NEW PATIENT PACKET

Cedar Park Psychiatry, PLLC

Welcome to Cedar Park Psychiatry! We are glad you have come to us for help. Dr. Arlinghaus and her staff are dedicated to providing you the highest quality psychiatric care with meticulous attention to your comfort and privacy in an environment that fosters security and trust. We appreciate in advance the time you will spend in completing the documents below.

In order to optimize the time spent during initial evaluation, please return the following to our office as soon as possible prior to your appointment (if you prefer to discuss/review this information in person with Dr. Arlinghaus, that is fine as well).

At the time of your initial appointment, please bring with you:

- this completed packet of contact information, signed consents, and clinical information forms
- any mental health records or other medical records that you have which may be relevant
- a government issued photo ID

Name_____ Date of Birth: _____Age: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____May we leave a message? _____

Cell Phone: _____ May we leave a message? _____

Work Phone: _____ May we leave a message? _____

Emergency Contact: _____Relationship: _____Phone: _____

How were you referred to us? _____

Primary Care Physician: _____

Phone Number: _____Date of last visit: _____

What pharmacy do you prefer? _____

Street address/City_____

Marital Status: ☐ Single ☐ Married ☐ Same Sex Partner ☐Significant Relationship ☐ Separated ☐Divorced ☐ Widowed

Name of Spouse/Partner: _____

Name(s) and age(s) of Children: _____

_____

Are you involved in any kind of legal matter or investigation? If so, please describe. _____

_____

*The Health Insurance Portability and Accountability Act of 1996

OFFICE POLICIES AND PROCEDURES

Cedar Park Psychiatry, PLLC

WELCOME

The following information is provided for you as a resource outlining our office policies. We strive to provide state-of-the-art, patient-centered psychiatric care supported by privacy-protected cutting edge-technology and outstanding customer service. I hope this information will answer most questions you might have about my practice. For more information about the practice, please visit our website at www.cedarparkpsychiatry.com.

OFFICE HOURS

Monday-Thursday	10 am-7pm
Friday	9 am-1pm

APPOINTMENTS

Patients are seen by appointment only. I make an effort to keep appointments running on schedule. Please be aware that emergencies occasionally arise which may cause unexpected delays. If this occurs, we will make an effort to notify you prior to your appointment. We ask that you help us by being on time for your appointment and by calling if you will be late or unable to keep your appointment. Due to the nature of our practice, we ask that you do not bring children or minors to the office.

Following an initial assessment period which can range from approximately one to three sessions, we can decide if we are "a good fit" and determine if I can provide the services you need. The frequency and scheduling of appointments will be determined during this evaluation period.

CONTACTING OUR OFFICE

Please call the office if you have any questions about your appointment, medications, or treatment. My office manager will answer the questions, if possible. If she is unable to do this, I will return your call. Any messages left on our voicemail will be answered by the next business day. If you need to contact me outside of our business hours please follow the instructions on our telephone greeting.

EMERGENCY CARE

In the event of a true emergency, it is best to call 911 or go to a hospital emergency room. The physician on duty can assess the problem, begin treatment, and call me.

If you have an urgent psychiatric problem, please call the office (512) 593-5577 and specify that you need to contact me urgently. If you reach voicemail, rest assured that my internet phone service routes all messages immediately to my cell phone and the cell phone of my office manager. I will call you back promptly. If I am unavailable due to illness or personal/business travel, arrangements will be made for alternate coverage by a qualified provider.

PROFESSIONAL FEES

The fees for my services are $300 for the initial evaluation appointment, $250 for a focused medication evaluation, $225 for 45 minute psychotherapy/medication management sessions, and $150 for 30 minute medication management appointments. Special consultations vary in cost depending on the time spent. **No show for appointments or cancellation without 24-hour notice will be charged at the regular session rate.** If you arrive late to your appointment, the time for your session will be reduced accordingly. Due to the time required for preparation, all forms, letters, and reports require payment of $50 in advance, unless the length or complexity of the documentation warrants a higher fee. A complete fee schedule is available on my website at www.cedarparkpsychiatry.com. If you have a question about my fees, please discuss with me.

BILLING AND PAYMENTS

Payment is expected at the time of service. We gladly accept cash, debit, or credit (MasterCard, VISA, Discover) for all patients and checks for established patients only. A receipt and/or insurance statement will be provided at the time of service. Reimbursement for out-of-network benefits will be your responsibility but we will assist you in any way we can. Overdue charges will incur a 5% compounding monthly fee. A **$35.00** service charge will be added to your account for all returned checks. You will be responsible for a **$50** collection fee if your account is turned over to collections due to non-payment.

PRESCRIPTIONS

You may receive a prescription the day you are here. You will generally not be given another prescription before seeing me again. Please take your medication as directed and keep up with your quantity. Please be sure you have enough to last until your next appointment. At times our office may call to reschedule an appointment. If we should call you, please check your medications to be sure you have enough to last until the date you return. Your medication is important and we do not want you to run out as this could be medically dangerous and sometimes life-threatening. It may take up to 24 hours from the time of your call to get your prescription refilled (48-72 hours on Fridays or holiday weekends).

PROFESSIONAL RECORDS

The law and standards of the mental health profession require that I keep treatment records. You are entitled to have access to your records. I can also prepare a summary for you if needed. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, it is recommended that you review them with me so that we can discuss the contents. Certain requests for information will incur a fee depending on the professional time spent responding to your request.

CONFIDENTIALITY

In general the law protects the privacy of all communications between a patient and a mental health professional, and this office can only release information about you and your treatment to others with your written permission. There are some exceptions including the following:

- In some legal proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

- I may be obligated to take action in a situation where I have to protect others from harm. For example, if I believe a child, elderly person, or disabled person is being abused or neglected, I must file a report with the appropriate state agency.

- If a patient threatens to harm himself/herself or others, I may be obligated to arrange hospitalization for him/her or contact family members or others who can help provide protection. This rarely occurs, however, if it does, I will make a good faith effort to fully discuss it with you before taking any action.

DOCTOR/PATIENT RELATIONSHIP

I make a special effort to explain all aspects of your problem and treatment. However, if something is not clear, please do not hesitate to ask. I respect professional boundaries at all times and practice in accordance with the highest of ethical principles and standards. If you have any suggestions or concerns, please feel free to discuss with me.

TERMINATION OF THE DOCTOR/PATIENT RELATIONSHIP

If you are contemplating terminating our relationship, please inform me in advance. Although difficult, talking about termination can uncover key issues in your treatment and facilitate great progress; dropping out of treatment without discussion is a lost opportunity. If you have concerns, please feel free to bring them to my attention so that we can address them. A good rule of thumb in psychotherapy is trying hard to talk about the things that feel too scary or painful or embarrassing to discuss…these are often the things that lead to the most progress when one has the courage to face them and work through them within the safety of your doctor's office.

Under certain circumstances I will assume that you have decided to terminate our relationship. If you fail to show up for a scheduled appointment and do not contact our office within 30 days, or if you do not schedule a follow up appointment within 6 months of your last scheduled appointment, I will assume that you have decided to terminate our relationship.

Under certain circumstances I may decide to terminate our relationship. This is a rare occurrence but is important when an unexpected conflict of interest arises or if I believe you would be better served by a different provider. This decision will only be reached after careful consideration and discussion with you. Written notification will be provided.

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Thank you for reviewing this important document. If you have questions about any of these policies or procedures, please discuss with me or refer to our website www.cedarparkpsychiatry.com for more comprehensive information.

NOTICE OF PRIVACY PRACTICES FOR CEDAR PARK PSYCHIATRY, PLLC

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this notice please contact:

Kimberly Arlinghaus, MD |1464 E. Whitestone Blvd. Suite 1504 |Cedar Park, TX 78613

Phone 512-593-5577 |Fax 512-593-5565

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our staff and other office personnel.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment

We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy and scheduling lab work. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

For Payment

We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations

We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you.

Appointment Reminders

We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law

We will disclose health information about you when required to do so by federal, state or local law.

Military, Veterans, National Security and Intelligence

If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities

We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement

We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors

We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable

We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends

We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization.* If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization,* in writing, at any time. If you revoke your *Authorization,* we will no longer use or disclose information about you for the reasons covered by your written *Authorization,* but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization from you that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to **Dr. Kimberly Arlinghaus.** in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If

such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend

If you believe health 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 as long as the information is kept by this office.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.

b) Is not part of the health information that we keep.

c) You would not be permitted to inspect and copy.

d) 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 medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to **Dr. Kimberly Arlinghaus**. It must state a time period, which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). 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 the right to request a restriction or limitation on the health 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 health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit *a Request for Restricting Uses and Disclosures and Confidential Communications Form* to **Dr. Kimberly Arlinghaus**.

Right to Request Confidential Communications

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 may complete and submit *the Requests for Restricting Uses and Disclosures and Confidential Communications* to **Dr. Kimberly Arlinghaus**. 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 paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact **Dr. Kimberly Arlinghaus**.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to 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. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, please contact **Dr. Kimberly Arlinghaus** at 512-593-5577. You will not be penalized for filing a complaint.

CONSENT AND AUTHORIZATION FORM

Please initial next to each acknowledgement then sign and date below.

_____ Acknowledgement of Receipt of Office Policies and Procedures
By signing this form you are agreeing that you have received a copy of our Office Policies and Procedures and agree to follow our policies as outlined in the document.

_____ Acknowledgement of Receipt of Privacy Notice
By signing this form you are agreeing that you have received a copy of the Privacy Notice for this office, which describes how we use and disclose your health information. You have the right to refuse to sign this acknowledgement, in which case we must document our good faith effort to obtain acknowledgement and the reason why it was not obtained.

_____ Acknowledgement of Financial Responsibility
I understand that I am financially responsible for all charges including missed appointments and appointments cancelled without giving 24 hour notice.

I have read and understand these statements.

_____ _____
Signature of patient/guardian Date

Authorization to exchange information with primary care provider/therapist/other health care provider
I give consent for information regarding my diagnosis(es) and treatment to be shared with my therapist, primary care provider, referring physician or other health care provider as follows:

Primary Care Provider (as previously listed above) Yes No (please circle)

Therapist: Name _____ Phone _____

Referring physician/provider: Name _____ Phone _____

Other provider: Name _____ Phone _____

_____ _____
Signature of patient/guardian Date

Authorization to communicate with third parties

You have the right to request that we restrict how protected health information about you is used or disclosed. Most patients have family members or friends that occasionally become involved in their care. (For example, your spouse calls to confirm your appointment time; OR your adult child calls with questions about your medications.) Please list any restrictions to the information we can communicate about you with those you have listed below. (Example: Appointments only, financial matters only; Medications Only, etc. If there are no restrictions, please list "NONE" beside their name).

Please list below any persons you will allow us to talk with about you. (If you prefer we do not speak with anyone, please write "NO ONE" across this section.

Name	Relationship	Phone Number	Restrictions (as defined above)

I understand that I have the right to revoke this authorization in writing at any time. I request that my confidential information be handled in the manner listed above and authorize Cedar Park Psychiatry staff to disclose information only to those individuals listed above and in the manner stated for oral and written communications. Any other release of information will require a signed authorization for Release of Medical Information.

_____ _____

Signature of patient/guardian Date

****

This consent and authorization form will remain in effect for the duration of my treatment unless revoked by me in writing and may not be revoked as to services rendered prior to my notice of revocation. A photocopy of this consent and authorization form is to be considered as valid as an original.

_____ _____

Signature of patient/guardian Date

CLINICAL INTAKE FORM

Please describe the reason(s) you are seeking psychiatric evaluation and what problems bring you to our office _____

_____

_____

_____

Please check all stressors you are experiencing currently:

□ Economic/Financial	□ Education/School	□ Relationship problem	□ Grief/Loss
□ Legal Problems	□ Medical Illness	□ Work	□ Living Situation
□ Social Environment	□ Extended Family Conflict	□ Unemployment	□ Family Disruption due to divorce or separation

Other stress(es)_____

Do you experience any of the following psychiatric or neurological symptoms? If so, please check/circle any that apply.

Depression, sadness, decreased interest or apathy, change in appetite or weight, change in sleep, nervousness or anxiety, panic, thoughts of suicide, poor concentration, loss of memory, too happy or energetic, mood swings, racing thoughts, pressured speech, hyperactivity, confusion, hearing voices, seeing things, paranoid thoughts, irritability, excessive anger, crying spells, nightmares, flashbacks, thoughts of killing another person, counting things, checking things, afraid of germs, afraid to touch doorknobs, washing hands more than 10 times daily, taking more than 2 baths or showers daily, anorexia, bingeing or purging, seizures, blackouts, numbness, tingling, headaches, weakness, balance problems, shaking, abnormal movements

Other symptoms _____

Please list all known mental health problems/diagnoses _____

_____

_____

_____

If you have seen a psychiatrist before, who was the last one you saw and where was he/she located? _____

_____

Why did you stop seeing your last psychiatrist? _____

If you are currently seeing, or have previously seen a counselor or therapist, what is her/his name and where is she/he located? _____

If you stopped seeing your last therapist, why did you stop? _____

Physical health history: Please check all that apply.

□ Glaucoma	□ Anemia	□ Arthritis
□ Asthma	□ Back Pain (Chronic)	□ BPH (enlarged prostate)
□ Cancer (type)	□ COPD/Emphysema/Bronchitis	□ Diabetes □ Type I □ Type II
□ Abnormal heart rhythm	□ Fibromyalgia	□ Stomach problems
□ Gout	□ Hearing Loss	□ Heart Disease
□ Hepatitis	□ Drop attacks/fainting	□ High Cholesterol
□ HIV	□ Blood pressure ___high ___low	□ Encephalitis/meningitis
□ Thyroid Disease ___under ___overactive	□ Multiple sclerosis	□ Irritable Bowel Syndrome
□ Kidney Disease	□ Kidney Stones	□ Liver Disease
□ Lupus	□ Migraine Headaches	□ Obesity
□ Dementia	□ Seizure Disorder	□ Sleep Apnea
□ Sexually Transmitted Disease	□ Stroke/TIA	□ Testosterone (Low)
□ Traumatic Brain Injury	□ High childhood fevers	□ Other brain disease/disorder

Other medical illness(es)_____

Have you ever received medications for emotional or sleep problems from a primary care doctor? _____

For women, method of contraception, if applicable_____ Last menstrual period_____

Number of pregnancies _____ Premenstrual depression? _____Postpartum depression? _____

Have you ever tried to take your life? If so, how, when, # of times? _____

_____

Do you have guns in your home? □ Yes □ No

Have you ever intentionally cut, burned, or otherwise harmed yourself in order to decrease emotional pain? If so, please describe _____

Past Psychiatric Hospitalizations (year, reason) _____

_____

Past outpatient psychiatric treatment not already listed above _____

_____

_____

Past counseling or psychotherapy not already listed above _____

_____

_____

Childhood development problems or problems during your mother's pregnancy or birth? _____

_____

Past surgeries_____

What psychiatric/psychological treatment(s) have helped you the most? _____

_____

What kind of help do you want or need at your first appointment? _____

_____

What are the goals that you would like to work toward with the help of psychiatric treatment? _____

_____

_____

Medications: please list all medications, over the counter drugs, vitamins, minerals, supplements, herbs, etc. that you take regularly:

Medication/Vitamin/Supplement/Herb	Strength	How Often

Allergies: please list any drug and/or non-drug allergies you have:

Family History: Has anyone in your family ever been treated for psychiatric condition or substance abuse (blood relative)?

□ **Yes** □ **No**

□ Family History is unavailable

Family Member	Type of Problem
□ Mother	
□ Father	
□ Brother	
□ Sister	
□ Son	
□ Daughter	
□ Maternal Grandmother	
□ Maternal Grandfather	
□ Paternal Grandmother	
□ Paternal Grandmother	
□ Aunt	
□ Uncle	
□ Other?	

Please list any stressful or traumatic events in your life that affected your ability to function or caused you significant distress.

_____

_____

Who are the people in your life you can depend on for help or support when you need it? _____

_____

How many serious relationships/partnerships/marriages have you had? _____

List the members of your current household _____

_____

_____

Religion, if applicable _____

Do you have a history of Substance Use? □ Yes □ No

If yes, please complete the table below.

Type of Substance Used	Year(s) Used/For How Long?	Amount Used/How Often?
□ Beer/liquor		
□ Marijuana		
□ Adderall, Ritalin, prescribed stimulant		
□ Prescription pain pills		
□ Xanax, Klonopin, Ativan, Valium		
□ Cocaine		
□ Ecstasy		
□ Methamphetamine/other type of speed		
□ Heroin		
□ Spice/K2/Bath salts		
□ Other illegal drug _____		
□ Other prescribed drug _____		

Have you ever used IV drugs? If so, please describe _____

Have you experienced any of the following as a result of your drug or alcohol use?

□ Arrests/DUI/PI	□ Consuming more than intended	□ Blackouts
□ Employment Issues	□ Financial problems	□ Feeling guilty
□ Fighting	□ Health Problems	□ Increased Tolerance
□ Unintentional Overdose	□ Legal problems	□ Seizures
□ Attempt to cut down use	□ Needing a morning drink/drug to function	□ Withdrawal symptoms

List any other consequences not listed above _____

_____

Caffeine use (coffee/tea/soda/energy drinks per day) _____

Tobacco use (current or past cigarette smoking or smokeless tobacco, amount) _____

_____

Education History

□ Currently in school	□ Less than a high school education	□ Graduated from high school
□ GED Obtained	Highest grade completed?	□ Associates Degree
□ College Degree	□ Some College	□ Doctoral Degree
□ Technical Degree	□ Master's Degree	Other certification:

Any problems in school (hyperactivity, discipline, learning)? _____

_____

Employment History

Current employment status

□ Full-time □ Part-time □ Unemployed □ Retired □ Disabled □ Homemaker

Name of Employer:_____

How long at your current job? _____

Occupation:_____

Military History (branch, time of service, combat, wounded, Article 17(s), honorable/dishonorable discharge, service connection) _____

_____

_____

Legal History

Have you ever been arrested, jailed, or imprisoned? If so, for what reason and for how long? _____

_____

Have you ever had a restraining order or emergency protective order filed against you? If so, please describe ___

_____

Have you ever been charged with spouse abuse, child/elder abuse or neglect, or terroristic threatening? If so, please describe _____

Have you ever been party to a lawsuit? If yes, defendant or plaintiff? Please describe _____

_____

Have you ever filed a workers compensation claim? If yes, please describe. _____

_____

Have you ever filed bankruptcy? If so, when? Please describe_____

_____

COMMON PSYCHIATRIC MEDICATIONS

Please indicate what medications you've tried (if not already mentioned in your history above) and anything you remember about its effect (helped, none, worse); problematic side effects; the highest dose you recall taking; and when and for how long you took it.

Antidepressants

SSRIs

- □ Celexa (citalopram)
- □ Lexapro (escitalopram)
- □ Luvox (fluvoxamine)
- □ Paxil (paroxetine)
- □ Pexeva (paroxetine mesylate)
- □ Prozac (fluoxetine), Sarafem (premenstrual dysphoric disorder)
- □ Zoloft (sertraline)

SNRIs

- □ Cymbalta (duloxetine)
- □ Effexor (venlafaxine)
- □ Fetzima (levomilnacipram)
- □ Pristiq (desvenlafaxine)

Heterocyclics/Others

- □ Brintellix (vortioxetine)
- □ Desyrel (trazodone)
- □ Remeron (mirtazapine)
- □ Serzone (nefazodone)
- □ Wellbutrin (bupropion)
- □ Viibryd (vilazadone)

Tricyclics

- □ Anafranil (clomipramine)
- □ Elavil (amitriptyline)
- □ Ludiomil (maprotiline)
- □ Norpramin (desipramine)
- □ Pamelor (nortriptyline), Aventyl
- □ Sinequan (doxepin)
- □ Surmontil (trimipramine)
- □ Tofranil (imipramine)
- □ Vivactil (protriptyline)

MAOIs

- □ Emsam (selegiline)
- □ Nardil (phenelzine)
- □ Parnate (tranylcypromine)

Antianxiety Drugs

Addictive Medications

- □ Ativan (lorazepam)
- □ Klonopin (clonazepam)
- □ Librium (chlordiazepoxide)
- □ Serax (oxazepam)
- □ Tranxene (clorazepate)
- □ Valium (diazepam)
- □ Xanax (alprazolam)

Non-addictive Medications

- □ BuSpar (buspirone)
- □ Neurontin (gabapentin)
- □ Vistaril (hydroxyzine), Atarax

Anti-manic Agents (Mood Stabilizers)

- □ Lithium, (lithium carbonate), Eskalith, Lithobid

Anti-seizure/Mood Stabilizers

- □ Depakote, Depakene (valproic acid, sodium divalproex), Depakote sprinkles
- □ Lamictal (lamotrigine)
- □ Tegretol (carbamazepine)
- □ Topamax (topiramate)
- □ Trileptal (oxcarbazepine)

Antipsychotic/Mood Stabilizers

- □ Abilify (aripiprazole)
- □ Clozaril (clozapine)
- □ Geodon (ziprasidone)
- □ Latuda (lurasidone)
- □ Risperdal (risperidone)
- □ Seroquel (quetiapine)
- □ Zyprexa (olanzapine)

Combination antipsychotic and antidepressant

- □ Symbyax (Zyprexa and Prozac)

Antipsychotics

Atypical, newer antipsychotics

- □ Abilify (aripiprazole)
- □ Clozaril (clozapine)
- □ Fanapt (iloperidone)
- □ Geodon (ziprasidone)
- □ Invega (paliperidone)
- □ Latuda (lurasidone)

- Risperdal (risperidone)
- Seroquel (quetiapine)
- Zyprexa (olanzapine)

Other new antipsychotics

- Saphris (asenapine)

Typical, older antipsychotics

- Haldol (haloperidol)
- Haldol Decanoate (long acting injectable)
- Loxitane (loxapine)
- Mellaril (thioridazine)
- Moban (molindone)
- Navane (thiothixene)
- Orap (pimizide)
- Perphenazine (trilafon)
- Prolixin (fluphenazine)
- Serentil (mesoridazine)
- Stelazine (trifluoperazine)
- Thorazine (chlorpromazine)

Combination antipsychotic and antidepressant

- Symbyax (Zyprexa and Prozac)

Sleep Medication

Addictive, newer agents

- Ambien (zolpidem, ER), Intermezzo (zolpidem SL)
- Lunesta (eszopiclone)
- Prosom (estazolam)
- Sonata (zaleplon)

Addictive, older agents

- Dalmane (flurazepam)
- Halcion (triazolam)
- Placidyl (ethchlorvinol)
- Restoril (temazepam)
- Somnote (chloral hydrate)

Non-addictive agents

- Benadryl
- Rozerem (ramelteon)
- Vistaril, Atarax (hydroxyzine)

Smoking Cessation

Chantix (varenicline)

Zyban (bupropion)

Stimulants and other ADHD Medications

Addictive stimulants

- □ Adderall (amphetamine, mixed salts, XR)
- □ Concerta (methylphenidate, long-acting)
- □ Cylert (pemoline)
- □ Daytrana (methylphenidate patch)
- □ Dexedrine (dextroamphetamine), Dextrostat
- □ Dexedrine Spansules (dextoamphetamine, long-acting)
- □ Focalin (dexmethylphenidate, XR)
- □ Metadate (methylphenidate, long-acting ER and CD),
- □ Methylin (methylphenidate solution or chewable)
- □ Ritalin (methylphenidate, SR, LA), Quillivant XR
- □ Vyvanse (lisdexamfetamine dimesylate)

Non-addictive ADHD medications

- □ Catapres (clonidine)
- □ Intuniv (guanfacine), Tenex
- □ Strattera (atomoxetine)
- □ Wellbutrin (bupropion)

Non-addictive stimulants

- □ Provigil (modafinil), Nuvigil (armodafinil)

Substance Abuse Medications

- □ Antabuse (disulfiram)
- □ Campral (acamprosate)
- □ Methadone
- □ Revia (naltrexone)
- □ Suboxone, Subutex (buprenorphine)
- □ Vivitrol (naltrexone injectable)

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