

WELLBEING INSTITUTE NEW CLIENT INFORMATION

Name (Last, First, M.I.): _____	<input type="checkbox"/> M <input type="checkbox"/> F	DOB: _____	SS #: _____
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Partnered <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	<input type="checkbox"/> Name and Phone # of Spouse/Guardian: _____		
Address _____		Phone # _____	H: _____ C/W: _____
Email: _____			
Profession: _____		Employer: _____ <input type="checkbox"/> Self-Employed	

INSURANCE/PAYER INFORMATION

Name of Insurance carrier:	<input type="checkbox"/> Self-Pay <input type="checkbox"/> UHC <input type="checkbox"/> CIGNA <input type="checkbox"/> AETNA <input type="checkbox"/> HEALTHNET <input type="checkbox"/> Others _____			<input type="checkbox"/> Copay (for Specialist/SP/SPEC) \$ _____
ID & Group #	<input type="checkbox"/> ID # _____	<input type="checkbox"/> Group # _____		
If you are not the primary card holder:	<input type="checkbox"/> Name of Primary Card Holder: _____	<input type="checkbox"/> DOB _____	<input type="checkbox"/> His/Her Employer: _____	
For my psychiatric care, I authorize Wellbeing Institute Providers to communicate with the following party: <i>(No information will be released without written consent)</i>		<input type="checkbox"/> Parents	<input type="checkbox"/> Spouse/Partner	<input type="checkbox"/> My PCP (Dr. _____)
		<input type="checkbox"/> My Therapist	<input type="checkbox"/> Other Relatives	<input type="checkbox"/> Others (Specify) _____

I read Wellbeing Institute policy listed below and agree to comply with it. I take full responsibility in case of non-compliance.

I hereby give my consent for medical treatment by my physician(s) or other health care provider(s) at Wellbeing Institute and collaborating Community Mental Health Center(s)/Health Home(s) (CMHC/HH), and authorize them to communicate freely, with no further written release of information, among them. I understand that should I require services in my doctor/provider's absence, this consent is transferable to the covering physician/provider(s) as designated by my doctor/provider, or to other services, hospitals in the nearby area that is available on urgent/emergent basis. I am informed the way to express my grievances is to directly sending written statement to Wellbeing Institute and CMHC/HH Administration. I understand that I have the patient's right for being treated at Wellbeing Institute and CMHC/HH, including but not limited to the right to refuse treatment.

Initial: _____

I understand that developing a treatment plan and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand that Wellbeing Institute and CMHC/HH providers keep minimal information in my medical/psychiatric records in accordance with the recommendations of the American Psychiatric Association and the American Psychoanalytic Study Group. This is because the effectiveness of psychiatric treatment has been shown to be dependent on true confidentiality. I understand that no promises have been made to me as to the results of treatment or of any procedures. I have been given the informed consent to any medication prescribed for me regarding their indication, contraindication, side effects (to the possibility of death), and the choice and outcome of not taking medication. I give the permission to be treated by taking recommended medication(s).

Initial: _____

I consent to the ongoing release of verbal or written communication between my doctor(s)/care provider(s) at Wellbeing Institute and CMHC/HH and my other physician(s), therapist, my spouse/significant other and my parents. I hereby authorize the physician/provider(s) to release any information acquired in the course of my examination or treatment to my insurance company and/or Utilization Review Organization contracted by my insurance company. I authorize that messages may be left for me regarding appointment reminders or instructions regarding my care. I acknowledge that telephone calls from my physician(s)/provider(s) may be returned by cellular phone. I may revoke consent for any of all of the above chosen party at any time in writing.

Initial: _____

I have been given the information about the patient rights, and understand that I will be treated with dignity, respect and consideration. No abuse/neglect/exploitation/coercion/manipulation/retaliation will be presented in my treatment at Wellbeing Institute. I am informed about the AZDHS website if I need to file complaint.

Initial: _____

Financial Policy Insurance: Payments for services are due at the time that services are rendered. Wellbeing Institute collects deductibles, co-payments and co-insurance that may be paid with cash and check. All balances not paid by insurance are due within **15 days. \$25** fee will be charged for all returned checks *in addition to* the bank extra charges and interest accrued since then, and all services in the future will need to be paid in cash. The accompanying parent or adult with a child is responsible for the full payment at time of service. In case of divorce, it is the parents' responsibility to work out the payment of their child's medical care between the two parents. *I agree to give 48 hour notice to reschedule or cancel appointment, or pay the \$225 missed appointment fee for each appointment missed.* I agree to pay for medical record copying and delivery expenses, time to spend for preparation of documents, letters of employment and legal purposes, disability, FMLA or other paperwork, pre-authorization effort with insurance companies for services or medication that are needed for my care, as well as excessive use of after hour calls.

Initial: _____

Stimulant Medication: Given the fact that DEA and State have particular rules in regulating stimulant medication prescribing activity, I agree to be seen in person for such a prescription for 30 days supply of medication, and will return to Wellbeing Institute when I have at least ONE WEEK medication supply.

Initial: _____

Signature: _____ Date: mm/dd/yyyy _____ Signed by: ☐ Client ☐ Guardian ☐ Personal Representative

Name _____

Date _____

Symptom Checklist(Check all that apply; then circle up to 10 items which are especially bothersome to you)**1) Please check any of the following which may have been particularly stressful to you:**

Recent Past

- ☐ ☐ Job related stress
☐ ☐ Marital conflict
☐ ☐ Death or loss of loved one
☐ ☐ Move to a new place and losing contact with friends or family
☐ ☐ Conflict with children
☐ ☐ Children with behavior problems
☐ ☐ Conflict with parents or extended family
☐ ☐ Feeling stressed due to recalling memories of an earlier time of trauma or stress in my life
☐ ☐ Family member with an alcohol or drug problem
☐ ☐ Being abused by someone
☐ ☐ Financial pressure

2) Any of the following symptoms for most of the day, nearly every day, for periods longer than several days at a time:

Recent Past

- ☐ ☐ Depressed or sad mood
☐ ☐ Loss of interest or pleasure in things I'm normally interested in
☐ ☐ Difficulty falling asleep
☐ ☐ Difficulty staying asleep or waking up too early (Average number of hours your are sleeping per night? _____)
☐ ☐ Sleeping too much
☐ ☐ Increased appetite/Weight gain (lbs. _____)
☐ ☐ Decreased appetite/Weight loss (lbs. _____)
☐ ☐ Fatigue/Poor energy level
☐ ☐ Decreased activity (work, social, physical, sexual)
☐ ☐ Poor concentration or slowed thinking
☐ ☐ Thoughts of suicide
☐ ☐ Excessive feelings of guilt or worthlessness
☐ ☐ Decreased sex drive or interest

3) Any of the following symptoms, more days than not, for months at a time:

Recent Past

- ☐ ☐ Excessive anxiety or worry for no good reason
☐ ☐ Trembling, twitching or feeling "shaky"
☐ ☐ Muscle tension or muscle aches
☐ ☐ Easily fatigued
☐ ☐ Dry mouth

- ☐ ☐ Dizziness or lightheadedness
☐ ☐ Nausea, diarrhea or other stomach problems
☐ ☐ Frequent urination
☐ ☐ Feeling keyed up or on edge
☐ ☐ Irritability
☐ ☐ Trouble falling or staying asleep

4) Panic attacks (any period of extreme, increased anxiety lasting from a few minutes up to several hours) with any of the following symptoms:

Recent Past

- ☐ ☐ Panic attacks/anxiety attacks
☐ ☐ Persistent worry that I will have a panic attack
☐ ☐ Heart pounding or racing heart
☐ ☐ Trembling or shaking
☐ ☐ Sweating
☐ ☐ Choking
☐ ☐ Nausea or stomach problems
☐ ☐ Feelings of unreality
☐ ☐ Numbness or tingling sensations
☐ ☐ Feeling of smothering or shortness of breath
☐ ☐ Fear of dying
☐ ☐ Fear of going crazy or doing something uncontrolled
☐ ☐ Chest pain or discomfort
☐ ☐ Dizziness, unsteady feelings or faintness
☐ ☐ Flashes, hot flashes or chills
☐ ☐ Avoiding situations or places that may cause panic or severe anxiety

5) Any of the following symptoms for most of the day, nearly every day, for more than four days at a time:

Recent Past

- ☐ ☐ Euphoric or "high" mood
☐ ☐ Irritable mood
☐ ☐ Decreased need for sleep without feeling tired
☐ ☐ Increased energy level
☐ ☐ Increased activity (work, social, physical, sexual)
☐ ☐ Thoughts speeded up or racing thoughts
☐ ☐ Much increased talkativeness or being much more socially outgoing
☐ ☐ Making decisions too impulsively
☐ ☐ Going on spending sprees

6) Check any of the following relating to your alcohol or drug use:

- | Recent | Past | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | I've felt alcohol or drugs were causing a problem for me |
| <input type="checkbox"/> | <input type="checkbox"/> | I have felt guilty about my use |
| <input type="checkbox"/> | <input type="checkbox"/> | Others have annoyed me about my use |
| <input type="checkbox"/> | <input type="checkbox"/> | I have had a desire (or made unsuccessful efforts) to cut down or control my use |
| <input type="checkbox"/> | <input type="checkbox"/> | I've tried unsuccessfully to control my use |
| <input type="checkbox"/> | <input type="checkbox"/> | I've used alcohol or drugs more often or in larger amounts than I intended |
| <input type="checkbox"/> | <input type="checkbox"/> | I've had to increase my use of alcohol or drugs to get the desired effect |
| <input type="checkbox"/> | <input type="checkbox"/> | I've had problems with withdrawal (shakes, nervousness, insomnia, etc.) when I've cut down or stopped using alcohol or drugs |
| <input type="checkbox"/> | <input type="checkbox"/> | I've been to a meeting of Alcoholics Anonymous or Narcotics Anonymous |

7) Any of the following disturbances in eating or maintaining normal weight:

- | Recent | Past | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Insistence on maintaining body weight below expected for age and height |
| <input type="checkbox"/> | <input type="checkbox"/> | Intense fear of gaining weight or becoming fat even though underweight |
| <input type="checkbox"/> | <input type="checkbox"/> | I feel "fat" even when others see me as underweight |
| <input type="checkbox"/> | <input type="checkbox"/> | Eating binges |
| <input type="checkbox"/> | <input type="checkbox"/> | Feeling of lack of control of eating during eating binges |
| <input type="checkbox"/> | <input type="checkbox"/> | Vomiting or using laxatives to prevent weight gain |
| <input type="checkbox"/> | <input type="checkbox"/> | Being overconcerned about body weight and shape |

8) Check any of the following that apply:

- | Recent | Past | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | I tend to do things on impulse which end up being damaging to me or others |
| <input type="checkbox"/> | <input type="checkbox"/> | I have mood swings (depression, irritability, anxiety, anger) lasting up to several hours |
| <input type="checkbox"/> | <input type="checkbox"/> | I have tried to commit suicide |
| <input type="checkbox"/> | <input type="checkbox"/> | I have made cuts, burns or other injuries to myself without wanting to kill myself |
| <input type="checkbox"/> | <input type="checkbox"/> | My relationships always seem to work out wrong |
| <input type="checkbox"/> | <input type="checkbox"/> | My mood often shifts from being either overconfident to having very low self esteem |
| <input type="checkbox"/> | <input type="checkbox"/> | I have a hard time sympathizing with others' pain |
| <input type="checkbox"/> | <input type="checkbox"/> | I often feel others do not understand me |
| <input type="checkbox"/> | <input type="checkbox"/> | I tend to get very hurt or angry when I am |

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | criticized or rejected by someone |
| <input type="checkbox"/> | <input type="checkbox"/> | I tend to need a lot of reassurance or approval from others |
| <input type="checkbox"/> | <input type="checkbox"/> | I am very concerned about my appearance |
| <input type="checkbox"/> | <input type="checkbox"/> | Others often expect too much of me |

9) Any of the following at any time:

- | Recent | Past | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing voices that sound real even though they are not actually there |
| <input type="checkbox"/> | <input type="checkbox"/> | Vivid voices in my head that do not seem like my ideas |
| <input type="checkbox"/> | <input type="checkbox"/> | Feeling that others might be putting thoughts in my head |
| <input type="checkbox"/> | <input type="checkbox"/> | Feeling others might be able to read my thoughts |
| <input type="checkbox"/> | <input type="checkbox"/> | Others feeling I am too suspicious or paranoid |
| <input type="checkbox"/> | <input type="checkbox"/> | Feeling others might be talking about me |

10) Any of the following problems relating to a past severe trauma or stress:

- | Recent | Past | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | I have had an experience which was so traumatic that nearly anyone would have been seriously stressed by it |
| <input type="checkbox"/> | <input type="checkbox"/> | History of relatives hurting me physically or touching me in sexual areas |
| <input type="checkbox"/> | <input type="checkbox"/> | History of unwanted sexual contact |
| <input type="checkbox"/> | <input type="checkbox"/> | I have memories or dreams of a stressful event that I have trouble putting out of my head |
| <input type="checkbox"/> | <input type="checkbox"/> | I sometimes have flashbacks of past events; or I act or feel as though I am re-living a stressful event from the past |
| <input type="checkbox"/> | <input type="checkbox"/> | I try to avoid situations or people that remind me of a severely stressful event in the past |

11) Any of the following obsessions or compulsions:

- | Recent | Past | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive doubting; or repeated, forced unreasonable thoughts, images, or sounds that I cannot get out of my mind |
| <input type="checkbox"/> | <input type="checkbox"/> | I urge to check things, wash things, or count repeatedly |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive concern about coming into contact with germs or dirt |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive concern with right/wrong or morality |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive need for things to be exact or symmetrical |

Patient Name: _____
Date: _____

Comprehensive Assessment Questionnaire

Presenting History

What is the main problem that caused you to seek help?

Why did you decide to seek help now?

Describe the main symptoms that are causing problems for you:

When did the problem first begin? _____

Describe any stresses in your life that may have contributed to the problem:

Have you had a similar problem in the past? Yes No . If so, please describe the episodes and the dates they occurred.

Where you treated for this problem? Yes No . If so, please describe the treatment you received.

Has this problem caused you to experience any decrease in your ability to function in the following areas?

School Performance_____	Work Performance_____	Relationship with spouse/significant other_____
Functioning as a parent_____	Social Life_____	Ability to manage chores at home_____

Past Medical History

Please list all medications you are currently taking:

Medication	Dose	Start Date (MMYY)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies to Medications	_____	Type of Allergic Reaction	_____
--------------------------	-------	---------------------------	-------

Past Mental Health History:

Please list any Psychiatrist/Psychologist/Therapist you have seen previously:

Name	Date of Treatment
------	-------------------

Medications prescribed in the past?

Medication	Date	Response
------------	------	----------

_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever been in a psychiatric hospital in the past? ☐ Yes ☐ No. If so, please list the facility and the dates of treatment.

Have you ever attempted suicide? ☐ Yes ☐ No If yes, please describe the nature of the event and the date(s) of occurrence.

Substance Use:

Do you use any of the following substance?

Tobacco ☐ Caffeine ☐ Alcohol ☐ Marijuana ☐ Cocaine ☐ Amphetamines ☐
LSD ☐ Heroin ☐ Pain Killers ☐ IV Drug Use ☐

Have you ever felt that you were abusing drugs or alcohol? ☐ Yes ☐ No

Have you tried to stop drinking? ☐ Yes ☐ No. Have you ever attended AA or NA? Yes ☐ No ☐

Medical History:

Who is your primary care physician? _____

What medical problem do you have? What current medication are you taking for the treatment? _____

Women only:

Are your periods regular? ☐ Yes ☐ No.

Method of contraception _____

How many pregnancies have you had? _____

Are you currently pregnant? ☐ Yes ☐ No

Are you planning to become pregnant in the near future? ☐ Yes ☐ No.

Family History

Psychiatric History (List any blood relative who have had emotional problems—such as depression, manic depression, alcoholism, drug abuse, suicide, schizophrenia, anxiety problems)

Problem	Relative	Maternal (M)/Paternal (P) side	Hospitalized
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Were your parents divorced? ☐ Yes ☐ No If so, how old were you _____ Who did you live with after the divorce? _____ What was your relationship with the stepparent(s)? _____

Were you ever subjected to any type of abuse? (emotional, verbal, physical, sexual). If so, describe the events. _____

Educational/Occupational/Social Histories

Are you currently working? ☐ Yes ☐ No What is your occupation? _____
Where do you work? _____ How long have you been there? _____
Are you satisfied with your job? ☐ Yes ☐ No If No, please explain _____

Are you graduated from ☐ High School ☐ College ☐ Graduate/Professional School _____
What is your highest degree? _____

Date of Birth: _____ Current Age _____ Place of Birth _____

Are you currently ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other?

How long? _____ What is your sexual orientation? _____