

_____

_____

Do you have chronic pain?_____Yes_____No (Answer the ** questions only if you have chronic pain)

**Where is your pain located?_____

**Have you been given a diagnosis and treatment plan for your pain? If so, please describe:_____

_____

**What are your expectations for pain relief?_____

_____

**Rate your pain on a 0-10 scale (0=no pain; 10=worst pain imaginable):

Current:_____ Highest:_____ Lowest:_____ Average:_____

**What helps your pain?_____

_____

**What makes your pain worse? _____

_____

**What treatments have you had for your pain and did they work?_____

_____

Psychiatric History:

Are you currently in psychotherapy or under psychiatric care?_____Yes_____No

Have you ever been seen by a psychologist, psychiatrist, counselor, or therapist for a mental health condition?_____Yes_____No

If yes, why, where, when, and how long?_____

_____

Past Psychiatric Medications:_____

_____

_____

_____

Past Psychiatric Hospitalizations (when, where, how long, psychiatrist's name):

_____

_____

_____

_____

_____

Have you had a prior psychological evaluation or neuropsychological evaluation?

_____Yes-if Yes, please list the provider_____

_____No

Have you ever been diagnosed with the following conditions? (check all that apply

__Schizophrenia

__Depression

__ Mental Retardation

__ Anxiety

__ Explosive Disorder
__ Learning Disability
__ Bipolar (Manic Depressive Disorder)
__ Multiple Personality Disorder/ Dissociative Disorder
__ Other (please specify):_____

__ Obsessive-Compulsive Disorder
__ Anorexia/Bulimia
__ Borderline Personality Disorder
__ Antisocial Personality Disorder
__Post Traumatic Stress Disorder

Comments: _____

Do you presently have depression? ____ Yes, ____ No
If yes, how long and describe: _____

Describe any past depression: _____

Do you presently have anxiety/nervousness? ____ Yes, ____ No
If yes, how long and describe: _____

Is your sleep: ____ good, ____ fair, ____ poor (How many hours per night? _____)
Is your appetite: ____ good, ____ fair, ____ poor
Have you: ____ lost some weight, ____ gained some weight. If so, how much and in what period of time? _____
Is your energy: ____ good, ____ fair, ____ poor? Since when? _____
Please list any mental illness or alcohol/drug abuse in the family:_____

Please list any psychiatric problems in your family:

Has anything happened recently to change your situation?	____Yes, ____No
Are you a "hyper" person who worries about everything?	____ Yes, ____No
Do you have a depressed mood?	____ Yes, ____ No
Do you have problems doing everyday chores/activities?	____ Yes, ____ No
Have you lost interest in your normal activities?	____ Yes, ____ No
Do you have a loss of feelings for relatives or friends?	____ Yes, ____ No
Do you have problems with memory or concentration?	____ Yes, ____ No
Do you have long-term feelings of guilt or low self-worth?	____ Yes, ____ No
Are you thinking worse and worse about the future?	____ Yes, ____ No
Do you sometimes feel as if you would be better off dead?	____ Yes, ____ No
Does suicide seem like a better solution to you at times?	____ Yes, ____ No
Have you ever had thoughts or plans of death or suicide?	____ Yes, ____ No
Have you ever attempted suicide?	____ Yes, ____ No

If yes, please explain: _____

Do you feel empty inside?	____ Yes, ____ No
Are you bored most of the time?	____ Yes, ____ No
Do you or have you ever cut or harmed yourself on purpose?	____ Yes, ____ No
Have you ever hurt other people because you are angry with them?	____ Yes, ____ No
Would you reveal to us your plans to hurt yourself or others?	____ Yes, ____ No
Do you or have you ever had any fits and lost control?	____ Yes, ____ No
Have you had multiple, intense, full of conflict relationships?	____ Yes, ____ No
Do you feel people are either good or bad with no in-between?	____ Yes, ____ No
Are you angry most of the time?	____ Yes, ____ No
Do you hear voices that other people don't hear?	____ Yes, ____ No
Do you have visions (see things that other people don't see)?	____ Yes, ____ No
Do you think that some people, thing or group is out to get you?	____ Yes, ____ No
Does your imagination play tricks on you?	____ Yes, ____ No
Does it seem as if someone/something is controlling your thoughts?	____ Yes, ____ No
Do you feel that you can read people's minds?	____ Yes, ____ No
Have you ever gone more than a couple days without sleeping?	____ Yes, ____ No
Have you experienced a traumatic event that still impacts you?	____ Yes, ____ No

Substance Use History:

I began drinking alcohol regularly at age:

_____Prior to age 10 _____10-15 _____16-18 _____19-21 _____over 21

I drink alcohol:

_____Rarely or never _____1-2 days/week _____3-5 days/week _____Daily

The usual number of drinks I have at one time:_____

My last drink was: _____

I used to drink alcohol but have stopped:_____ Date stopped:_____

I used to drink excessively: Yes No

Check all that apply:

_____I can drink more than most people my age and size before I get drunk.

_____I sometimes get into trouble (e.g. fights, legal problems, conflicts, problems at work, accidents, etc) after drinking.

_____I sometimes black out after drinking.

_____I have had legal problems associated with drinking.

_____I have been in alcohol treatment: _____Past _____Current

Drug Use: ___ past ___ current ___never

Please check all of the drugs you are now using or have used in the past:

	Presently Using	Used in Past	Age used
Amphetamines (including diet pills)	_____	_____	_____
Barbiturates (downers, etc.)	_____	_____	_____
Cocaine or Crack	_____	_____	_____
Hallucinogenics (LSD, acid, etc.)	_____	_____	_____
Inhalants (glue, nitrous oxide, etc.)	_____	_____	_____
Marijuana	_____	_____	_____
Methamphetamines	_____	_____	_____
Opiate Narcotics (heroin, morphine, etc.)	_____	_____	_____
PCP (angel dust)	_____	_____	_____

Other drugs_____

Do you consider yourself to be dependent on any of the above substances?

_____Yes _____No

Do you consider yourself to be dependent on any prescription medications?

_____Yes _____No

Have you had any drug or alcohol treatment? ___ past ___ current ___ never

Do you smoke?_____No _____Yes, amount per day_____

Do you drink caffeine?_____No_____Yes, amount per day_____

Legal History:

Have you been court ordered to receive psychiatric treatment? ___ Yes ___ No

Are you seeking Workman's Compensation? ___Yes ___No

Are you applying for Disability (SSI or SSDI)? ___ Yes ___No

Have you ever been to jail, prison or on probation? ___ Yes ___No

If yes, please explain:

_____

_____

_____

Are you presently in any legal trouble? ___ Yes ___No

If yes, please explain:_____

_____

_____

Do you own a weapon? ___ Yes ___ No

If yes, please explain what type(s) and how many:_____

_____

Social History:

Marital Status:___Single ___Married ___Partnered ___Divorced ___Widowed

How many times have you been married?_____

How long each marriage? 1st_____ 2nd_____ 3rd_____

How many children do you have?_____What are their ages?_____

Highest grade or degree you have earned:_____

How would you describe your performance as a student? (Please circle)

As/Bs Bs/Cs Cs/Ds Ds/Fs

Current job title:_____Spouse job title:_____

How long have you been at this job?_____

Prior jobs:_____

Have you ever been abused? ____ physically, ____ sexually, ____ psychologically

If so, at what age(s)? _____

What do you like to do in your spare time?_____

_____

Have you ever been in the military? _____Yes _____No

If yes, Branch_____Type of Discharge_____

Major duties in military:_____

_____

Please add any helpful comments: _____

Do you have any questions at this moment? _____

_____ _____

Patient Signature Date

REVIEW OF SYSTEMS

Patient Name:_____ Date:_____

Place check (✓) if present

Constitutional
- Chills or fever
- Fainting spells
- Night sweats
- Swollen glands
- Weight gain
- Weight loss
- Other

Skin
- Change in moles
- Itching
- Psoriasis
- Rashes
- Bumps
- Other

Head (HEENT)
- Cataracts
- Double Vision
- Glaucoma
- Headaches
- Hearing Loss
- Ringing in ears
- Wear hearing aid

- Bleeding gums
- Dentures
- Loose teeth
- Removal bridge
- Frequent colds
- Nosebleeds
- Persistent hoarseness
- Sore throat

Cardiovascular
- Artificial valve
- Chest Pain
- Fainting spells
- Heart attack in past
- Heart disease
- Heart murmur
- High blood pressure
- High cholesterol
- Irregular heartbeat
- Mitral valve prolapse
- Pacemaker
- Rheumatic fever (hx)
- Swollen ankles

Respiratory
- Asthma or wheezing
- Can't breathe when flat
- Chest colds
- Cough up blood
- Frequent cough
- Shortness of breath
- Other

Gastrointestinal
- Abdominal pain
- Appetite loss
- Blood/tarry stools/bleeding
- Changes in bowel habits
- Colon cancer in past
- Constipation/diarrhea
- Nausea/vomiting
- Frequent heartburn
- Gallbladder trouble/ulcers
- Hemorrhoids
- Hiatal hernia
- Jaundice/liver trouble
- Swallowing difficulty

Exposure to:
- Gonorrhea
- Herpes
- AIDS
- Syphilis
- Hepatitis
- Blood trans.
- TB

Genitourinary
- Bladder control prob.
- Blood in urine
- Frequent urination
- Kidney disease
- Night urination
- Painful urination
- Stones
- Other

(Men Only)
- Discharge - penis
- Erection problems
- Impotence
- Lump in testicles
- Other

(Women Only)
- Breast lump or mass
- Change in periods
- Discharge - nipple
- Endometriosis
- Hot flashes
- Menopause
- Painful periods
- Vaginal discharge

Endocrine
- Diabetes
- Excessive thirst
- Fatigue
- Swollen glands
- Intol to heat or cold

Musculoskeletal
- Arthritis
- Back pain
- Muscle cramps
- Muscle weakness
- Numbness tingling
- Walking problems
- Other

Neurological
- Dizzy spells
- Headaches
- Memory loss
- Paralysis
- Seizure/epilepsy
- Shakiness/weakness
- Stroke
- Other

Psychological
- Anxious
- Depression
- Family problems
- Fatigue
- Insomnia
- Marital problems
- Stress
- Other

Accidents or Injuries

Patient Signature _____