

**Adult Psychosocial Questionnaire**

(Ages 18+)

Date: \_\_\_\_\_

In order to better serve you, we would like you to **FULLY** complete this questionnaire and return it to the front desk as soon as it is complete. Please ensure that no question is left blank. This information is kept strictly **confidential** as required by State and Federal guidelines.

Name: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Why have you decided to come into treatment now? \_\_\_\_\_

What would you like to accomplish by coming today? \_\_\_\_\_

**In Case of Emergency, Contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Please indicate whether you are **experiencing** any of the following:

**suicidal ideas/expression**  **homicidal ideas/expression**  **physical violence**

**none**

Please explain: \_\_\_\_\_

Please indicate whether you have a **history** of any of the following:

**suicidal ideas/expression**  **homicidal ideas/expression**  **physical violence**

**none**

Please explain: \_\_\_\_\_

**Employment Status:**

employed  employed/Student  student  unemployed

Employer \_\_\_\_\_

Are you satisfied in your current job? Yes / No

Please explain: \_\_\_\_\_

What are your means of support?

self employed  full time/part time work  parents  unemployment  Retired

spouse  other: \_\_\_\_\_

**Education:**

Please indicate your current standing:

did not graduate High School  high School Diploma  GED  associates/bachelors degree  doctorate

Did you have any behavioral or learning issues? Yes / No

If yes, please explain: \_\_\_\_\_

**Residence Situation:**

lives with parents  lives with significant other  lives with spouse  lives alone  
 other

**Family Composition**

**Religion (Optional)**  Catholic  Protestant  Jewish  Hindu  Other: \_\_\_\_\_

How important are your Religious/Spiritual Beliefs:

very Important  somewhat important  not important

Would you like to talk to your therapist about your religious/spiritual beliefs? Yes / No

**Race (Optional)**  Caucasian  African-American  Native American

Hispanic  Asian-American  Other: \_\_\_\_\_

Would you like to talk to your therapist about any racial/cultural issues? Yes / No

**Behavioral Health Treatment History:**

Have you ever seen a behavioral health care provider before? Yes / No

If yes inpatient or outpatient? \_\_\_\_\_

If yes for Inpatient, Name of Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Length of Stay: Number of admissions: \_\_\_\_\_

If yes for Outpatient, Name of Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Name of Therapist: \_\_\_\_\_ Phone# \_\_\_\_\_

What type of therapist were they?  Psychiatrist  Psychologist  Social Worker

Other: \_\_\_\_\_

When did you see the therapist and for what reason: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medication History:**

What medications do you know you should not take? \_\_\_\_\_

\_\_\_\_\_

What medications do you know you should not discontinue to use? \_\_\_\_\_

\_\_\_\_\_

What herbal remedy are you currently taking? \_\_\_\_\_

\_\_\_\_\_

Please list all medications you are **currently** on or have taken in the **last year** (prescription and over-the-counter): \_\_\_\_\_

\_\_\_\_\_

Who has been prescribing the medications listed above?

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

**Current General Health Status:**

Please describe your current general health:

Excellent  Very Good  Good  Fair  Poor  Very Poor

Are you feeling any physical pain at this time? Yes / No

If yes please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Nutritional Screening:**

Have you **gained weight** or **lost weight** in the last 30-60 days? Yes / No

If yes, how much and reason? \_\_\_\_\_

Do you have any diet or nutritional concerns? Yes / No

If yes, please explain: \_\_\_\_\_

Do you have any food or medication allergies? Yes / No

If yes, please list: \_\_\_\_\_

**Substance Use:**

Do you use Nicotine? Yes / No

If yes, ( ) Cigarettes/Cigars/Pipe ( ) Chewing tobacco

Amount per day: \_\_\_\_\_ How long have you used? \_\_\_\_\_

Any related health problems? \_\_\_\_\_

Do you use Alcohol? Yes / No

If yes, How often do you use? \_\_\_\_\_ How long have you used? \_\_\_\_\_

How much do you usually drink? \_\_\_\_\_

Any related health issues? \_\_\_\_\_

If any Recovery, Longest length of Sobriety: \_\_\_\_\_

Do you use any Illegal Drugs? Yes / No

If yes, what drug (s) do you use? \_\_\_\_\_

How often do you use? \_\_\_\_\_ How much do you use? \_\_\_\_\_

When was the last time you used? \_\_\_\_\_

**Medical:**

Do you feel like you need a physical exam? Yes / No

When was the last time you had a physical exam? \_\_\_\_\_

Have you suffered from any recent or childhood illnesses/disorders, operations, and/or hospitalizations (please include dates and ages)

If yes, please explain: \_\_\_\_\_

Head Injuries: ( ) without loss of consciousness ( ) with loss of consciousness

Please explain: \_\_\_\_\_

Convulsions: ( ) without fever ( ) with fever

Please explain: \_\_\_\_\_

**Abuse:**

Have you ever experienced any:

( ) Physical Abuse ( ) Sexual Abuse

( ) Emotional Abuse ( ) Abandonment/Neglect

If yes, by whom: \_\_\_\_\_

Length/Duration of abuse: \_\_\_\_\_

Was it reported to the authorities: Yes / No

Please explain: \_\_\_\_\_

**Family Social History:**

Name of your mother: \_\_\_\_\_ Age of mother: \_\_\_\_\_

Level of Education: \_\_\_\_\_

Name of your father: \_\_\_\_\_ Age of father: \_\_\_\_\_

Level of Education: \_\_\_\_\_

Biological parents are : ( ) Married ( ) Separated ( ) Divorced ( ) Other: \_\_\_\_\_

How would you describe your relationships with your family/siblings? :

( ) Excellent ( ) Good ( ) Fair ( ) Poor

Please explain: \_\_\_\_\_

**Family History:**

Please indicate **any family history** of the following:

- ( ) Substance Abuse: If yes, indicate who: \_\_\_\_\_
- ( ) Mental Illness: If yes, indicate who: \_\_\_\_\_
- ( ) Suicide: If yes, indicate who: \_\_\_\_\_
- ( ) Autism: If yes, indicate who: \_\_\_\_\_
- ( ) Developmental Disability, if yes who: \_\_\_\_\_
- ( ) ADHD: if yes, who: \_\_\_\_\_

**Social History:**

Please indicate if you have any concerns regarding:

- ( ) Peer Relationships
- ( ) Marital/Significant other
- ( ) Social Support Networks
- ( ) Hobbies/Interest
- ( ) Relationships with your children
- ( ) Custody issues
- ( ) Sexual Issues

If any concerns please explain: \_\_\_\_\_

What do you think are your main strengths and abilities? \_\_\_\_\_

**Legal History:**

Are currently facing any pending charges or convictions? Yes / No

If yes, what for? \_\_\_\_\_

Have you ever been arrested or spent time in prison? Yes / No

Please explain? \_\_\_\_\_

Do you currently have a probation officer? Yes / No

Name of probation officer: Phone Number: \_\_\_\_\_

**Military History:**

Were you ever in the following organizations?

- ( ) Army ( ) Air force ( ) Coast Guard ( ) Marines ( ) Navy ( ) None

Duty Status: \_\_\_\_\_ Discharge Type: \_\_\_\_\_ Rank: \_\_\_\_\_

This certifies all of the information stated above is accurate and complete to the best of my abilities.

\_\_\_\_\_  
Signature of Patient/Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Mental Health Professional

\_\_\_\_\_  
Date

## AGREEMENT FOR PSYCHIATRIC TREATMENT

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(please print clearly)

Address: \_\_\_\_\_

Home Phone#: \_\_\_\_\_ Cell Phone#: \_\_\_\_\_

The purpose of this agreement is to give you information about the medications you will be taking and to assure that you and your provider complies with all state and federal regulations concerning the prescribing of controlled substances. The provider's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the provider/patient relationship and full agreement and understanding of the risks and benefits.

1. **You should use one** provider to prescribe and monitor your psychiatric medications.
2. You should use **one** pharmacy to obtain all prescriptions and adjunctive analgesics prescribed by your provider.
3. You should inform your provider of all medications you are taking, including herbal remedies, since medications can interact with over-the-counter medications and other prescribed medications.
4. You will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment, plus usually two to three days extra. This extra medication is **not** to be used without the explicit permission of the prescribing provider unless an emergency requires your appointment to be deferred one or two days.
5. Prescriptions will be done only during an office visit or during regular office hours. **No** refills of any medications will be done during the evening or on weekends.
6. You must bring back all medications and adjunctive medications prescribed by your provider in the original bottles.
7. If your account is delinquent and payments are not made timely, treatment will be terminated.
8. **You are responsible for keeping your medication in a safe and secure place.** You are expected to protect your medications from loss or theft. Stolen medications should be reported to the police and to your physician immediately. If your medications are lost, misplaced or stolen, your physician may choose not to replace the medications.

### Medication:

1. I understand that the medication(s) being prescribed for treatment of symptoms of an emotional disorder. The use of the medication(s) at this time may benefit the conditions for which I/we seek treatment. I understand that there is no guarantee that this medication(s) will be beneficial.
2. I understand that arrangements will be made to monitor response to this medication(s) to assess its effectiveness, and it will be discontinued if it is no longer found to be necessary or effective. It will be prescribed in the dose, which is thought to be effective.
3. I understand that all medication(s) may produce side effects, and some side effects may be serious and permanent. I have received instructions regarding this medication(s) and its common and serious side effects. I understand the importance of reporting side effects and unusual reactions to provider.
4. I understand the use of this medication(s) and was given the opportunity to ask questions pertaining to the medication(s).
5. I have told the provider my medical conditions, current medications and history of reactions to medications to the best of my knowledge.
6. I understand the importance of taking this medication(s) per provider's instructions.
7. I consent voluntarily to the prescription of this medication(s) and understand that I may withdraw this consent without prejudice to further treatment.
8. The provider has discussed alternative treatment options (including no treatment).

I agree with above: \_\_\_\_\_

Signature (patient/Guardian)

\_\_\_\_\_ Date

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(please print clearly)

**Psychiatrist Communication Form**  
**Primary Care Physician**  
**Mental Healthcare Professional**

Consent to Exchange Information

I, \_\_\_\_\_, **authorize THE PSYCHIATRY & PSYCHOLOGY CENTER**

and \_\_\_\_\_  
(Primary Care Physician Name, Address & Phone Number)

and \_\_\_\_\_  
(Mental Healthcare Professional Name, Address & Phone Number)

to exchange information regarding my mental health/substance abuse treatment and medical healthcare for coordination of care purposes as may be necessary for the administration and provision of my healthcare coverage. The information exchanged may include information on mental health care or substance abuse care and/or treatment such as diagnosis and treatment plan. I understand that this authorization shall remain in effect for one year from the date of my signature below or for the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above behavioral healthcare provider. I also understand that it is my responsibility to notify my behavioral healthcare provider if I choose to change my Primary Care Physician.

\_\_\_\_\_  
Signature (parent or guardian if patient is a minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature (Provider)

\_\_\_\_\_  
Date

**Robert Garcia, MD**  
**Child, Adolescent &**  
**Adult Psychiatrist**

**Robert Zoltowski, DO**  
**Adult Psychiatrist**

**William Guy, MD**  
**Adult Psychiatrist**

**Lauren Walters PA-C**  
**Physician Assistant**

Patient Information

DSM IV Diagnosis and Code: \_\_\_\_\_

Recommended Treatment:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

A COPY OF THIS FORM MUST BE SENT TO THE PRIMARY CARE PHYSICIAN, RETAINING THE ORIGINAL IN THE PATIENT'S CHART. IF THE FORM IS SENT BY FAX, ATTACH CONFIRMATION THAT FAX WAS SENT.

DATE SENT \_\_\_\_\_ RECEIVED BY (PCP OFFICE STAFF PLEASE INITIAL) \_\_\_\_\_

Please Check Method  
Fax  Mail

Please file in Patient's chart

**GENERAL CONSENT FOR TREATMENT  
(HIPPA)**

I, the undersigned,

1. Voluntarily consent to treatment as recommended and fully explained to me by staff of The PSYCHIATRY & PSYCHOLOGY Center and understand that I am free to withdraw my consent and discontinue treatment at any time.
2. Understand that I have rights as a recipient of counseling services, that I have received a description of my rights, and that I may receive additional information about my rights from the Recipient Rights Advisor identified to me.
3. Understand that the confidentiality of records maintained by The PSYCHIATRY & PSYCHOLOGY Center is protected by 42 CRF Part 2 Federal Regulation. Program staff may not disclose any identifying information to outside sources regarding a client's treatment unless the client gives consent. Program staff may release client information without client consent under the following specific conditions:
  - Client threatens to harm self or others;
  - Suspicion of child abuse or neglect;
  - Medical personnel, to meet a bona fide medical emergency when there is immediate threat;
  - Research activities and program evaluation. Personnel may not identify directly or indirectly any individual patient in any report or otherwise disclose patient identities in any manner.
  - Management and financial audits. Examiner must furnish to the program a written statement that no record will be made of patient identifying information unless notice is provided to the program, and, if necessary, setting forth the specific purpose for which identifying information is being retained, how it is to be retained and the contact person; or
  - Authorized by court order under Sub Part E – Section 2.61 of 42 CFR Part 2.

Violation of the Federal regulation is a crime. Suspected violations may be reports to appropriate authorities in accordance with Federal regulations. Federal regulations do not protect any information about a crime committed by a client either at the program or against any person who works for the program or about any threat to commit such a crime.

4. Acknowledge that any violent or hostile behavior will result in discharge. I understand that possession of a weapon on clinic property is prohibited. I understand that I will be refused a therapy appointment on any day that I come to my a appointment intoxicated. I understand and have been advised of additional program policies regarding conditions under which I may be discharged. I further understand that I have the right to appeal this action to the clinical manager within 15 days from which it occurs.
5. Understand I am to follow through to the best of my ability in developing and achieving treatment goals/objectives, as agreed upon by my therapist and myself. I understand that if I fail to follow through on significant parts of my treatment plan, possibly resulting in harm to myself or others, my therapist may choose to refer me to a more appropriate treatment setting.

**6. PAYMENT FOR SERVICES AGREEMENT**

I understand that I have disclosed all information regarding my health insurance. I further acknowledge the insurance information to be accurate and complete. I accept the responsibility for my fees, co-pays, deductibles, charges in insurance, and for all services rendered to me. I authorize The PSYCHIATRY & PSYCHOLOGY Center to submit billing statements to my insurance carrier(s) for the purpose of receiving reimbursement for services until payment is received for all services provided to me. I further understand that I am responsible for the cost of my treatment, and that I will be billed directly if insurance claims are rejected or denied. Finally, I understand that established appointments are reserved for me, and that I may be subject to the usual and customary charge for late arrival, all appointments missed or canceled without 24 hour notice. (EXCEPTION – UNDER CMS GUIDELINES MEDICAID RECIPIENTS CANNOT BE CHARGED ANY FEES). BY SIGNING THIS FORM I ACKNOWLEDGE THAT I HAVE HAD THE OPPORTUNITY TO READ THIS FORM (OR HAVE IT READ TO ME), ASK QUESTIONS AND HAVE THESE QUESTIONS ANSWERED. ACKNOWLEDGE OF PRIVACY PRACTICES The PSYCHIATRY & PSYCHOLOGY Center Notice of Privacy Practices provides information about how protected health information About me (the patient) – including information about human immunodeficiency virus (HIV), AIDS-related complex (ARC); and acquired immunodeficiency syndrome (AIDS); and including substance abuse treatment records protected under the regulations in 42 Code of Federal Regulations, part 2, if any, and psychological and social services records, including communications made by me to a social worker or psychologist (if any) – may be used and disclosed. I have been offered an opportunity to review the Notice before signing this consent. I understand that the terms of the Notice that I may change and that I may obtain a revised copy by contacting the privacy officer listed in the Notice. I understand that I have the right to request restrictions on how my protected health information is used or disclosed for treatment, payment or health care operations. My physicians and the facility are not required to agree to this restriction, but if they agree, they will be bound by the agreement. By signing this form, I acknowledge that I have been offered and/or received the PSYCHIATRY & PSYCHOLOGY Center Health Notice of Privacy practices.

**WITH MY SIGNATURE I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS NUMBERED 1 THROUGH 6, AND THE GENERAL RELEASE OF INFORMATION.**

\_\_\_\_\_  
Client (Parent/Guardian) Signature

\_\_\_\_\_  
Date