Cheney Psychiatric Associates, LLC
3901 Faulkner Drive
Lincoln, NE 68516

Patient Name: _____ DOB: ___/___/___ Today's Date: ___/___/___
Mailing Address: _____ City: _____ State: _____ Zip: _____
Check Appropriate: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Widowed
Best Phone: _____ SSN: _____ Email: _____
By checking this box, I agree or disagree to receive SMS texts from Cheney Psychiatric, LLC at this mobile number: _____ ☐ I Agree ☐ I Disagree
Reminder Call Preference: ☐ Call/Voicemail **OR** ☐ Text ▪ Gender (must match insurance) ☐Male ☐Female
Gender Identity: ☐ Male ☐ Female ☐Transgender ☐ non-binary ☐ _____
If patient is a full-time student, name of school: _____ City/State: _____
Highest Level of Education: _____
Primary Language Spoken: _____ Race: _____ Ethnicity: _____

GUARANTOR INFORMATION

Full Name: _____ Relationship to Patient: _____
DOB: ___/___/___ Social Security Number: _____ Phone: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____

***** MINORS ONLY (18 & UNDER) *****

Mother's Name: _____ Phone: _____ Ok to Release Info ☐ Yes / ☐ No
Father's Name: _____ Phone: _____ Ok to Release Info ☐ Yes / ☐ No

Emergency Contact Name: _____ Phone: _____
Relationship with Patient: _____

Insurance Information: Do you have Medicare? ☐ Yes ☐ No ▪ Do you have Medicaid? ☐ Yes ☐ No
Insurance Company: _____ Member ID: _____ Group #: _____
Subscriber's Name: _____ Relationship to Patient: _____
Subscriber's DOB: ___/___/___ Subscriber's SSN: _____ Subscriber's Phone: _____
Do you have additional insurance: ☐Yes ☐ No (If yes, please list below)
Insurance Company: _____ Member ID: _____ Group #: _____
Subscriber's Name: _____ Relationship to Patient: _____
Subscriber's DOB: ___/___/___ Subscriber's SSN: _____ Subscriber's Phone: _____

AUTHORIZATION AND RELEASE

I certify that the information provided above is true and correct to the best of my knowledge and belief. I authorize the provider to release any information including the diagnosis and the records for any treatment or examination rendered to me or my child during the period of such care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the providers office, insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual billed services. I understand I am responsible for all co-pays, deductibles, co-insurance and balances. I understand and agree that I am ultimately responsible for any unpaid balances. I understand and agree that any cellular or landline phone numbers provided by myself to this office and to any of our service providers may be left messages for me manually and by using automatic systems such as by artificial pre-recorded voice. I also agree that this office and any service providers may contact me by sending a text message and/or email to any number or email address I provide to this office or service providers and I consent to receive such text messages and emails which may identify the name of this office or service provider sending the communication, and which may disclose the nature of the communication.

X_____ Today's Date: ___/___/___
Signature of Patient/Parent or Guardian if Minor

Patient Responsibilities

Informed Consent for Assessment and Treatment

I understand that my provider will recommend appropriate treatment based on my assessment. I may ask questions, accept or refuse treatment, and stop treatment at any time after discussing it with my provider. No specific results or outcomes are guaranteed.
My treatment information is confidential unless disclosure is required by law, including to prevent serious harm, report suspected abuse or neglect, or comply with a court order. If information is released to insurance or other authorized third parties, confidentiality cannot be guaranteed.
By signing, I voluntarily consent to behavioral health assessment and treatment, acknowledge that I understand this information, and have had the opportunity to ask questions.

Signature: _____ **Date:** _____

Informed Consent for Patient Responsibilities

By signing, you agree that:

- My provider is an independent contractor, not an employee of Cheney Psychiatric Associates.
- My provider does not handle emergencies. If I have an emergency, I will go to the nearest hospital or call 911.
- I will pay my copay at the time of my appointment.
- I will pay any remaining balance within 30 days of receiving a bill.
- I am responsible for any charges my insurance does not pay.
- It is my responsibility to verify that my insurance covers these services.
- If my insurance has a deductible, I must pay a deposit before my appointment:
    - Existing patients: $75
    - New patients: $150
- If I am not using insurance or my provider is out of network, I will complete a Good Faith Estimate form. If my provider submits a claim to my insurance, I am responsible for resolving any issues with the insurance company.
- If I provide incorrect insurance information, I am responsible for paying the bill and filing it with the correct insurance plan.
- If my balance is more than 28 days overdue and I have not made payment arrangements, I may be charged a $5 rebill fee every 30 days.
- Phone calls to my provider are for urgent concerns only and are not a replacement for an office visit. I understand I may be charged for phone calls because insurance may not cover them.

Signature: _____ **Date:** _____

Nurse Practitioner/Medication Patients

Please read each bullet point thoroughly. By signing you acknowledge you have read and accept the following terms:

- Prescription refills will be filled Monday through Thursday and can take up to 48 hours to be sent in.
- No refills will be done on Friday's, during evening hours, weekends, and holidays.
- I will contact the office to refill ADHD/Stimulant medications, all other refills will be called into the pharmacy.
- Follow-up appointments are scheduled for 20 minutes. If longer time is needed this must be requested in advance when scheduling. There may be additional charges.
- **PDMP** (Prescription drug monitoring programs) data are routinely checked for all **patients** to enhance care, and you allow us to view your external prescription history. This will provide the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

Signature: _____ **Date:** _____

Notice of Privacy Practices

I acknowledge receipt of the Notice of Privacy Practices, which explains my rights and limits on ways my provider may use or disclose personal health information to provide service.

Signature: _____ **Date:** _____

Telehealth Consent

I consent to receive healthcare through telehealth (audio/video). I understand that:

- I can stop using telehealth at any time and choose in-person care instead.
- My privacy and confidentiality will be protected.
- I will be informed who is present during my telehealth visits and may ask others to leave.
- I have read and understand this consent, and my questions have been answered.

Signature: _____ **Date:** _____

Minor Consent

Only complete this section for patients 18 and under

As a parent/legal guardian, I understand that I have the right to information concerning my minor child, except where otherwise stated. I also understand that this provider believes that providing a minor child with a private environment in which to disclose helps facilitate treatment. I therefore give permission to the provider to use his/her discretion, in accordance with professional ethics and state and federal laws, in deciding which information is shared with me.

Signature: _____ **Date:** _____

Cancellation Policy

Cheney Psychiatric Cancellation Policy

Thank you for trusting your medical to Cheney Psychiatric Associates. When you schedule an appointment with Cheney Psychiatric Associates we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for appointment. Please see our Appointment Cancelation/No Show Policy below:

- Any established patient who fails to cancel an appointment with **at least 24 hours notice** will be considered a Late Cancellation and subject to a $50.00 fee.
- Any established patient who fails to attend their appointment without contacting the office prior to their scheduled appointment time will be considered a No Show and subject to a $100.00 fee.
- Any new patient who fails to cancel their initial appointment with at least 24 hours notice or no shows will not be rescheduled.
- The fee is charged to the patient, not the insurance company, and is **due prior to rescheduling or at the time of patient's next office visit if rescheduled already.**
- Appointment reminders are a courtesy but not a guarantee. If you do not receive a reminder call or message, the above policy will remain in effect.
- Any patient may be discharged from services when a Late Cancellation or No Show occurs.
- If a patient is 10 minutes past their scheduled appointment time we will have to reschedule and the appointment will be considered a Late Cancellation/No Show.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please let staff know when cancelling as the Office Manager takes all reasons into consideration when determining if a fee will be applied.

Should you need to cancel your appointment after hours or over the weekend you can contact Cheney Psychiatric Associates by calling **ONLY** at 402-875-9270 and leave a voicemail. Cancelations received by voicemail with 24 hours notice are accepted with no penalty.

Signature: _____ **Date:** _____

3901 Faulkner Drive ~ Lincoln, NE 68516
Tel: (402) 875-9270 Fax: (402) 875-9272

Cheney Psychiatric Provider Name: _____

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please complete this form for each person you would like us to release your information to such as: Therapist, Primary Doctor, Family.

I understand the advantages/disadvantages and freely and voluntarily give permission to release information about me.

Patient Name (Last, First MI)	Date of Birth
Social Security Number	Date of Consent

Information will be disclosed to and/or exchanged with Name of Person/Facility (PCP/School/Etc.):			Reason for Disclosure: ☐Request of patient ☐Obtaining past treatment records ☐Collaboration of care ☐Legal purposes ☐Consultation and/or treatment ☐Other (specify):
Address			
City	State	Zip Code	
Tel #	Fax # / Email		

Specific information to be disclosed: ☐All records ☐Phone contact ☐Psychiatric Assessment & Update ☐Treatment Plan & Update ☐Psychosocial Assessment & Update ☐Psychological Evaluation	☐Physician's Orders ☐Substance Use Assessment ☐Medication Administration Record ☐History & Physical Examination ☐Laboratory (X-ray, EKG, EEG) ☐Discharge Summary ☐Other:

This Authorization (unless revoked earlier in writing) shall terminate 90 days from date of discharge or one year from date of signature, whichever is the latter. By signing this Authorization, I acknowledge that the information to be released MAY INCLUDE material that is protected by Federal Law and may be applicable to Drug/Alcohol related information. My signature authorizes release of all such information. I also understand this Authorization may be revoked at any time by submitting a written request and it will be honored with exception of information that has already been released. I also understand that, if the person/organization authorized to receive my information is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulation.

Patient Signature	Date
Personal Representative Signature (☐Parent ☐Guardian ☐PoA)	Date

Clinical History Form

Patient First Name: _____ Patient Last Name: _____

Date completed: _____ Age: _____

Pharmacy Name/Location: _____

Who Referred to you to this office: _____

Reason for Visit: _____

How Long Has This Been a Problem: _____

Goal for Treatment: _____

Stressors: Given the list of categories below, how much stress is each area currently causing you?

	None	Mild	Moderate	Severe
Family				
Friends				
Relationships				
Educational				
Economic				
Occupational				
Housing				
Legal				
Health				

Review of Systems

Please look at the list of physical symptoms below and check off any that you have experienced in the last several days. If you have NOT experienced any symptoms in an area, be sure to check "None of the Above" for that area.

Constitutional

- o Chronic Pain
- o Loss of Appetite
- o Increase in Appetite
- o Unexplained Weight Loss
- o Weight Gain
- o Fatigue/Lethargy
- o Unexplained Fever
- o Hot or Cold Spells
- o Night Sweats
- o Sleeping Pattern Disruption
- o Malaise (Flu-like or Vague Sick Feeling)
- o Other: _____
- o None of the Above

Eyes

- o Eye Pain
- o Eye Discharge
- o Eye Redness
- o Blurred or Double Vision
- o Visual Change
- o History of Eye Surgery
- o Sensitivity to Light
- o Scotomas (Blind Spots)
- o Retinal Hemorrhage (Floaters in Vision)
- o Amaurosis (Feeling Like a Curtain is Pulled Over Vision)
- o Other: _____
- o None of the Above

Ears, Nose, Mouth, and Throat

- o Earache
- o Tinnitus (Ringing in Ears)
- o Decreased Hearing or Hearing Loss
- o Frequent Ear Infections
- o Frequent Nose Bleeds
- o Sinus Congestion
- o Runny Nose/Post-Nasal Drip
- o Difficulty Swallowing
- o Frequent Sore Throat
- o Prolonged Hoarseness
- o Pain in Jaw or Tooth
- o Dry Mouth
- o Other: _____
- o None of the Above

Cardiovascular

- o Chest Pain
- o Pacemaker
- o Palpitations (Fast or Irregular Heartbeat)
- o Swollen Feet or Hands
- o Fainting Spells
- o Shortness of Breath with Exercise
- o Other: _____
- o None of the Above

Respiratory

- o Pain with Breathing
- o Chronic Cough
- o Chronic Shortness of Breath
- o Chronic Wheezing/Asthma
- o Excessive Phlegm
- o Coughing Blood
- o Nocturnal Dyspnea (Shortness of Breath at Night)
- o Other: _____
- o None of the Above

Eyes

- o Swelling in Joints
- o Redness of Joints
- o Other Joint Paints or Stiffness
- o Muscle Pain or Cramping
- o Muscle Weakness
- o Muscle Stiffness
- o Decreased Range of Motion
- o Back Pain or Stiffness
- o History of Fractures
- o Past Injury to Spine or Joints
- o Other: _____
- o None of the Above

Gastrointestinal

- o Excessive Flatulence or Belching
- o Diarrhea
- o Constipation
- o Persistent Nausea/Vomiting
- o Abdominal Pain
- o Other: _____
- o Heartburn
- o Difficulty Swallowing Solids or Liquids
- o Recent Loss in Appetite
- o Sensitivity to Milk Products
- o Jaundice (Yellow Skin)
- o Change in Appearance of Stool
- o Blood in Stool
- o Dark/Tarry Stool
- o Loss of Bowel Control
- o None of the Above

Allergic/Immunologic

- o Frequent Infections
- o Hives
- o Anaphylaxis Reaction
- o Other: _____
- o None of the Above

Endocrine

- o Severe Menopausal Symptoms
- o Cold or Heat Intolerance
- o Excessive Appetite
- o Excessive Thirst or Urination
- o Excessive Sweating
- o Other: _____
- o None of the Above

Hematologic/Lymphatic

- o Blood Clots
- o Easy Bleeding After Surgery or Dental Work
- o History of Blood Transfusion
- o Excessive Bruising or Bleeding
- o Swollen Glands (Neck, Armpits, Groin)
- o Other: _____
- o None of the Above

Genitourinary (General)

- o Loss of Urine Control
- o Painful/Burning Urination
- o Blood in Urine
- o Increase Frequency of Urination
- o Up More than Twice/Night to Urinate
- o Urine Retention
- o Frequent Urine Infections
- o Other: _____
- o None of the Above

Genitourinary (Women)

- o Unusual Vaginal Discharge
- o Vaginal Pain, Bleeding, Soreness, or Dryness
- o Genital Sores
- o Heavy or Irregular Periods
- o No Menses (Periods Stopped)
- o Current Pregnant
- o Sterility/Infertility
- o Any other Sexual or Sex Organ Concerns
- o Other: _____
- o None of the Above

Genitourinary (Men)

- o Slow Urine Stream
- o Scrotal Pain
- o Lump or Mass in the Testicles
- o Abnormal Penis Discharge
- o Trouble Getting/Maintaining Erections
- o Inability to Ejaculate/Orgasm
- o Any Other Sexual or Sex Organ Concerns
- o Other: _____
- o None of the Above

Neurological

- o Paralysis
- o Fainting Spells or Blackouts
- o Dizziness/Vertigo
- o Drowsiness
- o Slurred Speech
- o Speech Problems (Other)
- o Short Term Memory Trouble
- o Memory Difficulties (Loss)
- o Frequent Headaches
- o Muscle Weakness
- o Numbness/Tingling Sensations
- o Neuropathy (Numbness in Feet)
- o Tremor in Hands/Shaking
- o Muscle Spasms or Tremors
- o Other: _____
- o None of the Above

Integumentary (Skin/Breast and Hair)

- o Lesions
- o Unusual Mole
- o Easy Bruising
- o Increased Perspiration
- o Rashes
- o Chronic Dry Skin
- o Itchy Skin or Scalp
- o Hair or Nail Changes
- o Hair Loss
- o Breast Tenderness
- o Breast Discharge
- o Breast Lump or Mass
- o Other: _____
- o None of the Above

Psychiatric

- o In-Depth Review of Psychiatric System Appears Earlier in Document
- o Feeling Depressed
- o Difficulty Concentrating
- o Phobias/Unexplained Fears
- o No Pleasure from Life Anymore
- o Anxiety
- o Insomnia
- o Excessive Moodiness
- o Stress
- o Disturbing Thoughts
- o Manic Episodes
- o Confusion
- o Memory Loss
- o Other: _____
- o None of the Above

Substance Abuse History: Do You Have a History of Recreational Drug Use/Alcohol Abuse? ☐ Yes ☐ No

If Yes, Fill Out Table Below to the Best of your Knowledge:

Substance Used	Yes	No	How Often Used	Date Last Used
Amphetamines/Speed				
Barbiturates/Downers				
Opiates				
Cocaine				
Psychedelics (LSD, Ecstasy, Bath Salts, Etc.)				
Inhalants				
Cannabis				
Alcohol				
Benzodiazepines				
Tobacco				
Other:				

History: Did You Receive Any Treatment for Substance Abuse? ☐ **Yes** ☐ **No**

Please Explain Type of Treatment: _____

Consequences of Substance Abuse: Have You Experienced Any of These Consequences as a Result of Alcohol Consumption or Abuse of Substances? (Please Check All That Apply)

☐ No Consequences	☐ Effects on Physical Health
☐ Felt That You Needed to Cut Down on Drinking	☐ Using/Consuming More than Intended
☐ Been Annoyed by Others Criticizing Your Drinking	☐ Unintentional Overdose
☐ Felt Guilty About Drinking	☐ DUI
☐ Needing a Drink First Thing in the Morning	☐ Arrests
☐ Increased Tolerance	☐ Physical Fights or Assaults
☐ Withdrawal (Shakes, Sweating, Nausea, Rapid Heart Rate)	☐ Relationship Conflicts
☐ Seizures	☐ Problems with Money
☐ Blackouts	☐ Job Loss or Problems at Work/School

Mental Health History:

Prior Inpatient Treatment/Hospitalizations (for Psychiatric, Emotional, or Substance Abuse Disorder)? ☐ Yes ☐ No

Reason	Date Hospitalized	Where

Past Mental Health Providers (Therapists/Psychiatrists/Nurse Practitioners)

Name	When Treated

Past Psychiatric History: Suicide/Self Harm

Have You Ever Tried to Harm or Kill Yourself? ☐ Yes ☐ No

If Yes, Please Answer the Following Questions:

Was your Intent to Die? ☐ Yes ☐ No

How Many Times Has This Occurred? _____

What Was the Most Severe Episode & When? _____

_____

_____

When Was Your Most Recent Episode of Suicidal Thoughts or Attempts? _____

_____

Have You Had Any History of Violent Behaviors? ☐ Yes ☐ No

If Yes, Please Describe: _____

_____

Past Medical History

Are You Currently Taking Any Medications? ☐ Yes ☐ No

If Yes, Please List Name & Dose: _____

_____

_____

Do You Have Any Medication Allergies? ☐ Yes ☐ No

If Yes, Please List Medication & Reaction: _____

_____

_____

Are Immunizations Up to Date? ☐ Yes ☐ No

Primary Care Provider: _____ Date of Last Physical: _____

Family Psychiatric History

Does Anyone in Your Family Have Mental Health Illness or Substance Abuse Problems? ☐ Yes ☐ No

If Yes, Please List Who & What Their Diagnosis is (ex: Mother – History of Depression): _____

_____

_____

_____

Please Check the Following Boxes for Physical Health Problems You Have Had or Current Experience:

☐ No Problems	☐ Fibromyalgia	☐ Iron Deficiency
☐ Allergies	☐ Gall Bladder Disease	☐ Kidney Disease
☐ Anemia	☐ Gastritis/Ulcer	☐ Kidney Stones
☐ Arthritis	☐ Glaucoma	☐ Liver Disease
☐ Asthma	☐ Gout	☐ Lupus
☐ Back Problems	☐ Hearing Loss	☐ Migraine Headaches
☐ Cancer	☐ Heart Disease	☐ Multiple Sclerosis
☐ Cataracts	☐ Heart Defect from Birth	☐ Obesity or Overweight
☐ Chickenpox	☐ Heart Valve Problems	☐ Parkison's Disease
☐ Chronic Bronchitis	☐ Hemorrhoids	☐ Polyps
☐ COPD (Emphysema)	☐ Hepatitis	☐ Seizures
☐ Diabetes	☐ Hernia	☐ Sleep Apnea
☐ Diverticulitis	☐ HIV	☐ Stroke/TIA
☐ Fainting Spells	☐ Hypertension (High Bloood Pressure)	☐ Testosterone (Low)
☐ High Cholesterol	☐ Hypotension (Low Blood Pressure)	☐ Thyroid Problems
☐ Other:	☐ Inflammatory Bowel Disease	☐ Tuberculosis

Do You Have a History of Head Injury? ☐ Yes ☐ No

If Yes, Please Describe:

_____

_____

_____

_____

Please Check the Following Boxes for Past Surgical History:

☐ No Surgical History	☐ Hip/Knee/Ankle/Foot	☐ Cesarean
☐ Back/Neck	☐ Hysterectomy (Ovaries Removed)	☐ Prostate
☐ Brain/Head	☐ Hysterectomy (Ovaries Retained)	☐ Kidney Stones
☐ Cardiac	☐ Kidney	☐ Shoulder/Elbow/Wrist/Hand
☐ Ear/Nose/Throat	☐ Liver	☐ Tonsils
☐ Gall Bladder	☐ Lung	☐ Vagina
☐ Hernia	☐ Pancreas	☐ Weight Loss Surgery
☐ Pelvis	☐ Other	

Social History: Developmental and Educational

Did You Have Any Complications After Your Birth (Premature, Jaundice, Difficulty Breathing, etc.?)
☐ Yes ☐ No

Did You Have Any Delays or Difficulties in Reaching the Following Developmental Milestones?

☐ None of These
☐ Walking
☐ Talking
☐ Toilet Training
☐ Other:
☐ Sleeping Alone
☐ Being Away from Parents
☐ Making Friends

Which Options Below Best Describe Your Childhood Home Atmosphere?

☐ Normal
☐ Supportive
☐ Parental Fighting
☐ Other:
☐ Parental Violence
☐ Financial Difficulties
☐ Frequent Moving

Highest Level of Education: _____

Social History: Menstruation and Pregnancy

Do You Have Children? ☐ Yes ☐ No If Yes, Ages? _____
Do You Have Any of the Following Symptoms Prior to Menstruation?

☐ Cramping
☐ Bloating
☐ Mood Changes
☐ None of the Above

Past Psychiatric Medications (If You Have Ever Taken Any of the Following Medications, Indicate the Date, Dosage, and How Helpful They Were):

Antidepressants	Check if Taken	When?	Dosage?	Did it Help?	Side Effects?
Prozac (Fluoxetine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Zoloft (Sertraline)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Luvox (Fluvoxamine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Paxil (Paroxetine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Celexa (Citalopram)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Effexor (Venlafaxine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Cymbalta (Duloxetine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Wellbutrin (Bupropion)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Remeron (Mirtazapine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Fetzima	☐			☐ Yes ☐ No	☐ Yes ☐ No
Anafranil (Clomipramine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Pamelor (Nortriptyline)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Tofranil (Imipramine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Elavil (Amitriptyline)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Pristiq (Desvenlafaxine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Trintellix (Vortioxetine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Viibryd (Vilazodone)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Silenor (Doxepin)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Norpramin (Desipramine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Lexapro (Escitalopram)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Antipsychotics/Mood Stabilizers	**Check if Taken**	**When?**	**Dosage?**	**Did it Help?**	**Side Effects?**
Seroquel (Quetiapine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Zyprexa (Olanzapine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Geodon (Ziprasidone)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Abilify (Aripiprazole)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Clozaril (Clozapine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Haldol (Haloperidol)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Invega	☐			☐ Yes ☐ No	☐ Yes ☐ No
Latuda	☐			☐ Yes ☐ No	☐ Yes ☐ No
Risperdal	☐			☐ Yes ☐ No	☐ Yes ☐ No
Saphris	☐			☐ Yes ☐ No	☐ Yes ☐ No
Prolixin (Fluphenazine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Vraylar	☐			☐ Yes ☐ No	☐ Yes ☐ No
Rexulti	☐			☐ Yes ☐ No	☐ Yes ☐ No
Fanapt	☐			☐ Yes ☐ No	☐ Yes ☐ No
Other Medications (Specify)	**Check if Taken**	**When?**	**Dosage?**	**Did it Help?**	**Side Effects?**
	☐			☐ Yes ☐ No	☐ Yes ☐ No
	☐			☐ Yes ☐ No	☐ Yes ☐ No
	☐			☐ Yes ☐ No	☐ Yes ☐ No

Sedative/Hypnotics	Check if Taken	When?	Dosage?	Did it Help?	Side Effects?
Ambien (Zolpidem)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Sonata (Zaleplon)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Restroil (Temazepam)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Rozerem (Ramelteon)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Desyrel (Trazodone)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Lunesta	☐			☐ Yes ☐ No	☐ Yes ☐ No
Belsomra	☐			☐ Yes ☐ No	☐ Yes ☐ No
ADHD Medications	**Check if Taken**	**When?**	**Dosage?**	**Did it Help?**	**Side Effects?**
Adderall (Amphetamine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Concerta (Methylphenidate)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Ritalin (Methylphenidate)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Strattera (Atomoxetine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Vyvanse (Lisdexamfetamine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Focalin	☐			☐ Yes ☐ No	☐ Yes ☐ No
Azstarys	☐			☐ Yes ☐ No	☐ Yes ☐ No
Adzenys	☐			☐ Yes ☐ No	☐ Yes ☐ No
Antianxiety Medications	**Check if Taken**	**When?**	**Dosage?**	**Did it Help?**	**Side Effects?**
Xanax (Alprazolam)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Ativan (Lorazepam)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Klonopin (Clonazepam)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Valium (Diazepam)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Tranxene (Clorazepate)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Buspar (Buspirone)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Propranolol	☐			☐ Yes ☐ No	☐ Yes ☐ No
Neurontin (Gabapentin)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Neuroleptics	**Check if Taken**	**When?**	**Dosage?**	**Did it Help?**	**Side Effects?**
Tegretol	☐			☐ Yes ☐ No	☐ Yes ☐ No
Trileptal	☐			☐ Yes ☐ No	☐ Yes ☐ No
Lamictal	☐			☐ Yes ☐ No	☐ Yes ☐ No
Depakote	☐			☐ Yes ☐ No	☐ Yes ☐ No
Other Medications (Specify)	**Check if Taken**	**When?**	**Dosage?**	**Did it Help?**	**Side Effects?**
	☐			☐ Yes ☐ No	☐ Yes ☐ No
	☐			☐ Yes ☐ No	☐ Yes ☐ No
	☐			☐ Yes ☐ No	☐ Yes ☐ No

Social History: General

Do You Have a Support System/Who? _____

Are You: ☐ Married ☐ Significant Other ☐ Divorced (Years Married: ____) ☐ Single

What is Your Current Living Situation? ☐ Live Alone ☐ Live with Family ☐ Live with Friends

Is Spirituality/Religion Important to You? ☐ Yes ☐ No

Are You Currently Employed? ☐ Yes ☐ No

IF Yes: What is Your Occupation? _____

Have You Ever Been in the Military? ☐ Yes ☐ No

What Are Your Hobbies and Interests? _____

_____

_____

Have You Ever Been a Victim of Verbal/Emotional Abuse? ☐ Yes ☐ No

Have You Ever Been a Victim of Physical Abuse? ☐ Yes ☐ No

Have You Ever Been a Victim of Sexual Abuse? ☐ Yes ☐ No

Have You Ever Been in Trouble with the Law? ☐ Yes ☐ No

IF Yes, Please Provider Details _____

_____

_____

Are Any of the Following Symptoms Currently Present?

Recurrent Dreams of the Traumatic Event	☐ Yes ☐ No	Dizziness	☐ Yes ☐ No
Flashbacks of the Traumatic Experience	☐ Yes ☐ No	Experience Chest Pain or Discomfort	☐ Yes ☐ No
Emotional Distress When Reminded of the Traumatic Event	☐ Yes ☐ No	Feeling Things Are Not Real	☐ Yes ☐ No
Avoid Situations That Evoke Memories of the Traumatic Event	☐ Yes ☐ No	Sensations of Chills or Hot Flashes	☐ Yes ☐ No
Diminished Interest or Participation in Significant Activities	☐ Yes ☐ No	Numbness and Tingling	☐ Yes ☐ No
Feeling of Detachment or Alienation from Others Has Occurred	☐ Yes ☐ No	Trouble Interacting, Playing with or Relating to Others	☐ Yes ☐ No
Sense of Foreshortened Future	☐ Yes ☐ No	Having Little or Brief Eye Contact with Others	☐ Yes ☐ No
Being Watchful or On Edge	☐ Yes ☐ No	Not Pointing to Objects to Call Attention to Them	☐ Yes ☐ No
Startle Easily	☐ Yes ☐ No	Unusual or Repetitive Movements, Such as Hand Flapping, Spinning or Tapping	☐ Yes ☐ No
Heart Palpitations, Pounding or Fast Heart Rate	☐ Yes ☐ No	Delays in Developmental Milestones or Loss of Milestones Already Achieved	☐ Yes ☐ No
Anxiety Causing You to Tremble or Shake	☐ Yes ☐ No	Playing with a Toy in a Way That Seems Odd or Repetitive	☐ Yes ☐ No
Sensations of Shortness of Breath or of Smothering	☐ Yes ☐ No	Not Exploring Surroundings with Curiosity or Interest (a Child Seeming to be in His/Her "Own World")	☐ Yes ☐ No
Panic Attacks are Accompanied by Sensations of Shortness of Breath or Smothering	☐ Yes ☐ No	Delays in Talking	☐ Yes ☐ No

Over the Past 2 Weeks, Have You Been Bothered by the Following Problems?

Lack of Energy	☐ Yes ☐ No	Disorganization	☐ Yes ☐ No
Anger and Angry Episodes	☐ Yes ☐ No	Inattention to Tedious Tasks	☐ Yes ☐ No
Lack of Ability to Enjoy Things	☐ Yes ☐ No	Loss of Necessary Items for Tasks or Activities	☐ Yes ☐ No
Changes in Appetite	☐ Yes ☐ No	Easily Distracted	☐ Yes ☐ No
Difficulty Concentrating	☐ Yes ☐ No	Forgetfulness	☐ Yes ☐ No
Crying Spells	☐ Yes ☐ No	Fidgety	☐ Yes ☐ No
Difficulty Making Decisions	☐ Yes ☐ No	Unnecessarily Leaves Seat	☐ Yes ☐ No
Excessive Worrying	☐ Yes ☐ No	Overactive or Restless	☐ Yes ☐ No
Excessive Fatigue	☐ Yes ☐ No	Often Being Noisy	☐ Yes ☐ No
Feeling Guilty	☐ Yes ☐ No	Talks Excessively	☐ Yes ☐ No
Irritability	☐ Yes ☐ No	Blurts Out Answers	☐ Yes ☐ No
Decreased Sex Drive	☐ Yes ☐ No	Can't Wait for his/her Turn	☐ Yes ☐ No
Memory Difficulties	☐ Yes ☐ No	Interrupts	☐ Yes ☐ No
Sadness	☐ Yes ☐ No	Loss of Temper	☐ Yes ☐ No
Social Isolation/Decrease in Socialization	☐ Yes ☐ No	Often Touchy	☐ Yes ☐ No
Feelings of Worthlessness	☐ Yes ☐ No	Often Angry or Resentful	☐ Yes ☐ No
Worrying Too Much	☐ Yes ☐ No	Easily Annoyed by Others	☐ Yes ☐ No
Feelings of Increased Muscular Tension	☐ Yes ☐ No	Often Argues with Adults or People In Authority	☐ Yes ☐ No
Difficulty Sleeping	☐ Yes ☐ No	Often Spiteful or Vindictive	☐ Yes ☐ No
Attention Span is Short	☐ Yes ☐ No	Often Blames Others for his/her Mistakes or Misbehavior	☐ Yes ☐ No
Trouble Listening	☐ Yes ☐ No	Often Deliberately Annoys People	☐ Yes ☐ No
Ability to Finish a Task is Poor	☐ Yes ☐ No	Often Actively Defies or Refuses to Comply with Adults Requests or Rules	☐ Yes ☐ No

Have You Ever Experienced Periods of:

Increased Physical Activity	☐ Yes ☐ No	Increase in Sociability	☐ Yes ☐ No
Decreased Sleep and Not Feeling Tired	☐ Yes ☐ No	Talking Too Fast	☐ Yes ☐ No
Periods of Very High Self Esteem	☐ Yes ☐ No	Talking Excessively	☐ Yes ☐ No
Racing Thoughts	☐ Yes ☐ No	Highs in Mood	☐ Yes ☐ No
Increase in Sex Drive	☐ Yes ☐ No		