

**Stonebriar Psychiatric Services, PA**  
**Medical and Social History**

Name: \_\_\_\_\_ Age: \_\_\_\_ M \_\_\_\_ F \_\_\_\_ Date: \_\_\_\_\_ DOB \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
 SS # \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work phone: \_\_\_\_\_  
 Cell phone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
 Emergency contact Name/Relationship/Number \_\_\_\_\_  
 How did you hear about our office: \_\_\_\_\_

**Primary Care Physician/Address:** \_\_\_\_\_  
 \_\_\_\_\_

**Date of Last Physical:** \_\_\_\_\_

**HISTORY OF PAST ILLNESS:** Have you had

Childhood

- Measles     Rheumatic fever or heart disease  
 Congenital Abnormalities     Mumps     Chicken Pox

Adult:

- Asthma     High Blood Pressure     Cancer  
 (Site \_\_\_\_\_)  
 Diabetes     Ulcer or Gastritis     Thyroid Problems  
 Tuberculosis     Kidney Problem     Liver Problem  
 Blood Problem     Venereal Disease     Heart Failure  
 Heart Attack     Abnormal Heart Rhythm  
 Osteopenia/osteoporosis

**OPERATIONS:**

Have you ever had any surgery?                     yes     no  
 If yes, what type and when:  
 \_\_\_\_\_  
 \_\_\_\_\_

**ALLERGIES:**

\_\_\_\_\_  
 \_\_\_\_\_

**CURRENT MEDICATIONS:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**INJURIES:**

Have you ever been in a serious motor vehicle accident?     yes     no  
 Have you had any head concussions or injuries?             yes     no  
 Have you ever been knocked unconscious?                     yes     no

**PAST PSYCHIATRIC HISTORY:**

List all therapists, counselors and hospitalizations (with dates)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SOCIAL HISTORY:**

Circle One:    Single    Married    Separated  
                   Divorced    Widowed    Significant Other  
 With whom do you live? \_\_\_\_\_  
 History of Drug Usage?                     yes     no

Do you have concerns regarding sexual function?  yes  no  
 Foreign Travel within the past year \_\_\_\_\_

Coffee \_\_\_\_\_    Tea \_\_\_\_\_    Colas \_\_\_\_\_ per day  
 Alcohol     Never     < 1 per week     1-5 per week     Other  
 Tobacco:     Never smoked                     Quit \_\_\_\_\_ years ago  
                    Packs per day                             Years smoked \_\_\_\_\_

**SOCIAL HISTORY: (continued)**

Are you employed?  Full Time     Part Time  
 What is your job? \_\_\_\_\_  
 \_\_\_\_\_

Are you a student?  yes     no    If so, where \_\_\_\_\_  
 How much time have you lost from work or school because of your  
 health during the past:    Six months \_\_\_\_\_    One year \_\_\_\_\_  
 5 Years \_\_\_\_\_

Education: (Years)  
 Grade School \_\_\_\_\_ College \_\_\_\_\_ Postgraduate \_\_\_\_\_  
 Do you wear seatbelts?  Always     Sometimes     Never

FAMILY HISTORY	AGE	HEALTH	If Deceased, Age @ Death	Cause of Death
Father				
Mother				
Brother/Sister				
Husband/Wife				
Son/Daughter				

Has either parent, sister, brother, child or grandparent ever had psychiatric problems, substance abuse, or treatment? If so, what type of illness and treatment \_\_\_\_\_  
 \_\_\_\_\_

Has any blood relative had diabetes     Yes     No  
 Has any blood relative ever attempted or completed suicide?  
                    Yes     No

**SYSTEMIC REVIEW:**

WEIGHT: Current \_\_\_\_\_ Max. \_\_\_\_\_ Min. \_\_\_\_\_  
 Recent weight change?     Yes     No  
 Height \_\_\_\_\_    Neck Circumference: \_\_\_\_\_ inches  
 Have you recently had:     Weakness     Fever     Chills

**Stonebriar Psychiatric Services, PA**  
**Medical and Social History**

Fainting    Problems Sleeping    Night Sweats

CIRCLE if you have had the following:

SKIN

Skin Disease ..... Yes No  
Jaundice ..... Yes No  
Hives, eczema, rash..... Yes No

Head-Eyes-Ears-Nose-Throat

Dry eyes or mouth ..... Yes No  
Bleeding gums – frequent or consistent ..... Yes No  
Blurred vision..... Yes No  
Date of last eye exam \_\_\_\_\_  
Nosebleeds – frequent ..... Yes No  
Chronic sinus trouble ..... Yes No  
Ear disease ..... Yes No  
Impaired hearing ..... Yes No  
Dizziness or sensation of room spinning ..... Yes No  
Frequent or severe headaches ..... Yes No

Respiratory

Asthma or Wheezing ..... Yes No  
Difficulty breathing ..... Yes No  
Pleurisy or Pneumonia ..... Yes No  
Cough up Blood (ever) ..... Yes No

Cardiovascular

Chest pain, pressure or tightness ..... Yes No  
Shortness of breath with walking or lying down ..... Yes No  
Palpitations ..... Yes No  
Swelling of hands, feet or ankles ..... Yes No  
Awakening in the nights feeling smothered ..... Yes No  
Heart murmur ..... Yes No

Gastrointestinal

Vomiting blood or food ..... Yes No  
Gallbladder disease ..... Yes No  
Change in appetite ..... Yes No  
Hepatitis / Jaundice ..... Yes No  
Painful bowel movements ..... Yes No  
Bleeding with bowel movements ..... Yes No  
Black stools ..... Yes No  
Recent change in bowel habits ..... Yes No  
Frequent diarrhea ..... Yes No  
Heartburn or indigestion ..... Yes No  
Cramping or pain in the abdomen ..... Yes No  
Does food stick in throat ..... Yes No

Endocrine

Hormone therapy ..... Yes No  
Any change in hat or glove size ..... Yes No  
Any change in hair growth ..... Yes No  
Have you become colder than before or skin dryer ..... Yes No

Neck

Stiffness ..... Yes No  
Enlarged glands ..... Yes No

Genitourinary:

Loss of urine ..... Yes No  
Blood in urine ..... Yes No  
Frequent urination ..... Yes No  
Burning or painful urination ..... Yes No  
Bedwetting ..... Yes No  
Kidney trouble ..... Yes No  
Testicular mass ..... Yes No  
Prostate problem ..... Yes No  
Sexual dysfunction ..... Yes No  
STD / AIDS risk ..... Yes No

Gynecological:

First day of last period \_\_\_\_\_  
Age periods started \_\_\_\_\_  
How long do periods last \_\_\_\_\_  
Frequency of periods every \_\_\_\_\_  
Pain with periods ..... Yes No  
Number of pregnancies \_\_\_\_\_  
Number of miscarriages \_\_\_\_\_  
Date of last cancer smear and results \_\_\_\_\_  
Breast lump or discharge..... Yes No  
Abnormal vaginal discharge ..... Yes No  
Pain with intercourse ..... Yes No

Locomotor-musculoskeletal

Stiffness or pain in joints..... Yes No  
Weakness of muscles or joints ..... Yes No  
Any difficulty walking ..... Yes No  
Any pain in calves/buttocks with walking relieved w/rest ... Yes No

Neuro-Psychiatric

Transient blindness    Tremor    Weakness    Fingers numb  
Have you ever had counseling for mental health ..... Yes No  
Have you ever been advised to see a psychiatrist ..... Yes No  
Have you or do you ever have fainting spells ..... Yes No  
Convulsions..... Yes No  
Paralysis ..... Yes No  
Problems with coordination ..... Yes No  
History of being physically or sexually abused ..... Yes No  
Depression symptoms (difficulty sleeping, loss of appetite,  
loss of interest in activities, feeling hopeless ..... Yes No  
History of ADHD ..... Yes No  
History of mood swings or bipolar illness ..... Yes No  
History of bingeing or purging ..... Yes No

Hematologic

Are you slow to heal after cuts ..... Yes No  
Anemia ..... Yes No  
Phlebitis or blood clots in veins ..... Yes No  
Have you had difficulty with bleeding excessively  
after tooth extraction or surgery? ..... Yes No  
Have you had abnormal bruising or bleeding ..... Yes No

Other

Do you snore loud enough to be heard through a closed door? Yes No  
Do you often feel tired, fatigued during the day? ..... Yes No  
Has anyone observed you stop breathing during sleep?..... Yes No  
Do you have/are you being treated for high blood pressure? Yes No

**The information provided herein is accurate to the best of my knowledge. I understand it is my responsibility to inform my doctor of any changes in this information.**

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_ Provider: \_\_\_\_\_

Signature of person providing this information: \_\_\_\_\_

**Stonebriar Psychiatric Services, P.A.**

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

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Home Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

*May we leave messages at home?*  Yes  No

*May we leave messages at work?*  Yes  No

*May we send mail to you at this address?*  Yes  No

Marital Status:  S  M  D  W Date of Current Marriage/Separation: \_\_\_\_\_

Number of Marriages: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Child(ren)'s Name(s): \_\_\_\_\_ Date of Birth: \_\_\_\_\_  M  F

\_\_\_\_\_ Date of Birth: \_\_\_\_\_  M  F

\_\_\_\_\_ Date of Birth: \_\_\_\_\_  M  F

Previously Married?  Yes  No If yes, when? \_\_\_\_\_ How long? \_\_\_\_\_

Occupation: \_\_\_\_\_ Highest Level of Education: \_\_\_\_\_

**COUNSELING AND PSYCHIATRIC HISTORY**

Have you had previous counseling?  Yes  No If yes, when? \_\_\_\_\_

Name and location of counselor: \_\_\_\_\_

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

For how long? \_\_\_\_\_ Was it helpful? \_\_\_\_\_

Have you ever been diagnosed with or treated for any type of mental illness?  Yes  No If yes, which type? \_\_\_\_\_

Has anyone in your family ever been diagnosed with or treated for any type of mental illness?  Yes  No

If yes, who and which type? \_\_\_\_\_

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**REASONS FOR SEEKING HELP**

What concerns have brought you to counseling today? \_\_\_\_\_

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Which of the following are causing the most concern for you? Please check all that apply:

- Home  Work  Marriage  Other Relationships  God

When did your present concerns begin to be a problem for you? \_\_\_\_\_

What concerns about you have been identified by others? \_\_\_\_\_

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**Please rate the severity of your present concerns on the following scale. Check one:**

- Mild  Moderate  Severe  Totally Incapacitating

Please indicate which of the following areas are currently problematic for you. Check all that apply:

- |   |   |
|---|---|
| <input type="checkbox"/> Blackouts or temporary loss of memory        | <input type="checkbox"/> Inability to concentrate while at school/work                          |
| <input type="checkbox"/> Insomnia (not being able to sleep)           | <input type="checkbox"/> Crying spells  |
| <input type="checkbox"/> Loss of appetite/increased appetite          | <input type="checkbox"/> Feeling “on top of the world”  |
| <input type="checkbox"/> Uncontrollable anxiety or worry              | <input type="checkbox"/> Nightmares   |
| <input type="checkbox"/> Lacking self-confidence                      | <input type="checkbox"/> Loss of interest in usual activities/lack of motivation                |
| <input type="checkbox"/> Feeling fat                                  | <input type="checkbox"/> Obsessions or compulsions with specific activities                     |
| <input type="checkbox"/> Eating and then vomiting to control weight   | <input type="checkbox"/> Inability to control thoughts  |
| <input type="checkbox"/> Excessive use of alcohol                     | <input type="checkbox"/> Feeling trapped in rooms/buildings                                     |
| <input type="checkbox"/> Abuse of non-prescription drugs              | <input type="checkbox"/> Hearing voices   |
| <input type="checkbox"/> Getting into trouble at school/work          | <input type="checkbox"/> Feeling that people are “out to get you” or that you are being watched |
| <input type="checkbox"/> Feeling inferior to others                   | <input type="checkbox"/> Angry outbursts  |
| <input type="checkbox"/> Under too much pressure and feeling stressed | <input type="checkbox"/> Excessive fear of specific places or objects                           |
| <input type="checkbox"/> Feeling down or unhappy/depressed mood       | <input type="checkbox"/> Difficulty making friends  |
| <input type="checkbox"/> Excessive anxiety or worry                   | <input type="checkbox"/> Difficulty maintaining friendships                                     |
| <input type="checkbox"/> Feeling lonely                               | <input type="checkbox"/> Feeling as if you’d be better off dead                                 |
| <input type="checkbox"/> Suspicious feelings toward other people      | <input type="checkbox"/> Feeling manipulated or controlled by others                            |
| <input type="checkbox"/> Afraid of being on your own                  | <input type="checkbox"/> Difficulty making decisions  |
| <input type="checkbox"/> Angry feelings                               |   |

- Concerns about finances
- Feeling “numb” or cut off from emotions
- Concerns about physical health
- Concerns about emotional stability
- Tremors
- Delusions
- Loss of interest in sexual relationships
- Feeling sexually attracted to members of your own sex
- Feeling distant from God
- Hallucinations
- Hypersomnia (sleeping all the time)
- Not being able to say what you really think or feel

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

What would you like to gain from counseling? \_\_\_\_\_  
 \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**SPIRITUALITY**

Do you believe in God?  Yes  No What is your religious preference? \_\_\_\_\_

Are you a member of a church?  Yes  No If yes, what church? \_\_\_\_\_

How much influence does your religion have on your day-to-day activity?  A lot  A moderate amount  A little  None

**EMERGENCY CONTACT**

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

**(Next of Kin – Other than Spouse)**

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

# Stonebriar Psychiatric Services, P.A. Policies

## OFFICE HOURS:

Monday through Thursday, 8:00 a.m. to 4:00 p.m. The office is closed major holidays and the week between Christmas Eve and New Year's.

## APPOINTMENTS:

Sessions are by appointment only during regular office hours. Fees are based on time and sessions that go over will be charged accordingly. With the exception of emergency situations over which we have no control, our appointments begin promptly as scheduled. Your appointment time is reserved for you and you are encouraged to be certain that you arrive on time. If you are late, you will cut into your appointment time but will be responsible for the fee for the full time. **It is your responsibility to keep track of your appointments.** We make efforts to provide a courtesy reminder, but cannot guarantee that the reminder will be made or that it has been received. Reminders will normally be made via email, the day prior to the appointment if you have signed permission for us to email, but this is not guaranteed and should not be relied.

## APPOINTMENT CHANGES/CANCELLATIONS:

Patients agree to notify the office of appointment changes or cancellations as far in advance of the scheduled time as possible to allow another patient to utilize the time. There is a required **minimum** notice of 24 business hours for individual sessions, a **minimum** notice of 48 hours for extended sessions (75, 90 and 120 minutes) and a **minimum** 1 week notice for scheduled intensives (over 120 minutes in one day) and all appointments during a holiday week, to avoid being charged for the time reserved. Monday appointments must be cancelled by the corresponding time on Thursday to avoid being a late cancel. If this minimum notice is not respected, patient will be charged the full fee for the time reserved. In the case of inclement weather, call the office first thing in the morning to see if the office has been closed. If not, and you are uncomfortable driving, you may have a phone session instead. In that case, you must call the office **prior to your appointment by at least 10 minutes** **and** give the receptionist your credit card information/authorization so you will be ready to be connected for your phone session. Receipts will be e-mailed to you if you have signed the authorization to do so. If you do not call or come to your appointment, you will be charged.

If, for any reason, SPS must cancel an appointment, the patient will be advised as soon as possible.

## FEES AND PAYMENT:

Payment is required at or before the time of the appointment. We provide coded receipts for patients who wish to file for reimbursement on their own, but we do not deal directly with health insurance companies, nor do we complete or sign forms, provide treatment plans, or forward records. Please keep the documentation given to you at time of treatment. Additional copies will incur a fee to research and photocopy receipts. You may also use this documentation to file your claim if you participate in a cafeteria or medical reimbursement plan at your place of employment. There is a \$ 40.00 charge for bounced checks and a \$ 30.00 fee for declined credit cards. Unpaid balances are charged a late fee of \$50.00/month. Fees stated are subject to change.

## EMERGENCY CALLS:

During office hours, for calls that are urgent but not life threatening, please speak to the staff. For those that represent a life threatening emergency, always call 911 immediately or go to your local emergency room. When you are expecting a return call and your telephone **Caller ID** does not accept "Private or Blocked Calls", we will not be able to return your phone call. Please **unblock** your **Caller ID** prior to placing your call. Fees will be charged based on time required to listen to your message, return the call and document the interaction.

## REPORTS, LETTERS, RECORDS, DISABILITY FORMS

May be provided at doctor's discretion and incur a fee, depending on the complexity of the document and time involved.

### CONTACT POLICY:

Except in extreme situations, contact will normally be restricted to session time. There will be a routine charge for phone calls based on the time spent per call. For more extensive phone calls, please schedule a phone appointment with your physician.

Although we have e-mail available, patients are advised that e-mail transmissions are not secure and therefore may not be confidential. We will not conduct e-mail therapy sessions.

### PRESCRIPTION POLICY:

If you have been given a controlled prescription, it is regulated by our state government. Please be aware that these prescriptions **must be filled within 21 days**, and no refills are allowed. If you do not fill the prescription in the 21 day time period you will be required to pay the **\$30.00 fee to re-issue it**. **PRESCRIPTIONS FOR CONTROLLED SUBSTANCES CANNOT BE CALLED IN AND MUST BE PICKED UP OR MAILED.** When requesting a refill, please provide all information regarding the prescription you are requesting, including your pharmacy name and number. Prescription refills incur a \$30.00 fee during office hours and \$45.00 outside of office hours. A mail out fee of \$10.00 is charged for prescriptions requested to be mailed. Fees stated are subject to change. Prescription preauthorizations incur a \$35.00 fee.

Take all medication as prescribed. As with all medications, these have been prescribed for you exclusively, based on knowledge of your personal needs and medical background. Sharing these medications is both medically contraindicated and illegal. Your cooperation is appreciated. Prescriptions will **only** be called in for those who are *current patients and who maintain their regularly scheduled appointments*. We do not participate in "auto refills". You will generally have enough refills on your prescriptions to last until your next appointment and it is your responsibility to schedule and keep your appointments as suggested. If you cancel or fail to schedule your next appointment, you will need to make arrangements to be seen prior to receiving a refill. Refills may be requested between 9:00 am and 4:00 pm on weekdays. **We will not be able to provide immediate refills to walk-in patients, nor do we issue refills in the evenings or on weekends or holidays.**

### TERMINATION POLICY:

Patients are under no obligation to continue services should they decide to terminate at any time. However, we strongly urge that the doctor be notified in person during a session regarding this decision so that it can be discussed openly. Dr. Tharp's goal is to make all terminations as therapeutically helpful as possible. We reserve the right to terminate treatment for individuals who repeatedly fail to make or keep appointments or follow treatment recommendations.

### ACCEPTANCE OF POLICIES:

Stonebriar Psychiatric Services, PA is committed to providing professional services of the highest quality and standards. In order to serve our patients efficiently and responsibly we require agreements be made as to the policies stated above. Patients are encouraged to ask questions before signing.

I have read the policies, understand, and agree to abide by them.

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Patient's Signature

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Date

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Guardian's Signature (if minor)

**Stonebriar Psychiatric Services, PA.**

**GENERAL CONSENT FOR TREATMENT**

I authorize my psychiatrist/therapist to carry out psychological examinations, treatment and/or diagnostic or medical procedures that now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

**GENERAL CONSENT FOR TREATMENT (if patient is a child or dependent of beneficiary)**

On behalf of the patient, \_\_\_\_\_ (name), I (the Legal Guardian or Legal Representative) legally authorize Stonebriar Psychiatric Services, PA to deliver mental health care services to the patient as deccribed in the "**GENERAL CONSENT FOR TREATMENT**" paragraph above.

I also understand that all policies in this statement apply to the patient I represent. **I acknowledge that my child's records are considered confidential except in the stated exceptions listed under "CONFIDENTIALITY and AUTHORIZATION TO RELEASE INFORMATION".**

I understand that a Family Systems Assessment and follow-up family therapy sessions may be recommended as part of my child or adolescent's treatment. along with individual therapy sessions and medication management appointments, if the child/adolescent is on medication.

\_\_\_\_\_  
Patient/Legal Representative    Date

\_\_\_\_\_  
Witness    Date



## **Welcome to Stonebriar Psychiatric Services, PA.**

Welcome! We are happy to have you or your family member as a patient and will do everything within our professional capacity to make the treatment as productive as possible.

The specifics of the treatment goals and the steps to achieve these goals will be discussed at the first appointment. Your participation and understanding of the treatment goals is essential for the best benefit of therapy. If you ever have questions about the nature of the treatment or any other aspect of your care, please do not hesitate to ask.

### **CONFIDENTIALITY and AUTHORIZATION TO RELEASE INFORMATION**

It is understood that all information between patient and psychiatrist/therapist is held strictly confidential, and the psychiatrist/therapist will not release any information about therapy unless permitted by law or:

1. It is agreed upon in writing and complies with State Laws.
2. The patient presents an imminent danger to self.
3. The patient presents an imminent danger to others.
4. Child/elder abuse/neglect is suspected.
5. As necessary for continuity of care.
6. If a judge determines that our discussions are not confidential, a judge may request specific information.
7. As requested by a court appointed attorney for a child involved in court proceedings.

It is understood that in cases #2, #3, and #4, the psychiatrist/therapist is required by law to inform potential victims and legal authorities so that protective measures can be taken. Our fees are based on professional time and patient and/or guardian is financially responsible for time spent on the above matters. Stonebriar Psychiatric Services, PA follows the “minimum necessary” rule when releasing information.

### **PATIENT CONSENT TO RELEASE OF INFORMATION**

I consent to information release about my case (or my child’s case) with the referral source and other co-treating health care providers and facilities for the purposes of treatment. I authorize that Stonebriar Psychiatric Services, PA providers may disclose any information, including drug and alcohol abuse and HIV status, regarding my or my child’s treatment for purposes of continuity of care. I know I have the right to revoke this authorization which must be in writing and given to my provider. I understand that if I revoke this authorization, my providers may determine that treatment cannot be effective without continuity of care, and may elect to transfer my care to another provider. This Authorization is valid as long as I am treated at Stonebriar Psychiatric Services, PA, or by my revoking the authorization.

\_\_\_\_\_  
Patient/Legal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**Stonebriar Psychiatric Services, P.A.**  
**Payment of Services and Missed Appointment Agreement Form**

Our services are provided by appointment only and when a patient schedules an appointment, time is reserved for that patient and not available to others. Missed appointments, as well as those cancelled with less than a **minimum 24 business hours' notice** (48 hour **minimum** on extended sessions and 1 full week **minimum** notice on intensives, which are appointments including over 120 minutes scheduled in one day) will be charged the fee for the visit. Business hours are when staff are in the office.

This same credit card will be used in the event of a phone session or other service whether patient is in the office or not (prescription refills, reports, forms, letters, phone calls, phone calls to outside therapists, legal authorities, CPS, etc), as well as to cover checks returned for nonsufficient funds (NSF), or an outstanding unpaid balance.

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

The fee for the visit will be charged on the day of the missed appointment (or day of the late-cancel) to the following credit card:

       **Visa**        **MasterCard**        **American Express**        **Discover**

Credit Card #: \_\_\_\_\_

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

Name as it appears on Card: \_\_\_\_\_

Security Code from back of card: \_\_\_\_\_

I, \_\_\_\_\_, cardholder for the credit card listed above, understand and agree that if I or my family member do not show up for a scheduled appointment or if I cancel a scheduled appointment with less than a minimum **24 business hours' notice** (48 hour minimum *business hours' notice* extended sessions) **and 1 full week minimum business hours' notice on intensives, which are appointments including over 120 minutes scheduled in one day**, the above named credit card will be charged for the full amount of the reserved session. Additional fees as listed above will also be charged.

**Cardholder Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Printed Name \_\_\_\_\_

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

City: \_\_\_\_\_ Zip: \_\_\_\_\_ Day Phone \_\_\_\_\_

- **To qualify for a timely cancellation on individual Monday appointments, the cancellation must be received by the corresponding time on the previous Thursday. Cancellations immediately preceding a holiday break must occur before the corresponding time on the last business day before the holiday. Voice mail and e-mail cancellations do not qualify as they can not be guaranteed as received.**

**ADDITIONAL AUTHORIZATION**

Use this authorization to charge services for all my family member(s) who are also seen at the office. \_\_\_\_\_ (initial your approval) Otherwise a separate form will be required for each individual.

All Family Members \_\_\_\_\_ (initial your approval)

Specific family member(s)

\_\_\_\_\_ (name) \_\_\_\_\_ (initial your approval)

\_\_\_\_\_ (name) \_\_\_\_\_ (initial your approval)

\_\_\_\_\_ (name) \_\_\_\_\_ (initial your approval)

\_\_\_\_\_ (name) \_\_\_\_\_ (initial your approval)

# Stonebriar Psychiatric Services, PA

## CAGE and SCOFF screens

	Yes	No
1. Have you ever felt you ought to cut down on your drinking?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have people annoyed you by criticizing your drinking?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever felt bad or guilty about your drinking?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had an “eye-opener” to steady nerves in AM?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you used substances more than intended this year?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you make yourself <b>SICK</b> because you feel uncomfortably full?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you worry you have lost <b>CONTROL</b> over how much you eat?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you recently lost more than <b>ONE STONE (15 pounds)</b> in a three-month period?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you believe yourself to be <b>FAT</b> when others say you are too thin?	<input type="checkbox"/>	<input type="checkbox"/>
10. Would you say that <b>FOOD</b> dominates your life?	<input type="checkbox"/>	<input type="checkbox"/>

## Stonebriar Psychiatric Services, PA Mood Disorder Questionnaire

- |    |   | YES                      | NO                       |
|----|---|--------------------------|--------------------------|
| 1. | Has there ever been a period of time <b>when you were not your usual self</b> and ...   |                          |                          |
|    | ... you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?                      | <input type="checkbox"/> | <input type="checkbox"/> |
|    | ... you were so irritable that you shouted at people or started fights or arguments?  | <input type="checkbox"/> | <input type="checkbox"/> |
|    | ... you felt much more self-confident than usual?   | <input type="checkbox"/> | <input type="checkbox"/> |
|    | ... you got much less sleep than usual and found that you didn't really miss it?  | <input type="checkbox"/> | <input type="checkbox"/> |
|    | ... you were more talkative or spoke much faster than usual?  | <input type="checkbox"/> | <input type="checkbox"/> |
|    | ... thoughts raced through your head or you couldn't slow your mind down?   | <input type="checkbox"/> | <input type="checkbox"/> |
|    | ... you were so easily distracted by things around you that you had trouble concentrating or staying on track?  | <input type="checkbox"/> | <input type="checkbox"/> |
|    | ... you had much more energy than usual?  | <input type="checkbox"/> | <input type="checkbox"/> |
|    | ... you were much more active or did many more things than usual?   | <input type="checkbox"/> | <input type="checkbox"/> |
|    | ... you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?   | <input type="checkbox"/> | <input type="checkbox"/> |
|    | ... you were much more interested in sex than usual?  | <input type="checkbox"/> | <input type="checkbox"/> |
|    | ... you did things that were unusual for you or that other people might have thought were excessive, foolish or risky?  | <input type="checkbox"/> | <input type="checkbox"/> |
|    | ... spending money got you or your family in trouble?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | If you checked YES to more than one of the above, have several of these ever happened during the same period of time?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. | How much of a problem did any of these cause you – like being able to work; having family, money or legal troubles; getting into arguments or fights?         |                          |                          |
|    | <input type="checkbox"/> No problem <input type="checkbox"/> Minor problem <input type="checkbox"/> Moderate problem <input type="checkbox"/> Serious problem |                          |                          |
| 4. | Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?            | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | Has a health professional told you that you have manic-depressive illness or bipolar disorder   | <input type="checkbox"/> | <input type="checkbox"/> |

**PERSONALITY PROFILE** NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**DIRECTIONS:** - Select one of the four words in each line that is most like you and place an X in front of that word. Continue through all forty lines. Be sure each numbered line is marked, and that each line has **only one** mark.

**STRENGTHS**

- |                         |                      |                  |                   |
|-------------------------|----------------------|------------------|-------------------|
| 1. ___ Adventurous      | ___ Adaptable        | ___ Animated     | ___ Analytical    |
| 2. ___ Persistent       | ___ Playful          | ___ Persuasive   | ___ Peaceful      |
| 3. ___ Submissive       | ___ Self-sacrificing | ___ Sociable     | ___ Strong-willed |
| 4. ___ Considerate      | ___ Controlled       | ___ Competitive  | ___ Convincing    |
| 5. ___ Refreshing       | ___ Respectful       | ___ Reserved     | ___ Resourceful   |
| 6. ___ Satisfied        | ___ Sensitive        | ___ Self-reliant | ___ Spirited      |
| 7. ___ Planner          | ___ Patient          | ___ Positive     | ___ Promoter      |
| 8. ___ Sure             | ___ Spontaneous      | ___ Scheduled    | ___ Shy           |
| 9. ___ Orderly          | ___ Obliging         | ___ Outspoken    | ___ Optimistic    |
| 10. ___ Friendly        | ___ Faithful         | ___ Funny        | ___ Forceful      |
| 11. ___ Daring          | ___ Delightful       | ___ Diplomatic   | ___ Detailed      |
| 12. ___ Cheerful        | ___ Consistent       | ___ Cultured     | ___ Confident     |
| 13. ___ Idealistic      | ___ Independent      | ___ Inoffensive  | ___ Inspiring     |
| 14. ___ Demonstrative   | ___ Decisive         | ___ Dry humor    | ___ Deep          |
| 15. ___ Mediator        | ___ Musical          | ___ Mover        | ___ Mixes easily  |
| 16. ___ Thoughtful      | ___ Tenacious        | ___ Talker       | ___ Tolerant      |
| 17. ___ Listener        | ___ Loyal            | ___ Leader       | ___ Lively        |
| 18. ___ Contented       | ___ Chief            | ___ Chartmaker   | ___ Cute          |
| 19. ___ Perfectionistic | ___ Permissive       | ___ Productive   | ___ Popular       |
| 20. ___ Bouncy          | ___ Bold             | ___ Behaved      | ___ Balanced      |

**WEAKNESSES**

- |                        |                       |                    |                    |
|------------------------|-----------------------|--------------------|--------------------|
| 21. ___ Blank          | ___ Bashful           | ___ Brassy         | ___ Bossy          |
| 22. ___ Undisciplined  | ___ Unsympathetic     | ___ Unenthusiastic | ___ Unforgiving    |
| 23. ___ Reticent       | ___ Resentful         | ___ Resistant      | ___ Repetitious    |
| 24. ___ Fussy          | ___ Fearful           | ___ Forgetful      | ___ Frank          |
| 25. ___ Impatient      | ___ Insecure          | ___ Indecisive     | ___ Interrupts     |
| 26. ___ Unpopular      | ___ Uninvolved        | ___ Unpredictable  | ___ Unaffectionate |
| 27. ___ Headstrong     | ___ Haphazard         | ___ Hard to please | ___ Hesitant       |
| 28. ___ Plain          | ___ Pessimistic       | ___ Proud          | ___ Permissive     |
| 29. ___ Angered easily | ___ Aimless           | ___ Argumentative  | ___ Alienated      |
| 30. ___ Naïve          | ___ Negative attitude | ___ Nervy          | ___ Nonchalant     |
| 31. ___ Worrier        | ___ Withdrawn         | ___ Workaholic     | ___ Wants credit   |
| 32. ___ Too sensitive  | ___ Tactless          | ___ Timid          | ___ Talkative      |
| 33. ___ Doubtful       | ___ Disorganized      | ___ Domineering    | ___ Depressed      |
| 34. ___ Inconsistent   | ___ Introvert         | ___ Intolerant     | ___ Indifferent    |
| 35. ___ Messy          | ___ Moody             | ___ Mumbles        | ___ Manipulative   |
| 36. ___ Slow           | ___ Stubborn          | ___ Show-off       | ___ Skeptical      |
| 37. ___ Loner          | ___ Lord over         | ___ Lazy           | ___ Loud           |
| 38. ___ Sluggish       | ___ Suspicious        | ___ Short-tempered | ___ Scatterbrained |
| 39. ___ Revengeful     | ___ Restless          | ___ Reluctant      | ___ Rash           |
| 40. ___ Compromising   | ___ Critical          | ___ Crafty         | ___ Changeable     |

**Stonebriar Psychiatric Services, P.A.**  
**Child Development Questionnaire**

**PREGNANCY**

1. Duration of pregnancy:  full term  early by \_\_\_\_\_  late by \_\_\_\_\_
2. Did mother smoke during pregnancy?  yes  no  
Number daily: \_\_\_\_\_
3. Did mother ingest alcohol during pregnancy?  yes  no  
Type and amount: \_\_\_\_\_
4. Did mother ingest drugs during pregnancy?  yes  no  
Details:  
\_\_\_\_\_  
\_\_\_\_\_
5. Was mother on medications during pregnancy?  yes  no  
Details:  
\_\_\_\_\_  
\_\_\_\_\_
6. Complications:  
\_\_\_\_\_  
\_\_\_\_\_

**DELIVERY:**

7. Was labor  spontaneous  induced
8. Duration of labor: \_\_\_\_\_ hours
9. Delivery was  normal  breach  cesarean
10.  premature \_\_\_\_\_ weeks
11. Birth weight \_\_\_\_\_ lbs \_\_\_\_\_ ozs. Length \_\_\_\_\_ inches
12. Infant days in hospital
13. APGAR scores \_\_\_\_\_
14. Complications:  
\_\_\_\_\_  
\_\_\_\_\_

**MILESTONES**

15. Describe motor skill development:

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16. Describe language development:

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17. Describe social development / attachment:

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18. Problems during infancy / early childhood:

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**ABUSE HISTORY:**

19. Has there been any

Type of Abuse	If yes, by whom?	How long did it last?	How old was the child	Was it reported to authorities?
Physical				
Sexual				
Emotional/Verbal Abuse/Neglect				

20. Witness of abuse?

- physical
- sexual

Details: \_\_\_\_\_  
 \_\_\_\_\_

21. Perpetrator of abuse:

- physical
- sexual

Details: \_\_\_\_\_  
 \_\_\_\_\_

