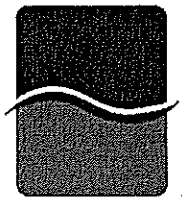


Behavioral Health of Cleveland

A SkyRidge Health Partner

2700 Westside Drive, Ste 204
Cleveland, TN 37312
Phone: 423.476.3711
Fax: 423.476.3718

Dear Patient,

Thank you for choosing Behavioral Health of Cleveland, a SkyRidge Health Partner. Please see the attached appointment confirmation for your appointment date and time.

We have enclosed directions to Behavioral Health of Cleveland for your convenience. Please bring the following to your first office visit:

- All forms in this packet **completed in full and signed.** If the patient is a minor, please complete the registration forms by listing the information of the legal guardians.
- If you are the legal guardian, please bring copies of your guardianship papers for our records.
- All insurance cards and a photo identification card. **These are both requirements to be seen. If you are unable to provide both of these at the time of service, your appointment will be rescheduled.** If you have more than one policy, please bring all cards. When completing your registration forms, please ensure you are listing the information of the policy holder if it is someone other than the patient.

Failure to arrive on time for your appointment, with the required materials, will result in your appointment being rescheduled.

If you are unable to attend your scheduled appointment, please be courteous and notify our office 24 hours in advance. If you are a new patient and you do not cancel your appointment within the required time frame or you do not show, we will not be able to reschedule you in our office.

It is your responsibility to confirm appointment coverage with your insurance carrier. If your insurance requires a referral, you must obtain this prior to your appointment from your primary care physician.

If you have questions, please do not hesitate to contact our office. Thank you for trusting us with your care.

Behavioral Health of Cleveland Staff

Behavioral Health
of Cleveland
A SkyRidge Health Partner

2700 Westside Drive Ste 204
Cleveland, TN 37312
Phone: 423.476-3711
Fax: 423.476-3718

Directions to Behavioral Health of Cleveland

From 75 North: (Chattanooga/Atlanta towards Knoxville)

- Proceed North on I-75 from Chattanooga towards Knoxville
- Take **exit 25** (Second Cleveland exit)
- Turn **left** onto 25th Street NE/Georgetown Pike
- At the first traffic light turn **left** onto Westside Drive
- Proceed **0.2 miles** down Westside Drive
- Your destination will be on the right hand side in the three-story 2700 Medical Office Building

From Dalton Pike: (Dalton, GA towards Cleveland)

- Take Dalton Pike/ TN-60N towards Cleveland
- Turn **Right** onto McGrady Drive (at Wal-Mart intersection)
- Take the 2nd right onto **TN-60 N/Apd 40** (go 5.7 miles)
- Apd 40 turns into 25th Street
- Turn **Right** at traffic light onto Westside Drive (25thstreet/Westside Drive intersection)
- Your destination will be on the right hand side in the three-story 2700 Medical Office Building

From Dayton/Rhea County: (Towards Cleveland)

- Take TN-60 until it turns into 25th Street/Georgetown Pike
- At the first traffic light (cross under interstate) turn **left** onto Westside Drive
- Proceed **0.2 miles** down Westside Drive
- Your destination will be on the right hand side in the three-story 2700 Medical Office Building

From Birmingham: (towards Knoxville)

- Merge onto I-24 towards Chattanooga then merge onto I-75 towards Knoxville
- Follow Directions above from Chattanooga towards Knoxville

Please, call 423.476.3711 with any questions.

Behavioral Health of Cleveland
A SkyRidge Health Partner

2012 Patient Registration Form

NAME: _____ MALE FEMALE

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

PRIMARY PHYSICIAN: _____ REFERRING PHYSICIAN: _____

PATIENT ADDRESS: _____

CITY: _____ STATE:TN, ZIP:_____ HOME PHONE: (___)_____

WORK PHONE: CELL PHONE:_____ E-MAIL ADDRESS: _____

EMPLOYER INFORMATION

PATIENT EMPLOYER: OCCUPATION : _____
EMPLOYER ADDRESS: _____

May we leave lab, testing results, appointment reminders and surgical procedure dates on your home answering machine?

YES NO Patient Signature: _____

SPOUSE INFORMATION:

NAME: _____ DATE OF BIRTH: _____
EMPLOYER:_____ WORK PHONE: _____

EMERGENCY CONTACT INFORMATION:

NAME: _____ HOME PHONE: _____ WORK PHONE: _____

ADDRESS: _____
Street / P.O. BOX / Apt.No City / State / Zip Code

INSURANCE INFORMATION:

WE NEED COPIES OF ALL INSURANCE CARDS IN ORDER TO FILE YOUR CLAIMS

Name of Primary Insurance: Subscriber's Name: _____
(Exact Name As Listed On the Card)

Subscriber's Social Security Number: _____ Date Of Birth: _____
(Required by All Insurance Carriers)

ADDITIONAL INSURANCE:

Name of Secondary Insurance: Subscriber's Name:_____
(Exact Name As Listed On the Card)

Subscriber's Social Security Number:_____ Date of Birth: _____
(Required by All Insurance Carriers)

ADVANCED DIRECTIVES:

It is the right of every adult citizen of Tennessee(18 years and over) to sign a Living Will, as well as a Durable Power of Attorney for Health Care that empowers an individual of your choosing to see that your wishes are carried out. It is important to decide whether or not you wish to sign a Living Will now when you are fully competent to make your own decision. The choices you make in your Living Will will be binding on doctors, hospitals and other healthcare providers in the event you become incapable of telling them your wishes. If you have signed either document, please make sure your provider has a copy for your file.

AUTHORIZATION:

I authorize CLEVELAND MEDICAL CLINIC INC. to release to my insurance company, managed care organization, state agency(ies), federal agency(ies), Health Care Financing Ad ministration, Third Party Administrators, and/or Workers' Compensation or its agents any information needed to process my claim and/or determine benefits payable for related services. I also authorize CLEVELAND MEDICAL CLINIC INC. to utilize a fax machine to transmit any or all of the above medical records pertaining to my medical care or insurance reimbursement. I acknowledge that faxing my medical records may increase the risk of accidental disclosure of my medical records.

I grant permission to CLEVELAND MEDICAL CLINIC INC. to release all or part of my medical record to any consulting entity that may be involved in my medical care. This includes, but is not limited to , testing facilities, consulting physicians, and outpatient facilities.

I request that payment of Medicare, MediGap, Traveler's Railroad Retirement, Managed Care Organization, Third Party Administrators, Commercial, Worker's Compensation, Liability, and/or any other insurance benefits be made on my behalf to CLEVELAND MEDICAL CLINIC INC. for services furnished to me or on my behalf by that provider.

Behavioral Health of Cleveland

A SkyRidge Health Partner

2012 Patient Registration Form

I understand that I am financially responsible for deductible amounts, co-payments, co-insurance amounts, non-covered charges and any and all balances not covered under a contractual write-off agreement between CLEVELAND MEDICAL CLINIC INC. and my third party payer. My carrier's failure to pay does not release me from this responsibility. I also agree that should this account be turned to collection, I will be responsible for all costs associated with debt collection, including attorney fees and court costs.

Signature of Patient _____ Date _____ Signature of Responsible Party/Insured _____

PLEASE COMPLETE THE FOLLOWING IF YOU ARE COVERED UNDER MEDICARE:

Medicare law requires that we determine if your medical services might be covered by another insurer. In order to assist us in the correct billing of these services, please answer the following questions:

Are you employed? _____ Date of Retirement _____ Is your spouse employed? _____ Date of Retirement _____

If you or your spouse is employed, please complete the health plan information on the front of this form.

MISCELLANEOUS:

Are you eligible for coverage under the Veteran's Administration? Yes No

Are you eligible for coverage under Worker's Compensation? Yes No

Is your injury/illness due to an automobile accident? Yes No

If yes, please complete the following:

Name and address of auto insurance carrier: _____

Names of Insured: _____ Policy or ID#: _____

Accident Date: _____ Accident Location: _____

IF SERVICES ARE BEING PROVIDED TO YOUR DEPENDENT, PLEASE COMPLETE THE FOLLOWING:

MOTHER'S NAME or Legal Guardian: _____ DOB: _____ SSN: _____

ADDRESS: _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE: ( ) _____ WORK PHONE: ( ) _____ CELL PHONE: ( ) _____

EMPLOYER: _____

ADDRESS: _____

FATHER'S NAME or Legal Guardian:: _____ DOB: _____ SSN: _____

ADDRESS: _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE: ( ) _____ WORK PHONE: ( ) _____ CELL PHONE: ( ) _____

EMPLOYER: _____

ADDRESS: _____

I hereby authorize, Behavioral Health of Oollewah, its physicians and staff, to render appropriate medical care to my dependent listed under patient information on the front of this form.

Signature of Responsible Party _____ Date _____

Behavioral Health
of Cleveland
A SkyRidge Health Partner
2012 Patient Registration Form

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, _____, grant permission for the person(s) listed below to have access to any and all of my medical information that pertains to my care from the physicians of this group. This includes, but is not limited to, appointment times, lab results, my physician's plans for health care, etc.
I AGREE TO NOTIFY IN WRITING, IF THERE ARE ANY CHANGES IN THE PERSON(S) AUTHORIZED.

Signature: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

NOTICE OF PRIVACY PRACTICES

Your rights under the Health Insurance Portability & Accountability Act of 1996 (HIPAA)

How Your Medical Information May Be Used and Disclosed & How You Can Get Access To This Information

If you have any questions about this notice, please contact the Facility Privacy Officer.

PLEASE REVIEW CAREFULLY.

Who Will Follow This Notice:

This notice describes the facility's practices and that of:

- Any health care professional authorized to enter information into your facility chart
- All departments and units of the facility
- Any member of a volunteer group allowed to help you while you are in the facility
- All employees, staff, agents and other facility personnel
- All entities, sites and locations within this facility's system will follow the terms of this notice. They also may share medical information with each other for treatment, payment and health care operations purposes.

Our Pledge Regarding Medical Information:

We understand that medical information about you and your healthcare is personal. We are committed to protecting medical information about you. A record is created of the care and services you receive at this facility. This record is needed to provide the necessary care and to comply with legal requirements. This notice applies to all of the records of your care generated by the facility. Your personal physician may have different policies or notices regarding the physician's use and disclosure of your medical information in the physician's office or clinic.

This notice will tell about the ways in which the facility may use and disclose medical information about you. Also described are your rights and certain obligations we have regarding the use and disclosure of medical information.

The law requires the facility to:

- Make sure that medical information that identifies you is kept private;
- Inform you of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

HOW THE FACILITY MAY USE and DISCLOSE YOUR MEDICAL INFORMATION:

The following categories describe different ways the facility uses and discloses medical information. Each category will be explained. Not every possible use or disclosure will be listed. However, all the different ways the facility is permitted to use and disclose information will fall within one of these categories.

- Treatment. Your medical information may be used to provide you with medical treatment or services. This medical information may be disclosed to physicians, nurses, technicians, or other agents of the facility who are involved in your care at the facility. Your medical information may also be disclosed to healthcare students, interns and residents.

  For example: A physician treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. The physician may need to tell the dietitian about the diabetes so appropriate meals can be arranged. Different departments of the facility may also share medical information about you in order to coordinate your different needs, such as prescriptions, lab work and x-rays. The facility also may disclose medical information about you to people outside the facility who may be involved in your medical care after you leave the facility, such as family members, home health agencies, or others used to provide services that are part of your care.

- Payment. Your medical information may be used and disclosed so that the treatment and services received at the facility may be billed and payment may be collected from you, the insurance company and/or a third party.

  For example: The health plan or insurance company may need information about surgery you received at the facility so they can provide payment for the surgery. Information may also be given to someone who helps pay for your care. Your health plan or insurance company may also need information about a treatment you are going to receive to obtain prior approval or to determine whether they will cover the treatment.

- Health Care Operations. Your medical information may be used and disclosed for purposes of furthering day-to-day facility operations. These uses and disclosures are necessary to run the facility and to monitor the quality of care our patients receive.
  For example: Your medical information may be:
  1. Reviewed to evaluate the treatment and services performed by our staff in caring for you.
  2. Combined with that of other facility patients to decide what additional services the facility should offer, what services are not needed, and whether certain new treatments are effective.
  3. Disclosed to physicians, nurses, technicians, and other agents of the facility for review and learning purposes.

Patient Label

4. Disclosed to healthcare students, interns and residents.
5. Combined with information from other facilities to compare how we are doing and see where we can improve the care and services offered. Information that identifies you in this set of medical information may be removed so others may use it to study health care and health care delivery without knowing who the specific patients are.

☒ Appointment Reminders. Your medical information may be used to contact you as a reminder of an appointment you have for treatment or medical care at the facility.

☒ Treatment Alternatives. Your medical information may be used to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

☒ Health-Related Benefits and Services. Your medical information may be used to tell you about health-related benefits or services that may be of interest to you.

☒ Individuals Involved in Your Care. With your permission, your medical information may be released to a family member, guardian or other individuals involved in your care. They may also be told about your condition unless you have requested additional restrictions. In addition, your medical information may be disclosed to an entity assisting in a disaster relief effort so your family can be notified about your condition, status, and location.

☒ Research. Under certain circumstances, your medical information may be used and disclosed for research purposes.
For example: A research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same conditions. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, balancing the research needs with the patients' need for privacy of their medical information. Your medical information may be disclosed to people preparing to conduct a research project; for example, helping them look for patients with specific medical needs, so long as the medical information they review does not leave the facility. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the facility.

☒ As Required by Law. Your medical information will be disclosed when required to do so by federal, state, or local authorities, laws, rules and/or regulations.

☒ Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, your medical information will be disclosed in response to a court or administration order, subpoena, discovery request, or other lawful process by someone else involved in the dispute when we are legally required to respond.

☒ Law Enforcement. Your medical information will be released if requested by a law enforcement official:
- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

☒ National Security and Intelligence Activities. Your medical information will be released to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

☒ Protective Services for the President and Others. Your medical information may be disclosed to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

☒ To Alert a Serious Threat to Health or Safety. Your medical information may be used and disclosed when necessary to prevent a serious threat to your health and safety and that of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

☒ Health Oversight Activities. Your medical information may be disclosed to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

SPECIAL SITUATIONS:

☒ Organ and Tissue Donation. If you are an organ or tissue donor, your medical information may be released to organizations that handle organ procurement or organ, eye and tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

☒ Military and Veterans. If you are a member of the armed forces, your medical information may be released as required by military command authorities. If you are a member of the foreign military personnel, your medical information may be released to the appropriate foreign military authority.

Patient Label

- Workers' Compensation. If you seek treatment for a work-related illness or injury, we must provide full information in accordance with state-specific laws regarding workers' compensation claims. Once state-specific requirements are met and an appropriate written request is received, only the records pertaining to the work-related illness or injury may be disclosed.
- Public Health Risk. Your medical information may be used and disclosed for public health activities. These activities generally include the following:
  - To prevent or control disease, injury or disability;
  - To report births and deaths;
  - To report child abuse or neglect
  - To report reactions to medications or problems with products;
  - To notify people of recalls of products they may be using;
  - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
  - To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- Coroners, Medical Examiners, and Funeral Directors. Your medical information may be released to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the facility to funeral directors as necessary to carry out their duties.
- Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the following reasons:
  - For the institution to provide you with health care;
  - To protect the health and safety of you and others;
  - For the safety and security of the correctional institution.

ADDITIONAL SITUATIONS:

- Other Uses of Medical Information. Other uses and disclosures of medical information not covered by this notice or the laws that apply to this facility will be made only with your written permission. If you provide the facility permission to use or disclose your medical information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your medical information for the reasons covered in your written authorization. You understand that we are unable to take back any disclosures already made with your permission, and that we are required to retain our records of the care that the facility provided to you.

ADDITIONAL INFORMATION CONCERNING THIS NOTICE:

- Changes To This Notice. We reserve the right to change this notice and make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. The facility will post a current copy of the notice with the effective date. In addition, each time you register at, or are admitted to, the facility for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.
- Complaints. You will not be penalized for filing a complaint. If you believe your privacy rights have been violated, you may file a complaint with the facility or with the Secretary of the Department of Health and Human Services. To file a complaint with the facility, contact the Facility Privacy Officer. All complaints must be submitted in writing.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

You have the following rights regarding medical information the facility maintains about you:
*** NOTE: All Requests Must Be Submitted In Writing to the Facility***

- Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care.

  To inspect and copy medical information or to receive an electronic copy of the medical information that may be used to make decisions about you, you must submit a written request.

  If you request a paper copy of the information, we may charge a fee for the cost of copying, mailing or other supplies associated with your request.

  If the facility uses or maintains an electronic health record with respect to your medical information, you have the right to obtain an electronic copy of the information if you so choose.

  - You may direct the facility to transmit the copy to another entity or person that you designate provided the choice is clear, conspicuous, and specific.
  - The facility may charge a fee equal to its labor cost in providing the electronic copy.

  We may deny your request to inspect and copy in some limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional, other than the person who denied your request, will be chosen by the facility to review your request and the denial. The facility will comply with the outcome of the review.

Patient Label

- A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person.
- The protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person.
- The request for access is made by the individual's personal representative, and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person.

☐ Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment to information kept by or for the facility. Except where individual state laws are more stringent, this facility has a minimum of 60 days to act on your request.

To request an amendment, your must submit a written request. You must also provide a reason that supports your request. Your request for an amendment may be denied if:

- Your request is not in writing or does not include a reason to support the request;
- The medical information was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- The medical information is not part of the medical information kept by or for the facility;
- The medical information is not part of the information you would be permitted to inspect and copy; or
- The medical information is accurate and complete.

☐ Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of your medical information for purposes other than treatment, payment and health care operations. Except where individual state laws are more stringent, this facility has a minimum of 60 days to act on your request.

To request this list or accounting of disclosures:

- You must submit your request in writing.
- Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003.
- Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

☐ Right to Request Restrictions. You have a right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member.

To request restrictions, you must make your request in writing. In your request, you must tell us:

- What information you want to limit;
- Whether you want to limit our use, disclosure or both;
- To whom you want the limits to apply, for example, disclosures to your spouse.

You also have a right to request that a health care item or service not be disclosed to your health plan for payment purposes or health care operations. We are required to honor your request if the health care item or service is paid out of pocket and in full. This restriction does not apply to use or disclosure of your health information related to your medical treatment.

☐ Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
For example: You can ask that we only contact you at work or by mail.
To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

☐ Right to a Paper Copy of This Notice. You have the right to a copy of this notice. You may ask us to give you a copy at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

I hereby acknowledge that I have been provided with a copy of this facility's Notice of Privacy Practices.

Patient's Signature or Legal Representative	Date	Time
Relationship to Patient	Interpreter, if utilized	
Witness Signature	If Telephone Consent, Second Witness' Signature	

Patient Label

Electronic Prescribing Notice

What is electronic prescribing? Why does your provider E-Prescribe?
E-Prescriptions, or Electronic Prescriptions, are computer-generated prescriptions created by your provider and sent directly to your pharmacy. Your provider participates in E-prescribing because he/she cares about your health and wellbeing and E-prescribing has multiple safety benefits.

How does E-Prescribing work?
Instead of writing out your prescription on a piece of paper, your provider enters it directly into the computer. Your prescription travels from your provider's computer to the pharmacy's computer. E-prescriptions are sent electronically through a private, secure, and closed network, so your prescription information is not sent over the open Internet or as e-mail. Your e-prescription arrives at the pharmacist's computer faster and may help to save you time. The e-prescription can be sent to the pharmacy you choose. If you do not want your prescription sent electronically, or your pharmacy does not accept e-prescriptions, your provider can print your prescriptions for you.

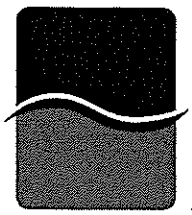
Privacy
The privacy of your personal health information contained in all your prescriptions, whether written or electronic, is protected by a federal law and state laws. The federal law is the Health Insurance Portability and Accountability Act (HIPAA). HIPAA requires that your personal health information be shared for treatment, payment, and healthcare operations. E-prescriptions meet this requirement.

Behavioral Health of Cleveland

Patient Consent for E-Prescribing (Electronic Prescribing)

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

Parent, Patient's Signature or Authorized Representative	Date	Time
Relationship to Patient	Interpreter, if utilized	
Witness' Signature		



Behavioral Health of Cleveland

A SkyRidge Health Partner

Patient Contact Information

Patient Name _____
Date of Birth _____
Primary Care Physician _____
Referring Physician _____

Reason for Referral: _____
_____

Have you previously been under the care of a psychiatrist? Yes or No (If yes, please list): _____
_____

Are you currently seeing a therapist? Yes or No (If yes, please list name and contact #):
_____

Are you currently under the care of pain management? Yes or No (If yes, please list name and contact # for the treating physician): _____
_____

Do you use drugs? Yes or No (If yes, please list drug name(s), frequency of use and date of last use): _____
_____

Education/Employment History

Highest grade completed: _____
Are you currently a student? Yes or No (If yes, please list name of school and grade):
_____
Do you have a history of in/out of school suspension? Yes or No
Are you employed? Yes or No

Legal History

Do you have a history of legal trouble? Yes or No
Are you on probation? Yes or No

Social History

Who do you live with? _____
Please list behaviors of concern at home: _____
_____
Please list behaviors of concern at school: _____
_____
Please list behaviors of concern socially: _____
_____

Have you been treated for any of the following (please check all that apply)?

___Depression	___ADHD	___Bipolar (Manic/Depressive) D/O
___Anxiety	___OCD	___Schizophrenia
___Panic Attacks	___PTSD	___Alcohol/Drug Dependency
___Anorexia/Bulimia	___Binge-Eating	___ECT Treatment

___Other_____

Inpatient Psychiatric Treatment (please list all prior psychiatric hospitalizations (if any) below:

Date	Length of Stay	Name of Hospital	Reason for Admission

Have you ever attempted to harm/kill yourself? If so, please list below:

Approximate date of attempt	How did you attempt (method)?

Please list ALL current medications:

Name of Medication	Dosage	Side Effects (if any)	Prescribing Physician

Please list ALL previous psychotropic medications:

Name of Medication Dosage Side Effects Reason for Discontinuing Use

_____

_____

_____

Medical History (please check all that apply)

___High Blood Pressure	___GI Problems	___Cancer
___Lung Disease	___Arthritis	___Genital Problems
___Diabetes	___Hepatitis/Liver Damage	___Eating D/O
___Heart Disease	___Endocrine/Hormone Problems	___Eye Problems
___Thyroid Disease	___Neurological Problems	___Chronic Pain
___Anemia	___HIV/AIDS	___Head Injury
___Asthma	___UTI/Kidney Problems	___Fibromyalgia
___Skin Disease	___Migraines/Headaches	___Lupus
___Seizures	___Ear/Nose/Throat Problems	___Sleep Apnea
___High Cholesterol	___Gynecological Problems/Hysterectomy	

___Other Medical Issues (please list) _____

List all prior surgeries and hospitalizations for medical illnesses: _____

_____

Are you allergic to any medication or food? If so, please list below:

_____

Family Psychiatric History

	Father	Mother	Aunt	Uncle	Siblings	Children	Other
Depression							
Anxiety							
Panic Attacks							
PTSD							
Bipolar D/O							
Schizophrenia							
Alcohol/Drug Dependency							
ADHD							
Suicide Attempts/Completion							
Inpatient Psychiatric Care							
Other							