Name:			
Address:			
City:	State:	Zip:	
DOB:	Age:	Sex:	SS#:
Phone #	Home:	Work:	Cell:
Employer:	Occupation:		
Emergency Contact:	Emergency Contact #:		
Who has custody of Minor/Relationship to Minor?			

Insurance Information

Primary Insurance Carrier:		
Policy Holder Name:	DOB:	
Relationship to Patient:	SS#:	
Address (if different):		
City:	State:	Zip
Policy ID:	Group #:	
Policy Holder Phone:	Insurance company Phone:	
Secondary Insurance Carrier:		
Policy Holder Name:	DOB:	
Relationship to Patient:	SS#:	
Address (if different):		
City:	State:	Zip
Policy ID:	Group #:	
Policy Holder Phone:	Insurance company Phone:	

Financial Responsibility

Name of Responsible Party (if different):			
Relationship to Patient:			
Address (if different):			
Phone #	Home:	Work:	Cell:

Primary Care Provider (PCP)

PCP Name:	
PCP Telephone Number:	PCP Fax Number:
Authorization to Release Medical Information to PCP (includes office visit notes):	( ) Yes ( ) No

Release of Information

Patient Name: ____ **Date of Birth:** ____/____/____

Please document below parties that you would allow medical information to be released to. It is often helpful in coordination of care if other providers are indicated on this list. Thank you!

Name of Person	Relationship to patient	Telephone Number	Medical Information	Appointments

Pharmacy Name/Location: ____Phone: _____________

**Release of information pertaining only to appropriate prescription information*

Permission to Call Home or Cell?	( ) Yes	( ) No	Preferred #:
Permission to Leave Voicemail?	( ) Yes	( ) No	
Permission to Email	( ) Yes	( ) No	Email:
Permission for Reminder call/text	( ) Yes	( ) No	Preferred method:

HIPAA and Email: Please note that many popular email services (Gmail, Yahoo, Hotmail) do not utilize encrypted email. When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the internet.

For Minors:

Due to concerns with custody, please state who has medical decision-making capacity.

____

If this is not the current representative, do you give permission for any other parent/guardian to make medical decisions? ( ) Yes ( ) No

Name of person(s):____

I hereby authorize the release of the medical information as documented above. I understand I retain the right to decline release of information to the above parties at any time and will notify staff of any changes that I wish to make in writing. I understand that in emergency situations the provider may contact other provider/caregivers to coordinate safe and appropriate care without my consent.

Signature of Patient/Guardian: ____ **Date:** ______________

Policies and Procedures

Insurance Verification: ***Payment is due at the time of the office visit (copy/deductibles etc.)*** Please be sure to verify coverage prior to your first visit. You as a patient are responsible for understanding your benefits for coverage. This helps to assure that the provider you are seeing is covered with your benefits. We do our best to help estimate patient costs including co-pays, co-insurance, deductibles and out of pocket limits. The information provided is often not up to date when patients present to the clinic, and we do our best to work with the information provided to us.

Insurance Filing: Please note that we will file your claims with the insurance providers as a courtesy. We require that you provide a current ID and copy of the insurance card. These may change over time, and we require that you inform us of any changes and provide copies of new insurance cards/information. It is important that we have the most up to date information as any errors in your information can result in denied claims. This includes insurance policy ID numbers, address changes, name changes, and telephone numbers. There may also be remaining fees because of insurance coverage or denied claims. Denied claims will result in your visit being billed at our clinics self-pay rates.
By signing this agreement, you authorize Angel Oak Counseling to release all medical information necessary to your insurance company to secure payment.

Billing Service:
Please note that Angel Oak Counseling utilizes an outside agency, Practical Management Solutions, for the purposes of billing and submitting claims to insurance providers. These individuals are provided limited access to patient demographics as required for the billing process and maintain appropriate HIPAA compliance. We will work to assist in explaining balances in office, but request that questions about outstanding balances be directed to that service at (843) 620-3763. Payments can be submitted directly to the outside billing service, or you may call the office to submit payment.

Referrals and Authorizations: As a specialist, some insurance companies require that prior to any visit you must obtain an authorization or referral from your primary care physician. It is your responsibility to know if this is required by your insurance and, if so, to obtain the referral. If this is not done 48 hours before your appointment, you will be asked to either reschedule your appointment or pay the full amount for all services on the day of service. If your insurance company rejects a claim because a valid authorization or referral was not in place, the full cost of the visit will be your responsibility.

Appointment/Cancellation/No-show/Late Arrivals Policy: Patients are responsible for scheduling follow up visits after each session. It is also the patient's responsibility to be aware of any upcoming appointments. We require 24-hour notice for cancellations, otherwise you may be charged a fee relative to the time of your scheduled appointment. You may also be charged for not showing up to your scheduled appointments. Should you arrive more than 15 minutes late for any appointment, you will be asked to reschedule so that an appropriate amount of time and attention may be devoted to your care. You will still be responsible for payment of the missed session. This fee is not covered by insurance and cannot be submitted for insurance reimbursement

Medication Requests: Please be proactive in monitoring the need for refills. We ask that you allow 24-48hrs for all refill requests. We do not respond to fax/email or patient portal requests for prescriptions refills. Our office does require an appointment for any medication changes. Medication refills will only be provided to patients who have been seen within 90 days of the last completed appointment. If the request falls outside of this timeframe, this will result in the patient being provided with the next available appointment which may result in a lapse in medication.

Business Hours/After Hours Communication:
Office hours are Monday through Friday from 9am-9pm. Our office is closed on the weekends and major holidays. We do not provide 24/7 call-coverage at our office. Please note that in case of emergency, we advise you to call 9-1-1 or go to your local emergency room.

- **Phone Calls-** Most routine calls are returned within 48 hours during the above stated business hours. This is our preferred method of communication. We do not communicate via text. * A fee may be charged for clinical phone calls between appointments. This fee is not covered by insurance. Please note that all communications will be added to your medical records

- **Emails-** We do not disclose any PHI, including records, through email. These communications are not protected and cannot be guaranteed as private. Please note that all communications will be added to your medical records. Email is not for urgent/emergency messages.
- **OnPatient Portal-** This is a secure method of communication. Portal communication is not for emergency or urgent issues. Please do not send us a message through the portal that is of an urgent or emergent nature. Please note that all communications will be added to your medical records.

**All messages received after hours, on weekends, or holidays are reviewed the next business day. Please allow at least 1-2 business days for a response*

Office/Administrative Fees:

Please note that office staff is often required to provide documentation to patients, providers, and outside agencies. The following are rates for the services rendered to complete that service.

- **Letters/Forms/Completed Paperwork for outside agencies:** We will try to complete all work during our scheduled sessions. It may occasionally be necessary for us to charge on a prorated basis for professional services that require extensive time commitment such as report/letter writing, completing forms, telephone conversations lasting longer than 5 minutes, and consultations with other professionals that you have requested.
  (Forms will only be completed with a scheduled appointment.)

- **Copies of Medical Records: $25.00** Medical records requested for the patient's own use carry a charge and may be provided in the form of a treatment summary at the discretion of the physician. Parts of your record that could potentially be detrimental to your psychological well-being may be withheld.

****We ask that you allow 24-48 hours turnaround time for the requested forms to be completed.***

Mental Health Records: Medical records are required by law. Our clinic currently uses an electronic health record (EHR) to record and store patient information. This EHR system is secure and abides by the HIPAA laws/regulations. However, as with all electronic systems, there are factors that are sometimes outside of our control. We will always strive to ensure your information is kept confidential and compliant with HIPPA regulations. We reserve the right to change electronic health record systems at any time.

Discontinuation of Treatment: The physician may discontinue treatment with a patient usually for one of the following reasons:

- Non-payment of your account.
- Canceling/missing appointments too often.
- Non-compliance with treatment recommendations.
- Withdrawal of treatment is necessary due to medical, financial, or legal problems or geographic relocation.
- Lack of attendance and/or motivation prevents further progress toward goal achievement.
- Inappropriate behavior relative to self, staff, or other clients (i.e., threatening and/or intimidating behaviors)
- Modification of medications prescribed by your physician is made by patient without first consulting the physician or a covering physician.
- Obtaining psychiatric medications from another prescriber.
- Failure to comply with the provisions of the Policies and Procedures as stated in this document.
- Successful completion of the treatment program initially agreed upon, implying that the patient has made significant progress toward meeting treatment goals.
- Patient chooses to terminate treatment.

If you foresee problems in any of these areas, please let your physician know your concerns. If you decide to discontinue treatment, you can do so at any time in person, by phone, or in writing. If you discontinue treatment without notifying your physician, it will be assumed that your therapeutic relationship with him or her terminated 90 days after your last visit,

unless you have an appointment scheduled for a future date, beyond which Angel Oak Counseling carries no further responsibility for your care. You may re-enter treatment with your physician if your treatment ended in good standing, and he/she is accepting new patients.

Patient Etiquette: Disrespectful/abusive behavior or harassment towards office staff or physicians will not be tolerated and patients will be immediately terminated from the practice should this occur.

Third Party Entities: Angel Oak Counseling does utilize outside agencies to help provide services to patients. These companies are HIPAA compliant, and we have appropriate BAAs with each company. These individuals are provided limited access to patient demographics. Below are the companies we have a BAA with:

- Genesight (genetic testing)
- Genomind (genetic testing)
- Cambridge Sciences (ADHD Assessments)
- Athelas (remote patient monitoring)
- Practical Management Solutions (billing)

HIPAA

Angel Oak Counseling is required by the Health Insurance Portability & Accountability Act (HIPAA) to provide confidentiality for all medical/mental health records and other individually identifiable health information in our possession. This Notice is to inform you of the uses and disclosures of confidential information that may be made by Angel Oak Counseling, and of your individual rights and Angel Oak Counseling's legal duties with respect to confidential information.

Release of Information

- Please complete a release of information form to indicate any parties to which you wish to have your protected health information (PHI) released. Other than the indicated parties, our clinic may release the information for payer-source purposes (insurance companies).

Disclosures that do not require authorization to release your PHI:

- Disclosure required by law, such as a court order by a judge.
- Disclosure for use in judicial or administrative proceedings, such as a malpractice case or board complaint.
- Disclosure to maintain safety of patients or others, such as communication with probate court for commitment.
- Disclosure during emergent care situations, such as discussing care with emergency room providers.
- Disclosure for suspected abuse, neglect, or domestic violence, as required as a mandated reporter and for duty to warn.

Telehealth Policies and Consent

Introduction

Telepsychiatry is the delivery of psychiatric services using interactive audio and visual electronic systems where the psychiatrist and the patient are not in the same physical location.
The interactive electronic systems used in telepsychiatry incorporate network and software security protocols to protect the confidentiality of patient information and audio and visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

My Rights

I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry.
I understand that the telepsychiatry platform used by Angel Oak Counseling is encrypted to prevent the unauthorized access to my private medical information.
I have the right to withhold or withdraw my consent to the use of telepsychiatry during my care at any time.
I understand that my withdrawal of consent will not affect any future care or treatment.

I understand that the Angel Oak Counseling provider has the right to withhold or withdraw his consent for the use of telepsychiatry during my care at any time.
I understand that all rules and regulations which apply to the practice of medicine in the state of South Carolina also apply to telepsychiatry.

My Responsibilities
I will not record any telepsychiatry sessions without written consent from the Angel Oak Counseling provider.
I understand that all Angel Oak Counseling providers will not record any of our telepsychiatry sessions without my written consent.
I will inform the Angel Oak Counseling provider if any other person can hear or see any part of our session before the session begins. Any Angel Oak Counseling provider will inform me if any other person can hear or see any part of our session before the session begins.
I understand that I, not the Angel Oak Counseling provider, am responsible for the configuration of any electronic equipment used on my computer which is used for telepsychiatry.
I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.
I understand that I must be a resident of the state of South Carolina to be eligible for telepsychiatry services from Angel Oak Counseling.
I understand that my initial evaluation will not be done by telepsychiatry except in special circumstances under which I will required to verify my identity to his satisfaction before the evaluation.
I understand that medication evaluation and management will require in office visits and will not be provided via telepsychiatry.
I accept financial responsibility for my appointments should my insurance provider not cover medical expenses related to telepsychiatry services.

Patient Consent to The Use of Telepsychiatry
I have read and understand the information provided above regarding telepsychiatry, have discussed it with an Angel Oak Counseling provider and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telepsychiatry in my medical care and authorize Angel Oak Counseling to use telemedicine during my diagnosis and treatment.

Credit Card Authorization
I consent to Angel Oak Counseling having my credit card on file and understand that I will be billed for the balance of my session on the day of my appointment.

Informed Consent and Treatment Agreement for Controlled Substances

Your licensed prescribing practitioner has indicated that a controlled medication may assist in your symptomatic relief. Controlled medicine can be dangerous and habit forming. These medicines must be taken only as prescribed by your doctor. Please read this agreement thoroughly and ask any questions you may have.

If you agree and fully understand the benefits and risks of the medications, sign, and date below.

- I understand that the medication I am being prescribed may cause addiction, but my licensed prescribing practitioner feels it is necessary for treatment of my condition. My practitioner has explained to me the potential risks, the potential short- and long-term side effects; the risk of drug interactions and over-sedation; the risk of misuse and overdose. I accept these risks.
- I agree to take this medication only as prescribed by my licensed prescribing practitioner.
- I agree to attend all scheduled appointments with my physician, APRN, or PA.
- I understand that refills will not be given early.
- I will not obtain controlled substances from any other providers unless authorized by my primary prescriber, because it may be considered illegal to obtain controlled substances from multiple providers. • I understand that these medications are for my personal use only.
- I understand that it is illegal, and can be reported to the police, to give or sell my medication to others. • I understand that it is illegal for me to use medications that are not prescribed to me.

- I understand that I am responsible for my own medication. Lost or stolen medication will not be replaced.
- I give up the right to privacy protections regarding my prescription for controlled substances. The prescriber or their staff may talk with other healthcare practitioners, pharmacists, or family members to confirm appropriate medication use.
- I agree to submit to random drug screening tests when ordered by my prescriber, and I will be responsible for payment for the tests.
- If requested of me, I agree to bring my medication bottle(s) to the office for the purpose of a pill count.
- I understand that I may obtain my controlled substances from only one pharmacy, and it will be in South Carolina, and I agree to update my physician's office of any changes in the pharmacy I use.
- I understand these medications may impair my ability to drive and/or operate heavy machinery.
- I agree to not use alcohol or any illegal substances, including but not limited to marijuana, cocaine, or any other "street drugs".
- I agree to notify my prescriber should I become pregnant while taking these medications.
- I agree to inform and have informed my prescriber of all medications that I currently take (prescribed and or over the counter) as well as any illegal substances or alcohol that I have consumed. I have further informed my prescriber of any known medication allergies or any known adverse medication side effects.

I have reviewed this Informed Consent and Treatment Agreement for Controlled Substances. I understand it and continue to agree to honor the Agreement. I understand that failure to do so may result in my discharge from Angel Oak Counseling.

By signing below, you certify that you have read and understand the terms stated in this Policies and Procedures Treatment Consent Form. You agree to abide by the terms stated above throughout the course of the professional relationship.

____

Patient/Guardian Signature

____

Date

Angel Oak Counseling Intake Form

Please complete all information on this form and bring it to the first visit.

Name____Date____________________

What is the problem(s) for which you are seeking help?

1.____

2.____

3.____

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

( ) Depressed mood
( ) Unable to enjoy activities
( ) Sleep pattern disturbance
( ) Loss of interest
( ) Concentration/forgetfulness
( ) Change in appetite
( ) Excessive guilt
( ) Fatigue
( ) Decreased libido

( ) Racing thoughts
( ) Impulsivity
( ) Increase risky behavior
( ) Increased libido
( ) Decrease need for sleep
( ) Excessive energy
( ) Increased irritability
( ) Crying spells

( ) Poor focus
( ) Distractibility
( ) Interrupting others
( ) Getting off task
( ) Mood Swings
( ) Checking Behaviors
( ) Difficulty in crowds
( ) Nightmares

( ) Excessive worry
( ) Anxiety attacks
( ) Avoidance
( ) Hallucinations
( ) Suspiciousness
( ) ________________
( ) ________________

Suicide Risk Assessment

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? _____________________________
Would anything make it better? ____
Have you ever thought about how you would kill yourself? ______________________________
Is the method you would use readily available? _______________________________________
Is there anything that would stop you from killing yourself? _____________________________
Have you ever tried to kill or harm yourself before? ____________________________________
Do you have access to guns? If yes, please explain. ____________________________________

Past Psychiatric History:

Outpatient treatment ( ) Yes ( ) No If yes, Please describe when, by whom, and nature of treatment.

Reason Dates Treated by Whom

____

____

____

Psychiatric Hospitalization ( ) Yes ( ) No If yes, describe for what reason, when and where.

Reason Date Hospitalized Where

____

Current Psychiatric Medications:

Please list Name, Dose and Times of Day

____
____
____
____

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 in what you do remember).

Antidepressants

( ) Prozac (fluoxetine) ________________________
( ) Zoloft (sertraline) ________________________
( ) Luvox (fluvoxamine) ______________________
( ) Trintellix (vortioxetine) ___________________
( ) Cymbalta (duloxetine) _____________________
( ) Fetzima (levomailnacipran)________________
( ) Wellbutrin (Buproprion) ___________________
( ) Elavil (amitriptyline) ______________________
( ) Tofranil (imipramine) ______________________
( ) Other _____________________________________
( )Lexapro (escitalopram) _______________________
( )Celexa (citalopram) ___________________________
( )Paxil (paroxetine) ______________________________
( )Viibryd (vilazodone) ___________________________
( )Effexor (venlafaxine) __________________________
( ) Pristiq (desvenlafaxine) _______________________
( ) Remeron (mirtazapine) _________________________
( ) Serzone (nefazodone) __________________________
( ) Anafranil (clomipramine) _______________________
( ) Pamelor (nortriptyline) _________________________

Mood Stabilizers

( )Tegretol (carbemazapine) ________________
( )Lamitcatl (lamotrigine) __________________
( )Lithium ______________________________
( )Other ________________________________
( ) Trileptal (oxcarbazapine) _____________________
( ) Depakote (valproate) _________________________
( ) Topamax (topiramate) _________________________
( )

Sleep Medications

( ) Ambien (zolpidem) ____________________
( ) Sonata (zaleplon) ______________________
( ) Restoril (temazepam) ___________________
( ) Rozerem (ramelteon)____________________
( ) Tylenol PM/Zzzquil)____________________
( ) Clonidine ______________________________
( ) Neurontin (gabapentin) ______________________
( ) Lunesta (eszopiclone) _______________________
( ) Desyrel (trazodone) _________________________
( ) Belsomra (suvorexant) ______________________
( ) Melatonin _______________________________
( ) Benadryl (diphenhydramine) ________________
( ) Other ___________________________________

ADHD/Stimulants

( ) Adderall (amphetamine)________________ ( ) Ritalin (mehtylphenidate)___________________

( ) Adderall XR____________________________ ( ) Concerta ________________________________

( ) Vyvanse ________________________________ ( ) Focalin ___________________________________

( ) Mydayis ________________________________ ( )Evekeo _________________________________

( )Focalin XR ______________________________ ( ) Adzenys ________________________________

( ) Daytrana patch ___________________________ ( ) Dyanavel ______________________________

( ) Methylin__________________________________ ( ) Zenzedi ________________________________

( ) Procentra _________________________________ ( ) Kapvay (clonidine)_____________________

( ) Aptensio ER______________________________

( ) Tenex (guanfacine) _____________________ ( ) Quillicant/Quillichew ______________________

( ) Intuniv _________________________________ ( ) Strattera (atomoxetine) _____________________

( ) Other ___________________________________

Anxiety Medications

( ) Ativan (lorazepam)_____________________ ( ) Xanax (alprazolam)______________________

( ) Klonopin (clonazepam) _________________ ( ) Tanxene (clorazepate)___________________

( ) Valium (diazepam) _____________________ ( ) Buspar (buspirone)_____________________

( ) Serax (oxazepam) _______________________ ( ) Neurontin (gabapentin)_________________

( ) Vistaril (hydroxyzine)___________________ ( ) Meprobamate__________________________

( ) Other _________________________________

Anti-psychotic Medications

( ) Abilify (aripiprazole)___________________ ( )Zyprexa (olanzepine)_______________________

( ) Geodon (ziprasidone)___________________ ( )Risperidal (risperidone)_____________________

( ) Seroquel (quetiapine)___________________ ( )Saphris (asenapine) _________________________

( ) Rexulti (brexipiprazole)_________________ ( )Fanapt (illoperidone) _______________________

( ) Latuda (lurisadone)_____________________ ( )Haldol (haloperidol)________________________

( ) Vraylar (cariprazine)____________________ ( )Prolixin (fluphenazine)______________________

( ) Clozaril (clozapine)_____________________ ( )Thorazine _______________________________

( ) Other _________________________________

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
ADHD/ADD	( ) Yes ( ) No		

If yes, who had each problem? ____

____

Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No

If yes, who was treated, what medications did they take, and how effective was the treatment?____

Educational History:
Do you have a high school diploma or GED? __________ Where? ___________________________________
Did you attend college? ________ Where? _________________________Major? _________________________
What is your highest educational level or degree attained? ____

Occupational History:
Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired
What is/was your occupation? ____
Where do you work? ____
Have you ever served in the military? _______ If so, what branch and when? ____________________________

Relationship History and Current Family:
Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed
Do you have any Children? ___________ If so, how many? __________
Who lives at home with you? ____
Do you feel you have a good support network? _________________________

Stress Factors:
Financial: ____
Relationship: ____
Legal: ____
Occupational: ____
Educational: ____

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: ____
____

Past Medical History:

Allergies______________________________ Current Weight ____________ Height ____________

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

Medication Name	Total Daily Dosage	Estimated Start Date

Current over-the-counter medications or supplements: ____
____

Current medical problems: ____
____

Past medical problems, nonpsychiatric hospitalization, or surgeries:
____

Have you ever had an EKG? ( ) Yes ( ) No If yes, when _________
Was the EKG ( ) normal ( ) abnormal or ( ) unknown**?**

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 soon? ( ) Yes ( ) No

Birth control method ____

How many times have you been pregnant? ________________________________

How many live births? ____

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: ____

Personal and Family Medical History:

	You	Family	Which Family Member?
Thyroid Disease ----------------------	( )	( )	________________
Anemia-------------------------------	( )	( )	________________
Liver Disease ------------------------	( )	( )	________________
Chronic Fatigue ----------------------	( )	( )	________________
Kidney Disease ----------------------	( )	( )	________________
Diabetes -------------------------------	( )	( )	________________
Asthma/respiratory problems ------	( )	( )	________________
Stomach or intestinal problems ---	( )	( )	________________
Cancer (type) -----------------------	( )	( )	________________
Fibromyalgia -------------------------	( )	( )	________________
Heart Disease ------------------------	( )	( )	________________
Epilepsy or seizures -----------------	( )	( )	________________
Chronic Pain ------------------------	( )	( )	________________
High Cholesterol --------------------	( )	( )	________________
High blood pressure------------------	( )	( )	________________
Head trauma -------------------------	( )	( )	________________
Liver problems ----------------------	( )	( )	________________
Other ---------------------------------	( )	( )	________________
		( )	

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, for which substances? ____

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 greatest number of drinks you will drink in a day? ________

In the past three months, what is the largest number 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 people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No

Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Have you used any street drugs in the past 3 months? ( ) Yes ( ) No
If yes, which ones? ____

Have you ever abused prescription medication? ( ) Yes ( ) No
If yes, which ones and for how long? ____
____

Check if you have ever tried the following:

	Yes	No	If yes, how long and when did you last use?
Methamphetamine	( )	( )	______________________________
Cocaine	( )	( )	______________________________
Stimulants (pills)	( )	( )	______________________________
Heroin	( )	( )	______________________________
LSD or Hallucinogens	( )	( )	______________________________
Marijuana	( )	( )	______________________________
Pain killers (not as prescribed)	( )	( )	______________________________
Methadone	( )	( )	______________________________
Tranquilizer/sleeping pills	( )	( )	______________________________
Alcohol	( )	( )	______________________________
Ecstasy	( )	( )	______________________________
Other			______________________________

How many caffeinated beverages do you drink a day? Coffee _______ Sodas ________ Tea ________

Tobacco History:
How 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, or chewing tobacco: Currently? **( )** Yes **( )** No
In the past? **( )** Yes **( )** No
What kind? ____
How often per day on average? ____
How many years? ____

I agree that the above information is correct to the best of my knowledge.

Signature: ____Date: ______________

Guardian Signature (if under age 18): ____Date: ______________