WAYNE C. JONES, M.D. and ASSOCIATES

CONSENT FOR TREATMENT

I voluntarily agree to receive medical/psychiatric services from Wayne C. Jones, M.D. and Associates. I understand and agree that I will participate in my treatment plan and that I may discontinue treatment and/or withdraw my consent to treatment at any time. I also acknowledge that my non-compliance with treatment may result in being released as a patient. In such an event, a 30 - day notice of termination of treatment will be sent to me by my doctor.

I have read and understand the information provided in the document(s).

Signed:_____

Print Name:_____

Witness:_____

Date:_____

Wayne C. Jones, M.D. and Associates
American Board of Psychiatry and Neurology
375 Municipal Drive, Suite 224
Richardson, Texas 75080

PATIENT FEES AND SERVICES

Our goal is to give you the highest quality of care possible. We strive to do this by finding the most accurate diagnosis, explaining the reason(s) for your symptoms, and providing the most effective treatment program. We constantly improve our own knowledge and expertise through extensive continuing medical education.

- **Physician Fees:** $ 90.00 per 15 min.
  Wayne C. Jones, M.D. $180.00 per 30 min.
  $270.00 per 45 min.
  $360.00 per 60 min.

- **Clinical Assistant/Therapist Fees:** $ 60.00 per 20 min.
  Paige Embrey, LPC $100.00 per 40 min.
  $150.00 per 60 min.

- **New patient evaluations:** $300.00 - $500.00 (can vary from range listed)
  Varies by time and complexity
- **Routine medication follow-ups:** $ 60.00 - $150.00 (can vary from range listed)
  Varies by time and complexity
  Rates are same for in office or on phone
- **Regular fee rates will be charged to patient for consultations with:**
  - Family members
  - Attorneys/legal issues
  - Occupational issues
  - Other Physicians
  - Insurance issues

Other services that require fees:

- Record Requests (Fee depends on time involved and complexity of request)
- Letters (usually $30.00-60.00 payable in advance)
  - Insurance company
  - Disability
  - Precertification for medication
- MISSED appointments cancelled with less than 24 hours notice ($50.00)
- MISSED new evaluations not cancelled with 24 hours notice ($100.00)
- Stimulant prescription processing fee, unless during an appointment ($10.00)
- Precertification of medication by phone ($15.00)
- Shipping fees for prescriptions and samples sent by mail or Fed-Ex (varies)
- Late fee for balances not paid in 30 days ($15.00)
- After hours medication requests and other after hours calls ($25.00 minimum)
- Non-refundable advance deposit for new evaluations that will be applied to appointment ($100.00)

We cannot compromise the quality of care that we determine is necessary for any patient in order to accommodate those that cannot afford the cost involved. This is a fee for service office. We do not carry balances. If payment becomes a problem, we will be happy to evaluate the situation with you if it is a temporary situation. Your primary care doctor may be willing to continue prescribing your medication if finances become a long-term issue. Please feel free to discuss with us any comments or questions you might have on policies/fees.

OFFICE POLICIES AND PROCEDURES

It is my pleasure to welcome you to our office! This letter will acquaint you with our office policies. My office staff works as a team. I take great pride in my staff's training, knowledge, and capabilities. I believe that you will also learn to have confidence in and utilize their services as a part of your overall treatment.

OUR MISSION STATEMENT

We provide the most advanced treatments and comprehensive care to help you meet your needs and reach your goals.

OFFICE HOURS AND APPOINTMENTS

Regular office hours are: Monday-Friday: 9:00am to Noon and 2:00pm to 5:00pm

During all other times, the telephone is transferred to voicemail that will be answered on the next business day. If you feel that the situation requires immediate action, call the emergency number, 214-500-8181.

I and my Clinical Assistant consult with patients in the office or on the phone by appointment only. Please arrive for appointments in the office 15 minutes early. This will allow extra time to complete paperwork. Please keep the staff informed of current phone numbers and address. This will allow us to give a courtesy reminder call the day before appointments, and to remind you when it is time for a med check to be scheduled. However, it is still your responsibility to note scheduled appointments and follow through. A cancellation fee will be charged if 24 hour notice is not given when an appointment is missed. Thank you for your consideration in maintaining this policy so that the time blocked for your treatment can be given to another patient should you need to cancel.

EMERGENCIES

If an urgent or emergency situation arises, call the office and inform the staff of the degree of attention required. In acute life threatening situations, go to your local hospital emergency room or dial 911. If a situation arises where you require acute medical attention under the care of another physician/hospital, please make them aware that you are being treated by me. Request that they call me if there are any questions concerning your medications or treatment.

APPOINTMENT SCHEDULING AND FOLLOW-UP

It is our goal to provide the most effective, safest treatment possible. The Texas State Board also requires that treatment be adequately monitored. For these reasons, the following policy must be complied with for medication management.

- Patients that must schedule appointments every six months (At least once in office per year)*:
  (1) Patients that are stable and functioning well
  (2) Are on NO controlled substances
- Patients that must schedule appointments every three months (At least once in office per year)*:
  (1) Patients that are stable and doing well
  (2) Are on one or more controlled substances
- Patients that must schedule appointments on an individualized basis as determined by the doctor:
  (1) Having trouble adjusting medication
  (2) Have current life stressors that require closer monitoring
  (3) Have issues of non-compliance or abuse of medication
  (4) Controlled substances include benzodiazepines, stimulants, pain medications, sleep medications.

TELEPHONE COMMUNICATION

My entire office staff is a competent, experienced part of my team, and all have college degrees. Each staff member has extensive training in stress disorders. Feel free to leave information or questions about your treatment/medication with them for my review. The office staff will then call you with my recommendations. If the problem does not require any further action, there will be no charge. However, if your question(s) is complex and requires more attention, the office staff will set up a phone or office appointment with the Clinical Assistant. After the CA discusses the information with you, I will review the information and one of us will contact you, depending on the complexity of the problem. You will be billed for the time required to provide the best quality of care.

PRESCRIPTIONS AND REFILLS

You are responsible for making sure that you do not run out of medication! Please allow 48 hours for processing of refills. Do not request refills of controlled substances 5 or more days earlier than the date of the next refill. (This includes benzodiazepines, stimulants, pain medications, sleep medications). DO NOT CALL the office to request any refills except stimulant medications. Instead, call your pharmacy to request a refill. The pharmacy will call our office to approve your refill. If you call the office emergency line after 5:00pm for a refill there will be an after hours charge. After hour refills will be a two day supply since chart review is not possible at that time.

Stimulant prescriptions CANNOT be called in to the pharmacy. This is a state law. You must receive a written prescription that is only good for seven days. Call the office at least **24 hours in advance** for refill requests of stimulants. If the refill is approved, you may pick up the prescription at the office, or it can be sent via Federal Express to those that wish to pay shipping fees and do not have a balance.

FEE FOR SERVICE

Payment is expected at the time services are rendered. We accept credit cards, checks, and cash only. We do not carry balances and we do not accept insurance or Medicare for payment of services. We will be happy to provide a statement to file your insurance for reimbursement from your insurance carrier if requested.

MEDICAL RECORDS

Your medical records are protected by *doctor/patient confidentiality rights*. Information will not be provided to a third party (including family members), unless we have a written authorization from you, except when required by law. If you want information provided to others, i.e., attorney, insurance company, a written authorization must be signed by you.

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE INFORMATION. I AGREE TO AND WILL COMPLY WITH THESE POLICIES.

_____ _____

Name Date

Notice of Privacy Policies

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.

Protected health information, about you, is obtained as a record of you contacts or visits for healthcare services with WAYNE C. JONES, MD. This information is called protected health information. Specifically, "Protected Health Information" is information about you, including demographic information (i.e., name, address, phone, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related health care services.

WAYNE C. JONES, MD is required to follow specific rules on maintaining the confidentiality of your protected health information, how our staff uses you information, and how we disclose or share this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control you protected health information. It also describes how we follow those rules and use and disclose your protected health information to provide your treatment, obtain payment for services you receive, manage our health care operation and for other purposes that are permitted or required by law.

If you have any questions about this notice, please contact our privacy manager at 972-234-0489

Your Rights Under The Privacy Rule

Following is a statement of you rights, under the Privacy Rule, in reference to your protected health information. Please feel free to discuss any questions with our staff.

You have the right to receive and we are required to provide you with a copy of this Notice of Privacy Policies- We are required to follow the terms of this notice. We reserve the right to change the terms of our notice at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

You have the right to authorize other use and disclosure- This means you have the right to authorize or deny any other use or disclosure of protected health information not specified in this notice. You may revoke an authorization, at any time, in writing, except to the extent that your physician or our office has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to authorize a personal representative- This means you may designate a person with the delegated authority to consent to, or authorize the use or disclosure of protected health information.

You have the right to inspect and copy your protected health information- This means you may inspect and obtain a copy of protected health information about you that is contained in your patient record. In certain cases we may deny your request.

You have the right to request a restriction of your protected health information- This means, you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. In certain cases, we may deny your request for a restriction.

You may have the right to have us amend your protected health information- This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

You have the right to request a disclosure accountability- This means that you may request a listing of your protected health information disclosures we have made to entities or persons outside of our office.

Complaints

You may complain to us or to the secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Manager of your complaint.

How We May Use or Disclose Protected Health Information

Following are examples of use and disclosures of your protected health care information that we are permitted to make. Theses examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

For treatment- We may use and disclose your protected health information to provide coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that is involved in your care and treatment. For example, we would disclose your protected health information, as necessary, to a pharmacy that would fill you prescriptions. We will also disclose protected health information to other physicians who may be involved in your care and treatment.

We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to

provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. And, we may contact you to provide information about health related benefits and services offered by our office.

For payment- Your protected health information will be used, as needed, to obtain payment for our health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

For Healthcare Operations- we may use or disclose, as needed, your protected health information in order to support the business activities of our practices. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, and auditing functions. It also includes education, provider credentialing, certification, underwriting, rating, or other insurance related activities. Additionally it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets, and creating de-identified information.

Other Permitted and Required Uses and Disclosures

We may also use and disclose you protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

To other Involved in Your Healthcare- Unless you object, we may disclose to a member of your family, a relative, a close friend or person you identify, your protected health information that directly relates to that person's involvement in you health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, person representative or any other person that is responsible for your care, general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician ma, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

As Required by Law- We may use or disclose your protected health information to the extent that the use or disclosure is required by the law.

For Public Health- we may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.

For Communicable Diseases- we may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

For Health Oversight- We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections.

In Cases of Abuse or Neglect- We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

To the Food and Drug Administration- We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

For Legal Proceedings- we may disclose protected health information in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to subpoena, discovery request or other lawful process.

To Law Enforcement- We may also disclose protected health information so long as applicable legal requirements are met, for law enforcement purposes.

To Coroners, Funeral Directors, and Organ Donation- We may disclose protected health information to a coroner or medication examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

In Cases or Criminal Activity- Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend and individual.

For Military Activity and National Security- When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command

authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services.

For Worker's Compensation- Your protected health information may be disclosed by us as authorized to comply with worker's compensation laws and other similar legally-established programs.

When an Inmate- We may disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures- Under the law, we must make disclosures about you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule

Acknowledgement of Privacy Practices

I have received the Notice of Privacy Practices and I have been provided an opportunity to review said form.

NAME:_____

Signature:_____

DATE:_____

Questions & Complaints

Questions about this notice should be directed to:

Wayne C. Jones, M.D.
375 Municipal Dr., # 224
Richardson, TX 75080
Phone: 972-234-0489
info@askdrjones.com

If you think we may have violated your privacy rights, contact the person named above. You may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you the address to file your complaint with this Department. We will not in any way retaliate if you choose to file a complaint.

Wayne C. Jones, M.D. and Associates
375 Municipal Dr., Suite 224, Richardson, TX 75080
972-234-0489 FAX 972-235-1558 E-Mail: Penco17@aol.com

WELCOME TO OUR OFFICE

Name_____ Date_____

Birth date _____Relationship/Marital Status_____Home Phone_____

Address_____

City, State, Zip_____

Cell Phone_____Fax_____E-Mail_____

SSN_____Occupation_____

Name of Employer_____Work Phone_____

Do you have insurance?_____Name of Insurance Co._____

Insurance Member #_____Do you have medication card?_____

If so, what type of prescription plan (e.g., 90 day mail order, 30 day, etc.)_____

Payment is required at time of service. Circle how you will pay? Cash Check Credit Card
(We accept MC, Visa, Amex, Disc)

If minor, parent or guardians name_____

Nearest friend or relative not living with you_____

Relationship_____Home Phone_____Work Phone_____

Whom may we thank for referring you?_____

Signature_____

For Office Use Only	Date	Additional Diagnoses
I. _____	_____	_____
_____	_____	_____
_____	_____	_____
III._____	_____	_____

JONES SCREENING QUESTIONNAIRE FOR STRESS DISORDERS

NAME:_____ DATE:_____

IMPORTANT: Only Circle "yes" if the symptoms described cause you significant distress and/or cause problems at work, home, or in relationships.

NO	YES	Do you frequently have difficulty getting to sleep or staying asleep? Do you feel unrested or function poorly due to lack of sleep or poor quality of sleep?
NO	YES	Do you have anxiety or worry excessively about things such as work, finances or relatives? Have you found it difficult to control?
NO	YES	Do you have unexpected or out-of-blue periods associated with shakiness, shortness of breath, racing heart or other symptoms?
NO	YES	Do you experience intense feelings of anxiety or fear of embarrassment or humiliation in front of others? Do you avoid or anxiously endure things such as speaking in public, parties, dating, writing or eating in front of others?
NO	YES	Are you bothered by intrusive thoughts or mental images? Do you have to perform repetitive behaviors (e.g. hand washing or checking), or mental rituals (e.g. counting, repeating words) to control anxiety or distress?
NO	YES	Have you experienced a traumatic event(s) that cause actual or threatened serious sexual or physical injury to you or others? As a result, do you have significant stress such as flashbacks, nightmares, persistent anxiety or feeling of emotional numbness?
NO	YES	Do you have times when you feel depressed or down most of the day, nearly every day? AND/OR have you lost interest, motivation, have low energy or no pleasure in usual daily activities?
NO	YES	Do you have chronic problems paying attention or concentrating due to either mind wandering or being easily distracted?
NO	YES	Are you frequently hyperactive (mental or physical) finding it hard to relax or be still or quiet as though driven by a motor?
NO	YES	Do you frequently do things impulsively that you regret or that cause you trouble because you act first and think second?

NO YES Do you ever have a period of time when you feel “up” or “high” or so full of energy that you get into trouble, or people think that you aren’t your usual self? (Not including drug or alcohol induced states)

NO YES Have others expressed concern about your alcohol consumption? Have you tried to cut down or felt guilty about drinking?

NO YES Do you have eating binges or times when you eat a very large amount of food within a two-hour period?

NO YES Do you have a lack/loss of interest in sex, decreased arousal, erectile dysfunction, or premature ejaculation (men); delayed or absent orgasm (women)?

NO YES Have others expressed concerns that you are too thin?

NO YES Are you preoccupied by or frequently stress over some aspect of you appearance, e.g., face, hair, nose, genitals? This includes excessive time with grooming or looking in the mirror?

Circle ALL of the physical symptoms that apply to you:

Stomach/Bowel Problems	Fatigue	Tremor/Shakiness
Light Headedness	Dizziness	Restless Legs
Daytime Sleepiness	Swelling	Loud Snoring
Night Sweats	Rashes	Shortness of Breath
Urinary Problems	Tingling	Blurred Vision
Heart Racing	Swelling	Headaches
Hair Loss	Cold	

Pain (Explain)_____

Menstrual/Hormone Problems (Explain)_____

Other (Explain)_____

Name:_____ **Date:**_____

CHIEF COMPLAINT: What symptoms are currently causing you the most distress or are interfering with your daily functioning?

_____

What life situations/stressors are currently affecting your life?

_____

_____

How would you rate the severity of your current symptoms: *(Circle)*

Mildly Disturbing 1 10 20 30 40 50 60 70 80 90 100 *Severely Disturbing*

During the past month, CIRCLE the degree of difficulty of each item:

	No Difficulty				*Very Difficult*
Routine Daily Activities:	1	2	3	4	5
Getting dressed, having meals, bathing, cleaning					
Activities Outside the Home:	1	2	3	4	5
Work, school, shopping, other					
Social Activities:	1	2	3	4	5
Visiting family/friends, parties, social events					

MEDICATION LIST

Please list ALL current prescription medications that you are prescribed from other physicians as well as any herbal medication or supplements that you take.

Medication & Strength	***Time Doses Taken (in milligrams)***				***Total Dose***	***Time on Med***
	AM	*Lunch*	*Supper*	*Bedtime*		
Anxietyaway 50mg	*25mg*	*25mg*	*25mg*	*25mg*	*100mg*	*10 years*

Birth Order: *(Circle)* Only Oldest Middle Youngest

Childhood Environment: *(Circle)* Big City Small Town Rural Moved Frequently

Did you experience childhood abuse? *(Circle)* Sexual Verbal Physical Emotional

If there were any major events in your childhood that you feel were traumatic, explain:

_____

_____

Circle all of the following that characterize your childhood:

In trouble (School/legal)	Normal	Aggressive	Rebellious	Stammering
Verbal/Expressive	Isolated	Happy	Acted Out	Thumb sucking
Sleep Walking	Leader	Shy	Adopted	Bedwetting
Teased/Bullied	Afraid	Sad	Follower	Night Terrors
Fearful	Quiet			

Other_____

PERSONALITY AND LIFE FACTORS

Circle the words that you feel apply to you now:

Can't Make Friends	Overambitious	Worthless	Horrible	Attractive	Ugly
Can't Keep a Job	Misunderstood	Useless	Incompetent	Repulsive	Evil
Can't Make Decisions	Unattractive	Intelligent	Lonely	Unassertive	Shy
Horrible thoughts	Aggressive	Inadequate	Unloved	Confused	Stupid
Life is Empty	Cowardly	Worthwhile	Confident	In Conflict	Guilty
Financial Problems	Full of Regret	Full of Hate	Considerate	Sympathetic	Hostile
Inferiority feelings	Home life stressful	A "Nobody"	Immoral	Angry	

Other_____

HEALTH INFORMATION

How you rate your overall health and physical condition: *(Circle)*

Excellent Above Average Average Below Average Poor

How you rate your overall weight: *(Circle)*

Too Thin Average Overweight Obese **Height:**_____ **Weight:**_____

How you rate your usual diet: *(Circle)*

Poor Fair Average Good Healthy

How many Caffeinated beverages do you consume per day? _____

Number of times per week you exercise or are physically active: _____

On average, how much time do you spend outside in daylight, not counting the car? *(Circle)*

< 30 minutes ½ to 2 hours > 2 hours

Substance Use

Substance	*Circle*	*Amount*	*Frequency*	*Date Last Used*
Alcohol	Y N	_____	_____	_____
Tobacco	Y N	_____	_____	_____
Marijuana	Y N	_____	_____	_____
Cocaine/Crack	Y N	_____	_____	_____
LSD/Hallucinogens	Y N	_____	_____	_____
Heroin	Y N	_____	_____	_____
IV Drug Use	Y N	_____	_____	_____
Other_____	Y N	_____	_____	_____

Have you ever felt that you were abusing drugs or alcohol? *(Circle)* Yes No

If so, describe when and the nature of the problem.

_____

_____

GENERAL INFORMATION

How do you relax, escape, have fun or manage stress?

_____

_____

Education & Vocation

Last Grade Completed:_____ Current Occupation:_____

What is the longest you have been at one job? _____

Have you ever had periods of Occupational Disability? *(Circle)* Yes No

If so, Explain.

_____

Circle all that apply:

Work Full-Time Work Part-Time Full-Time Student Part-Time Student

Military Technical Training Unemployed Retired

How Satisfied are you with work or school? *(Circle)*

Not at all 1 2 3 4 5 6 7 8 9 10 *Very Satisfied*

If not satisfied, explain_____

How Stressful is work or school? *(Circle)*

Not at all 1 2 3 4 5 6 7 8 9 10 *Extremely*

Have you experienced any event in adulthood that has been stressful or traumatic (such as military combat, serious car wreck, natural disaster, violent crime, etc)? *(Circle)* Yes No **If so, explain.**

_____

_____

Have you ever been arrested? *(Circle)* Yes No **If so, explain.**

_____

_____

FAMILY AND RELATIONSHIPS

Relationship Status: *(Circle)*

Single Engaged Married/Partner Separated Divorced Widowed Dating

If married, or in a committed relationship, how long? _____

How many previous marriages? _____

Please rate your relationship with spouse/significant other: *(Circle)*

Dysfunctional 1 2 3 4 5 6 7 8 9 10 *Satisfying*

List all persons that live in your household:

_____

_____

Please List Your Children *(biological, step children & adopted)*:

Age	*Sex*	*Quality of Relationship*	*Special Needs/Problems*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If divorced, circle custody arrangement: *(Circle)* Husband Wife Joint

Relationships with family members:*(Circle)* *Explain if Needed*

Mother:	Good	Fair	Poor	Deceased	_____
Father:	Good	Fair	Poor	Deceased	_____
Step Parent:	Good	Fair	Poor	Deceased	_____
Brother #1:	Good	Fair	Poor	Deceased	_____
Brother #2	Good	Fair	Poor	Deceased	_____
Sister #1	Good	Fair	Poor	Deceased	_____
Sister #2	Good	Fair	Poor	Deceased	_____

Do you have a family member that you feel comfortable bringing to the office to discuss your condition and treatment? *(Circle)* Yes No

If so who, and what is your relation to them?_____

NOTE: You must sign a release before we can discuss any medical information with a relative or friend. Please inform our front office staff if you would like to take this action.

PSYCHIATRIC HISTORY

Date	*Hospital/Physician*	*Reason for Treatment*
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever attempted Suicide? *(Circle)* Yes No **If yes, explain.**

_____

_____

List all medications previously taken for psychiatric conditions:

Medication	*Did It Work?*	*Side Effects*

Please Check Any Known Conditions Among Family Members:

	Father	***Mother***	***Sibling***	***Children***	***Other***
Alcoholism	☐	☐	☐	☐	☐
ADHD	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Panic	☐	☐	☐	☐	☐
Agoraphobia	☐	☐	☐	☐	☐
Social Anxiety	☐	☐	☐	☐	☐
Suicidal	☐	☐	☐	☐	☐
Bipolar	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐
Drug Abuse	☐	☐	☐	☐	☐
Antisocial	☐	☐	☐	☐	☐
Alzheimer's	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐
Phobias	☐	☐	☐	☐	☐
OCD	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Psych Hospital	☐	☐	☐	☐	☐
Suicide	☐	☐	☐	☐	☐