Laura N. Antar, MD, PhD, PLLC
224 N Main Street
New City, NY 10956
(845) 367-4800

Office Policies

Please read the following information about our office policies on appointments, insurance, fees, calls, cancellations and confidentiality.

Insurance: Dr. Antar is an out of network provider which means that you pay up front for your visit, and we give you paperwork to submit your claim to your insurance.

● Be sure to check your health care coverage for outpatient mental health care. Usually there is a yearly deductible and a co-payment for each visit. **Dr. Antar is not contracted with any insurance, nor does she submit claims to insurance companies.** Our office will, however, do its best to help you submit to your own insurance by providing you with necessary treatment plans and receipts so that you may submit as "out of network."

● Psychiatric illnesses with a biological cause (most depressions, many anxiety disorders, bipolar disorder, and some other illnesses) are covered, as long as medically necessary, without a yearly maximum, just like other medical illnesses. Remember that you will be responsible for paying for your appointment, so be sure to get the details of your reimbursement in case you are not fully covered for your visits.

● Dr. Antar is **"opted out" of medicare**. This means if you have medicare, you must see if your secondary insurance will cover your visits. If not, you would be financially responsible for your visits.

Fees: You or your legal guardian are financially responsible for the total cost of services rendered. **Full payment is expected at the time of the office visit**. If you cannot afford your visits, you must **cancel within 48 business hours,** and Dr. Antar will help you identify less expensive treatment options. If you do not do this, you will be financially responsible for the visit time you reserved.

Appointments: Appointments are scheduled according to each patient's needs and Dr. Antar's availability. The time of your appointment is reserved for you. **Absences that are not approved 48 business hours in advance or are not the result of a documented serious medical illness, will be charged in full.** You and Dr. Antar will collaboratively decide how often / how long you need to be seen.

● Please note that because your visit is a reserved time, **if you arrive late, you may only use your remaining time**, you will be charged from the time you were expected.

● **Please keep in mind that your insurance company will not reimburse you for missed appointment charges; they are your responsibility.** Continually missing or cancelling appointments too frequently, even if canceled 48 hours in advance, may be cause to end the treatment.

● You may elect to get text, voice and email reminders about your appointment through Patient Fusion, Dr. Antar's EMR; it will remind you about appointments one week and one day in advance. **Please note, should you for any reason not receive a reminder, you are still fully responsible for making your appointment.** It is recommended that you request a card with your appointment written on it by staff before you leave.

I_____have read and accept these policies.

(Print Full Name)

Signature:_____**Date**:_____

Phone calls: **In case of a life or death emergency of any nature, please call the local emergency room, or go directly to your nearest hospital.**

● Some appropriate questions/concerns to call about are urgent matters such as concerning side effects (rashes, severe pain or dizziness) or psychiatric urgencies **Please note: medication changes, new symptoms or events likely require an office visit; Dr. Antar cannot diagnose or treat over the phone.**

● We take responding to your calls very seriously. Dr. Antar sees patients throughout the day and may be unable to answer calls directly; if appropriate/possible, leave a detailed message for her with the front desk. Either she will call you back between visits, if possible or through the front desk. If you have a brief message or question you do not feel comfortable leaving with the office staff, you can reach Dr. Antar directly through your patient portal on Patient Fusion and she will reply during business hours. We usually respond that day or within 24 business hours. If for some reason you do not receive a response in 24 hours, assume something went wrong and please call again.

Medication Refills: Dr. Antar handles all refills during your regular scheduled appointments. **If you need refills that Dr. Antar is not aware of, please inform her at the beginning of your appointment.**

● If medication refills become necessary between appointments, please call the front desk to make a refill request. Remember to call three days prior to running out in order to avoid missing your medication cycle. Include your medication name, spelled out, dosage, how you take it and your preferred pharmacy and its zip code.

● If you missed your scheduled appointment and have run out of medication, Dr. Antar will provide you with enough medication to get you through to your next appointment; which must be within a maximum of two weeks (5 days with controlled substances).

Confidentiality: Your patient records are strictly confidential. For this reason, no information concerning you as a patient is released without your written consent (an exception is limited information sent to other doctors or your pharmacist). Disclosure of information to anyone such as an attorney and/or a family member must be accompanied by a release of information form, available on the website laurantar.com.

● In an emergency situation, should you be at imminent risk of death or serious medical consequence, Dr. Antar will release minimal, critical information to assist in preventing dire medical consequences that may result if that relevant information is not released. In the case of a minor, their legal guardian must sign the authorization. **The physician is legally bound to break doctor-patient confidentiality in cases of threat of harm to self or others and in cases of child or elder abuse. A court judge may additionally order documents to be released.**

● If you are using your insurance to pay, the carrier requests the diagnostic code (a number), the dates of service, and the type of treatment (evaluation, therapy or medication). If you have a managed care plan, that plan will sometimes request more detailed information about your symptoms and life situation in order to authorize treatment.

● Dr. Antar sometimes obtains consultation for her cases. While information is exchanged in these meetings, it remains anonymous, stripped of identifying information.

I_____have read and accept these policies.

(Print Full Name)

Signature:_____**Date**:_____

Maintaining Patient Status: It is important that you be seen on a regular basis. At the end of each appointment, Dr. Antar will discuss when to schedule your next appointment, and how long it should be. If you do not keep follow-up appointments greater than 120 days, Dr. Antar will conclude that you have terminated the patient-physician relationship which may or may not be re-initiated with a phone call.

Electronic Medical Records, Prescriptions and Prior Authorizations: In today's health care system, medical records are stored electronically, which involves our office utilizing an Electronic Medical Record (EMR) System. Our EMR is entirely cloud based, meaning that records are nearly impossible to lose, and no data stored directly on our computer hard drive (preventing loss in crashes, and making your data less vulnerable to hackers). This is HIPAA-compliant system, designed to maintain patient privacy.

● Additionally, the Electronic Medical Record has a **patient portal called Patient Fusion** through which you may access portions of your medical record: your diagnosis, your lab work, and sometimes see treatment plans. You may also communicate with Dr. Antar confidentially through this portal.

●Prescriptions are sent through a HIPAA-compliant e-script program. It is the safest means to transfer information directly to your pharmacy and reduces medical errors. It is now the law in New York State.

● Finally, prior authorizations are required by some insurance companies before they will approve non-formulary medications; requests for medication approval is made through a HIPAA-compliant company that ensures safe, rapid and confidential processing and faxing to the insurance company, called Cover My Meds.

Coverage: If Dr. Antar is out of town, the name and number of the covering psychiatrist will be on the answering machine, or Dr. Antar will check her own messages and respond to patient's needs.

Discontinuation of Treatment: Dr. Antar will usually discontinue treatment with a patient only after considerable discussion and usually for one of the following reasons: (1) not paying the bill, (2) canceling too often, or (3) not doing work in treatment. If you foresee a problem in any of these areas, please feel free to inform our office staff or Dr. Antar herself. If Dr. Antar sees a difficulty in any of these areas, She will bring it up with you right away so you can discuss it and correct the problem.

● You can discontinue with Dr. Antar at any time in person, by phone, or in writing. Our office is not easily offended if you want to quit or change providers. Transfer will be facilitated if you can first confer about the ending of treatment. You can usually reopen your case simply by calling our office if you ended treatment in good standing, or if you have made changes that will allow the treatment to go forward again.

● Hopefully, these policies will make our interactions easier, but sometimes there are snags or unplanned issues. Please bring to our attention any questions or difficulties with these policies. Our office will try to be flexible but consistent. Thank you.

I_____have read and accept these policies.

(Print Full Name)

Signature:_____**Date**:_____

Individual (Patient) Rights

● All patients have the right to inspect and copy their own protected health information (the medical record) on request, except for mental health records, which must be reviewed with a psychiatrist first. In cases where exposure to the record might be harmful to the patient, the psychiatrist may deny the request. If you request a copy of your psychiatric record, Dr. Antar will generally review the record with you. Dr. Antar rarely has information in her charts that a patient should not or could not read, but much may require explaining.

● Patients also have the right to amend or append their medical (or psychiatric) record. Dr. Antar, as your physician, has the right to deny such a request if she believes that the information in the medical record is accurate, but in that case, the patient request must still be attached to the medical record.

● Patients have the right to an accounting of all disclosures to other parties. This means that if you ask Dr. Antar for a list of whom she has released psychiatric information to, She will supply it to you.

● Patients have the right to have reasonable requests for confidential communication accommodated.

● You can give written authorization for our office to disclose your psychiatric information to anyone you choose, and you may revoke the authorization in writing at any time.

● Patients can file a complaint with Dr. Antar or with the Office of Civil Rights in the Department of Health and Human Services about any violation of the rights listed above. There will be no prejudice for filing such a complaint.

● Patients have the right to receive a written notice of privacy practices from providers and health plans.

Initials: _____ Date: _____

New Privacy Provisions and Changes

New HIPAA (Health Insurance Portability and Accountability Act) standards were created to protect patient's health information when it is disclosed, but also to facilitate the flow of medical information between treaters. With other medical treaters, billing, and for safety or security reasons, there is less protection of confidentiality than there used to be. However, in other areas, such as releasing psychotherapy records, there is more privacy protection. Please read below to understand your rights as a patient as well as the new rules about patient confidentiality. Feel free to ask questions about privacy, confidentiality, or your psychiatric record.

1. **Permission from the patient is no longer required for transfer of psychiatric and medical information between treaters as long as only the necessary information is supplied.** This means that if your primary care doctor, pharmacist, or an emergency room physician calls to find out if you are in treatment, what the diagnosis is, or what medications you are on, our office can convey this information, if it is medically relevant to your treatment with them. In practice, Dr. Antar will almost always discuss this with you personally before or after the fact, depending on the urgency and depth of the request. If you think this might present a problem for you, let us know ahead of time.

2. **Permission from the patient is no longer required for transfer of psychiatric information needed for business pertaining to insurance or payment as long as only the necessary information is supplied** (usually the diagnosis and type of treatment, but perhaps more). In practice, many insurance companies still require you to sign the first insurance sheet for authorization. In general, Dr. Antar discusses any unusual requests for information from an insurance company with a patient first.

3. Remember that if all the psychiatric records are requested, a treatment summary is usually given instead, except if the treatment consists solely of psychopharmacological treatment or brief medication visits. While brief medication visits fall under HIPAA guidelines, **psychotherapy visits are specifically excluded, meaning authorization from the patient is still required for release of the information** in those notes and a summary is often given in place of the record.

4. **The substance abuse records from alcohol and drug programs are exempt from any disclosure without patient permission.** If you are admitted to a treatment program for substance abuse, be sure to sign a release for Dr. Antar so she can talk to the treaters and obtain a discharge summary and lab data upon your discharge. Without this, Dr. Antar cannot obtain any information.

5. Dr. Antar might have to disclose some of your psychiatric information when required to do so by law. This includes **mandated reporting of child abuse or elder abuse** (this is not new).

6. **National security and public health issues**. Dr. Antar may be required to disclose certain information to military authorities or federal health officials if it is required for lawful intelligence, public health safety or public security.

Initials: _____ Date: _____

Consent For Treatment

The undersigned patient or responsible party (parent, legal guardian or conservator) consents to, and authorizes services, by Laura N. Antar, M.D., Ph.D., PLLC

These services may include psychotherapy, medication therapy, laboratory tests, diagnostic procedures and other appropriate alternative therapies.

The undersigned understands that he/she has the **right to**:
● Be informed of and participate in the selection of treatment modalities.
● Receive a copy of this consent.
● Withdraw this consent at any time.

The undersigned also understands that he/she has the **responsibility to**:
● Pay for services, in full, at the time of the visit.
● Abide by the policies of the patient information guidelines as presented at the time of initial visit.
● Acquire any lab tests or other medical treatments (physical exams or physician referrals) deemed medically necessary in order to maintain a safe and healthy lifestyle.

Signature of Patient:_____ **Date:** _____

Signature of Parent, Legal Guardian:_____**Date:**_____

Patient Information

Name:_____Date of Birth _____

Street Address_____

City_____State_____Zip_____

Cell_____Email:_____

Gender Male_____Female_____ Gender Fluid (describe)_____
Marital Status: (circle) Single/ Married/ Divorced/ Widowed/ Partnered/ Other_____

****Emergency Contact (required):**
Name_____Relation_____

Address_____Phone_____

Responsible Party: Provide information on who is responsible for paying for the service (if different from yourself).
Name:_____Phone:_____Relation_____

Address:_____

****Insurance Information: Please provide insurance card for copying.**

Payer Name:_____ID#_____

Plan Name:_____Effective since (MM/DD/YY)_____

Plan Type (circle): EPO/ HMO/ HSA/ Medicaid/ Medicare/ Other/ POS/ PPO/ Private Pay.
Order of Benefit (circle): Primary/ Secondary/ Tertiary/ Unknown.
Out of network benefits: YES____ NO____
(Out of network benefits are when you pay out of pocket but your insurance company reimburses you for a certain percentage or full appointment fee.)

Release of Information

Exchange of Information is when you, the patient, allow Dr. Antar to receive, release and discuss your information with another party; this can be signed for doctors, therapists, counselors, parents, etc.

I_____hereby authorize Dr. Laura N. Antar, M.D., Ph.D. to:
(Print Full Name)

Exchange information with:_____Phone_____

Please provide the address and fax of the person above:
Address:_____
_____
Fax (if available):_____

The information requested or authorized for release or exchange pertains to:
Mental Health
Education
Drug or alcohol abuse

This authorization will be valid until it is either revoked by the patient or the patient is discharged from treatment. You may cancel this authorization verbally, or by sending a written, signed and dated request to the doctor above indicating your desire to cancel.

I_____understand that once my information has been released, the recipient might re-disclose it, my doctor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

Patient Name (print):_____Date Of Birth_____

Patient's Signature:_____Date Signed_____

Guardian's Signature (if patient is a minor):_____**Date**_____

Visit Reminders

The time of your appointment is reserved for you; absences that are not approved 48 business hours in advance or are not the result of a serious, documented, medical illness, will be charged in full. We do not take any pleasure in charging for missed appointments!

As a courtesy, Dr. Antar provides the option to receive appointment reminders, by voice, text and email. Our office strongly suggests that you sign up for these reminders.

- The EMR we use will remind you of your appointments by email, delivered by PATIENT FUSION one week and three days in advance of that appointment.
- Our EMR will also remind you of your appointments by text twenty four hours in advance.

Please note that 24 hour or same-day cancellations are billed, you MUST cancel two full business days in advance to avoid the appointment fee.

- You will also receive a phone call reminder from our office staff three days prior to your appointment, which allows you to keep within the 48 hour cancellation policy.

Please note that if you should for any reason not receive a reminder, you are still responsible for making your appointment.

To Enroll in Visit Reminders, please fill in all the following information:

Name:_____ Date:_____.

Cell phone:_____ Email:_____.

☐ **I_____have read and understood all the above information and**
(your name)
would like to receive phone, text and email reminders.

☐ **I_____have read and understood all the above information and**
(your name)
would NOT like to receive phone, text or email reminders.

I have read and agree to these practice policies:

Signature: _____ Date: _____

PART TWO OF PATIENT INTAKE FORM

Mental Health Intake Form

Please complete all information on this form and bring it to your first visit. It may seem long, but most of the questions only require a check, so it will go quickly. You may need to ask family members about the family history. Thank you!

Name:_____Date_____
DOB_____Primary Care Physician_____Phone_____
Specialist/specialty_____Phone_____
Current Therapist/Counselor/Psychiatrist _____Phone_____
What are the problem(s) for which you are seeking help?

_____

_____

Are you coming to see Dr. Antar for medication/therapy or both? ☐ Medication ☐ Therapy ☐ Both
What are your current treatment goals? (be specific)

_____

_____

Current Symptoms Checklist: (Check once for any symptoms present, twice for major symptoms)

☐☐ Depressed mood	☐☐ Increased irritability	☐☐ Chills/ hot flash
☐☐ Unable to enjoy Activities	☐☐ Crying spells	☐☐ Nausea/diarrhea/GI
☐☐ Sleep pattern disturbance	☐☐ Binging	☐☐ Dizzy/faint
☐☐ Loss of interest	☐☐ Purging	☐☐ Tingling
☐☐ Concentration/forgetfulness	☐☐ Natural loss of weight	☐☐ Shoke
☐☐ Change in appetite	☐☐ Excessive worry	☐☐ Fear of dying
☐☐ Excessive guilt	☐☐ Avoidance	☐☐ Comes out of the blue
☐☐ Fatigue	☐☐ Hallucinations	☐☐ Worry about next attack a lot
☐☐ Decreased libido	☐☐ Suspiciousness	☐☐ Woke from sleep
☐☐ Racing thoughts	**Anxiety attacks**	**Other Symptoms**
☐☐ Impulsivity	☐☐ Short of breath	☐☐
☐☐ Increase risky behavior	☐☐ Heart race	☐☐
☐☐ Increased libido	☐☐ Chest pain	☐☐
☐☐ Decrease need for sleep	☐☐ Sweat	☐☐
☐☐ Excessive energy	☐☐ Feeling like choking	☐☐

Educational History:
Highest grade completed?_____Where?_____
Did you attend college?_____Where?_____Major?_____
What is your highest education level or degree attained?_____

Occupational History:
Are you currently: ☐ Working ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired
How long in present position?_____
What is/was your occupation?_____Are you satisfied with it?_____
Where do you work?_____
Have you ever served in the military?_____If so, what branch and when?_____
Honorable discharge? ☐ YES ☐ NO. Other type of discharge?_____
Do you have a performance issue with your boss or others?_____

Your Exercise Level:
Do you exercise regularly? ☐ YES ☐ NO
How many days a week do you get exercise?_____
How much time each day do you exercise?_____
What kind of exercise do you do?_____
Nutrition:
Do you purge, restrict or overeat?_____
Do you have any food difficulties?_____

Spiritual Life:
Do you belong to a particular religion or spiritual group? ☐ YES ☐ NO
If yes, what is the level of your involvement?_____
Do you find your involvement helpful, or does the involvement make things more difficult/stressful for you?
☐ more helpful ☐ stressful.

Family Background and Childhood History:
When your mother was pregnant with you, were there any complications during the pregnancy or birth?

_____
Were you adopted? ☐ YES ☐ NO. Where did you grow up?_____
List your siblings and their ages:_____
_____
What was your father's occupation?_____
What was your mother's occupation?_____
Did your parents divorce? ☐ YES ☐ NO. If so, how old were you when they divorced?_____
If your parents divorced, whom did you live with?_____
Describe your relationship with him or her:_____
_____
How old were you when you left home?_____
Has anyone in your immediate family died?_____Who and when?_____

Relationship History and Current Family:

Are you currently: ☐ Married ☐ Partnered ☐ Divorced ☐ Single ☐ Widowed. How long?_____

If not married, are you currently in a relationship? ☐ YES ☐ NO. If yes, how long?_____

Are you sexually active? ☐ YES ☐ NO. What kind of contraception, if any do you use?_____

How would you identify your sexual orientation?

☐ Straight/heterosexual ☐ Lesbian/gay/homosexual ☐ Bisexual ☐ Transsexual

☐ Unsure/questioning ☐ Asexual ☐ Other ☐ Prefer not to answer

What is your spouse or significant other's occupation?_____

Describe your relationship with your spouse or significant other:_____

_____

Have you any prior marriages?_____If so, how many_____How long_____

Do you have any children? ☐ YES ☐ NO. If yes, list ages and gender:_____

_____

Describe your relationship with your children:_____

_____

List everyone who currently lives with you:_____

_____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically, or by neglect? ☐ YES ☐ NO.

Please describe when, where and by whom:_____

_____

Have you ever had feelings or thoughts that you didn't want to live? ☐ YES ☐ NO

- If YES, please answer the following. If NO, please skip to the next section.

Do you currently feel that you don't want to live? ☐ YES ☐ NO

- How often do you have these thoughts_____

When was the last time you had thoughts of dying?_____

- Has anything happened recently to make you feel this way?_____

On a scale of 1 to 10 (ten being strongest) how strong is your desire to kill yourself currently?_____

- Would anything make it better?_____

Have you ever thought about how you would kill yourself?_____

- Is the method you would use readily available?_____

Have you planned a time for this?_____

- Is there anything that would stop you from killing yourself?_____

Do you feel hopeless and worthless?_____

- Have you ever tried to kill or harm yourself before?_____

Do you have access to guns? If yes, please explain_____

Behavioral History:

Have you ever been arrested?	NO	YES	RECENTLY	TODAY
Do you have any pending legal problems?	NO	YES	RECENTLY	TODAY
Have you had any thoughts of seriously hurting someone?	NO	YES	RECENTLY	TODAY
Have you hurt someone [slap/kick] punch intention to harm?	NO	YES	RECENTLY	TODAY
Have you destroyed property on purpose?	NO	YES	RECENTLY	TODAY

Past Psychiatric History:

Outpatient treatment? ☐ YES ☐ NO. If yes, please describe when, by whom, and nature of treatment.

Reason	Dates treated	By whom you were treated.
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Psychiatric Hospitalization? ☐ YES ☐ NO. If yes, please describe when, by whom, and nature of treatment.

Reason	Dates treated	By whom you were treated.
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ☐ YES ☐ NO

If yes, for which substance?_____

If yes, where were you treated and when?_____

_____

How many days per week do you drink any alcohol?_____

What is the least number of drinks you will drink in a day?_____

What is the most number of drinks you will drink in a day?_____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day?_____

Have you ever felt you ought to cut down on your drinking or drug use? ☐ YES ☐ NO

Have you felt guilty about your drinking or drug use? ☐ YES ☐ NO

Have you ever had a drink or use drugs first thing in the morning to steady nerves? ☐ YES ☐ NO
Have people annoyed you by criticizing your drinking or drug use? ☐ YES ☐ NO
Do you think you have a problem with alcohol or drug use? ☐ YES ☐ NO
Have you used any recreational drugs in the past three months? ☐ YES ☐ NO
If yes, which ones_____
_____

Have you ever abused prescription medication? ☐ YES ☐ NO
If yes, which one(s)_____
_____

Check if you have ever tried the following:			**If yes, how long and when did you last use?**
☐ Methamphetamine	☐ YES	☐ NO	_____
☐ Cocaine	☐ YES	☐ NO	_____
☐ Stimulants	☐ YES	☐ NO	_____
☐ Heroin	☐ YES	☐ NO	_____
☐ LSD or Hallucinogens	☐ YES	☐ NO	_____
☐ Marijuana	☐ YES	☐ NO	_____
☐ Pain killers (not as prescribed)	☐ YES	☐ NO	_____
☐ Methadone	☐ YES	☐ NO	_____
☐ Tranquilizer/sleeping pills	☐ YES	☐ NO	_____
☐ Alcohol	☐ YES	☐ NO	_____
☐ Ecstasy	☐ YES	☐ NO	_____
☐ Other	☐ YES	☐ NO	_____

How many caffeinated beverages do you drink a day? Coffee_____Soda_____Tea_____

Tobacco History:
Have you ever smoked cigarettes? ☐ YES ☐ NO.
Currently? ☐ YES ☐ NO. How many packs per day on average?_____How many years?_____
In the past? ☐ YES ☐ NO. How many years did you smoke?_____When did you quit?_____

Pipe, cigars, vaping, or chewing tobacco: Currently? ☐ YES ☐ NO. In the past? ☐ YES ☐ NO.
What kind?_____ How often per day or average?_____How many years?_____

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write what you do remember).

ANTIDEPRESSANTS	Dates	Dosage	Reason/Side-Effects
Prozac (fluoxetine)			
Zoloft (sertraline)			
Luzox (fluvoxamine)			
Paxil (paroxetine)			

Celexa (citalopram)			
Lexapro (escitalopram)			
Effexor (venlafaxine)			
Cymbalta (duloxetine)			
Wellbutrin (bupropion)			
Remeron (mirtazapine)			
Serzone (nefazodone)			
Anafranil (clomipramine)			
Pamelor (nortriptyline)			
Tofranil (imipramine)			
Elavil (amitriptyline)			
Other_____			

MOOD STABILIZERS	Dates	Dosage	Reason/Side-Effects
Tegretol (carbamazepine)			
Lithium			
Depakote (valproate)			
Lamictal (lamotrigine)			
Trileptal (oxcarbazepine)			
Topamax (topiramate)			
Other_____			

MOOD STABILIZERS ANTIPSYCHOTICS	Dates	Dosage	Reason/Side-Effects
Seroquel (quetiapine)			
Zyprexa (olanzapine)			
Geodon (ziprasidone)			
Abilify (aripiprazole)			
Clozaril (clozapine)			

Haldol (haloperidol)			
Prolixin (fluphenazine)			
Risperdal (risperidone)			
Other_____			

SLEEP AID	Dates	Dosage	Reason/Side-Effects
Ambien (zolpidem)			
Sonata (zaleplon)			
Rozerem (ramelteon)			
Restoril (temazepam)			
Desyrel (trazodone)			
Other_____			

ADHD medication	Dates	Dosage	Reason/Side-Effects
Adderall (amphetamine)			
Concerta (methylphenidate)			
Ritalin (methylphenidate)			
Strattera (atomoxetine)			
Other_____			

ANTIANXIETY MEDICATION	Dates	Dosage	Reason/Side-Effects
Xanax (alprazolam)			
Ativan (lorazepam)			
Klonopin (clonazepam)			
Valium (diazepam)			
Buspar (buspirone)			
Other_____			

Please list allergies and what happened when exposed to the allergens: (ex. rash, hives, etc.)

1. _____ 2._____
3. _____ 4._____
5. _____ 6._____

List **ALL** current prescription medications and how often you take them: (if none, write none)

Medication Name	Total Daily Dosage	Estimate Start Date

Current over-the-counter medication or supplements:_____

_____

Current medical problem(s): (ex. heightened blood pressure, cholesterol, etc.) _____

_____

Past medical problems, nonpsychiatric hospitalizations, or surgeries and dates _____

_____

Have you ever had an EKG? ☐ YES ☐ NO. If yes, when_____

- Results were ☐ Normal ☐ Abnormal ☐ Unknown

Do you have any concerns about your physical health that you would like to discuss with us? ☐ YES ☐ NO

Date and place of last physical exam:_____

For women only:

Date of last menstrual period_____

Are you currently pregnant or do you think you might be pregnant? ☐ YES ☐ NO.

Are you planning to get pregnant in the near future? ☐ YES ☐ NO

Birth control method_____

How many times have you been pregnant?_____How many live births?_____

Personal and Family Medical History:

Medical Problems	You	Family member	If YES, which family members?
Thyroid Disease	☐ YES	☐ YES	
Anemia	☐ YES	☐ YES	
Liver Disease	☐ YES	☐ YES	
Chronic Fatigue	☐ YES	☐ YES	
Kidney Disease	☐ YES	☐ YES	
Diabetes	☐ YES	☐ YES	
Asthma/respiratory problems	☐ YES	☐ YES	
Stomach or intestinal problems	☐ YES	☐ YES	
Cancer (type)	☐ YES	☐ YES	
Fibromyalgia	☐ YES	☐ YES	
Heart Disease	☐ YES	☐ YES	
Epilepsy or Seizures	☐ YES	☐ YES	
Chronic pain	☐ YES	☐ YES	
High Cholesterol	☐ YES	☐ YES	
High blood pressure	☐ YES	☐ YES	
Head trauma	☐ YES	☐ YES	
Liver problems	☐ YES	☐ YES	

Is there any additional personal or family medical history? ☐ YES ☐ NO. If yes, please explain:

_____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	☐ YES	☐ NO	Schizophrenia	☐ YES	☐ NO
Depression	☐ YES	☐ NO	Post-traumatic stress	☐ YES	☐ NO
Anxiety	☐ YES	☐ NO	Alcohol abuse	☐ YES	☐ NO
Anger	☐ YES	☐ NO	Other substance abuse	☐ YES	☐ NO
Suicide	☐ YES	☐ NO	Violence	☐ YES	☐ NO

If yes, who had each problem?_____

_____

Has any family member been treated with psychiatric medication? ☐ YES ☐ NO. If yes, who was treated, what medication did they take and how effective was the treatment?_____

MOOD DISORDER QUESTIONNAIRE

Has there ever been a period of time when you were not your usual self and…

a)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?	☐ YES ☐ NO
b) You were so irritable that you shouted at people or started fights or arguments?	☐ YES ☐ NO
c) You felt much more self-confident than usual?	☐ YES ☐ NO
d) You got much less sleep than usual and found you did not really miss it?	☐ YES ☐ NO
e) You were much more talkative or spoke much faster than usual?	☐ YES ☐ NO
f) Thoughts raced through your head or you could not slow down your mind?	☐ YES ☐ NO
g) You were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐ YES ☐ NO
h) You had much more energy than usual?	☐ YES ☐ NO
i) You were much more active or did many more things than usual?	☐ YES ☐ NO
j) You were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐ YES ☐ NO
k) You were much motr interested in sex than usual?	☐ YES ☐ NO
1) You did things that were unusual for you or that other people might have thought were excessive, foolish, risky?	☐ YES ☐ NO
m) You spend money so much that it got you or your family in trouble?	☐ YES ☐ NO
If you checked YES to more than one of the above, have several of things ever happened during the same period of time?	☐ YES ☐ NO
How much of a problem did any of these cause you—like being unable to work; having family, money or legal troubles; getting into arguments or fights? ☐ No problem ☐ Minor Problem ☐ Moderate Problem ☐ Serious problem	

Check any that were a problem in the last month.

GENERAL	**NOSE**	**NECK**	**GASTROINTESTINAL**	**VASCULAR**
☐ Weight loss or gain	☐ Stuffiness	☐ Lumps	☐ Swallowing difficulties	☐ Calf pain with walk
☐ Fatigue	☐ Discharge	☐ Swollen glands	☐ Heartburn	☐ Leg cramping
☐ Fever or chills	☐ Nosebleeds	☐ Pain	☐ Change in appetite	**HEMATOLOGIC**
☐ Weakness	☐ Itching	☐ Stiffness	☐ Nausea	☐ Ease of bruising
☐ Trouble sleeping	☐ Hay fever	☐ Other_____	☐ Change in bowel habits	☐ Ease of bleeding
☐ Trembling	☐ Other_____	☐ Other_____	☐ Rectal bleeding	**ENDOCRINE**
☐ Other_____	**EYES**	**BREASTS**	☐ Constipation	☐Head intolerance
SKIN	☐ Vision loss/change	☐ Lumps	☐ Diarrhea	☐ Sweating
☐ Rashes	☐ Pain	☐ Discharge	☐ Stomach ache	☐ Frequent urination
☐ Lumps	☐ Redness	☐ Other_____	☐ Yellow eyes or skin	☐ Change in appetite
☐ Itching	☐ Double vision	**RESPIRATORY**	☐ Other_____	**NEUROLOGIC**
☐ Dryness	☐ Flashing lights	☐ Cough	**GENITOURINARY**	☐ Dizziness
☐ Color changes	☐ Specks	☐ Sputum	☐ Frequency	☐ Fainting
☐ Hair and nail change	☐ Glaucoma	☐ Coughing up blood	☐ Urgency	☐ Seizures
☐ Other_____	☐ Cataracts	☐ Shortness of breath	☐ Burning or pain	☐ Weakness
HEAD	☐ Other_____	☐ Wheezing	☐ Blood in urine	☐ Numbness
☐ Head injury	**THROAT**	☐ Other_____	☐ Incontinence	☐ Tingling
☐ Neck pain	☐ Bleeding	**CARDIOVASCULAR**	☐ Other_____	☐Tremor/Twitching
☐ Other_____	☐ Choking	☐ Palpitations	**MUSCULOSKELETAL**	**PSYCHIATRIC**
EARS	☐ Dry mouth	☐ Tightness	☐ Muscle or joint pain	☐ Nervousness
☐ Decreased hearing	☐ Sore throat	☐ Swelling	☐ Stiffness	☐ Stress
☐ Ringing in ears	☐ Hoarseness	☐ Chest pain	☐ Back Pain	☐ Depression
☐ Earache	☐ Thrush	☐ shortness of breath	☐ Redness of joints	☐ Memory loss
☐ Drainage	☐ Non-healing sores	☐ Other_____	☐ Swelling of joins	☐ Other_____
☐ Other_____	☐ Other_____	☐ Other_____	☐ Trauma	☐ Other_____

Please let us know anything else that would help us treat you more efficiently

Signature_____Date_____
Guardian Signature (if under age 18)_____Date_____
Emergency Contact_____Telephone #_____