Today's Date: ______________________________

Patient Name: ____ Age: _________________

Birth Date: _________________ Sex: _______ Marital Status: ☐Single ☐Married ☐Divorced ☐Widow

Language(s): __________________________________ Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino

Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Pacific Islander ☐White

Social Security Number: ___________________________ Email ___________________________________

Address: ____

City: ____ State: _______________ Zip: ________________

Phone :(Primary) ___________________________________ Phone :(Alt.) _________________________________

Primary Care Physician: ______________________________________ Phone: ____________________________

Who referred you to our office? ____

IN CASE OF EMERGENCY PLEASE NOTIFY:

Name: ____

Address: ____

Phone: ______________________________________ Relationship: ______________________________________

EMPLOYMENT INFORMATION

Employer's Name: ____

City: ____State: __________________ Zip: _______________

Patient's Occupation: ____

DISCLOSURE

I hereby authorize ____
(Primary and secondary insurance carrier name)

To pay directly to **Quality Care Wellness LLC** any insurance payments otherwise payable to me for services rendered. I also authorize **Quality Care Wellness LLC** to release any information requested by the above named insurance company/companies, which might be needed to process claims. I am aware that MEDICARE Part B may deny benefits for "Medical Necessity" should services rendered exceed Medicare Part B authorized guidelines. I have obtained proper authorization from my insurance carrier to be evaluated by **Quality Care Wellness LLC** and to accept responsibility compliant with my insurance carrier's requirements.

Signature:____Date:_______________________

I acknowledge that payment/co-payments for services rendered are due and payable at the time services are rendered and that I am responsible for all annual deductible and co-payments as determined by my insurance policy. I acknowledge that interest charges may be applied should my account become delinquent. I accept responsibility for consistently missed appointments and/or late cancellations (less than 24 hour's notice) and am aware that $30.00 charge maybe assessed to my account if this occurs for any scheduled appointment.

I acknowledge that I am giving **Quality Care Wellness LLC** authorization to treat me based on her evaluation today.

Signature:____ Date:______________________

MEDICAL RECORDS RELEASE

Date ______________________________

Patients' Name ____

Date of Birth_____________________________________

I, ____, hereby authorize:

Quality Care Wellness LLC
3640 N. Federal Hwy
Suite 5
Lighthouse Point, FL 33064

To release psychiatric / psychological / medical information from my health records in accordance with Florida Statutes 394.459 (9) b90.503.

To (e.g. Immediate Family members, Primary Care Physician or other part.) Please specify (If you do not want this information released)

____

____

____

____

A GENERAL AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS OR OTHER INFORMATION IS NOT SUFFICIENT TO RELEASE PSYCHIATRIC/PSYCHOLOGICAL INFORMATION.

I ____ understand that I have the right to refuse / revoke this authorization by written notice to the source of the information listed above at any time before information is disclosed.

The above listed person / facilities are released all legal liability that may arise from the release of the information requested.

PROHIBITATION ON REDISCLOSURE: This information has been disclosed from record whose confidentiality is protected by Federal Law (42 CRF Part 2). The recipient is prohibited to whom it pertains or the legal guardian thereof.

This authorization will be valid for one (1) year from the date on the authorization.

Patients Signature:____

Guardian / Legal Representative: ____
(If patient is a minor or unable to sign, a copy of Power of Attorney must be on file.)

Witness Signature:____

Date:____

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was informed of the "Notice of Privacy Practices" and that I have had the opportunity to read or was provided a copy (upon request) and understood the Notice.

______________________________________ ____________________________

Patient's Name (Please print) Date

____

Authorized Representative (if applicable)

____

Patient's Signature

Date: ____

Patient Name:____

Why are you seeing the doctor today?

____
____
____

List **CURRENT** medications: (name / strength / when taken / prescribing MD)

____
____
____

List **CURRENT** medical problems / treatment: (condition / medication / treating physician)

____
____
____

Allergies:

____
____
____

List three (3) behaviors which concern you **MOST** (most troubling first and when you first noticed them):

____
____
____

If no changes occur, what are you **MOST** concerned / worried will happen?

____
____
____

What are the **MOST** stressful things in your life currently?

____
____
____

Are you currently involved in litigation (lawsuit)? Describe.

____
____
____

Patient Name:____

Have you ever had similar behavior or emotional problems before? _____________

If YES, describe them, when they occurred (date), what treatment was given (outpatient / inpatient)?

____
____
____
____

FAMILY HISTORY

Please list any relative (maternal or paternal) who may have been diagnosed / treated for the following:

Nervousness / panic / anxiety: ____
Depression: ____
Mania / Manic-Depression: ____
Suicide / homicide: ____
Alcohol / Drugs: ____
Police record (arrests, jail / reason): ____
Schizophrenia: ____
Mental Retardation: ____
Learning Disorder (dyslexia): ____
Attention Deficit / Hyperactivity: ____
Other (describe): ____

BEHAVIORAL / EMOTIONAL HISTORY: (circle Yes or No)

Have you <u>ever</u> had a period of time (at least 2 weeks) when:

You seemed to be sad, depressed, moody, or very irritable?	Yes	No
Didn't feel much like eating or having lost weight without dieting?	Yes	No
Felt like eating more than usual or have gained more than 15 pounds in 2 – 3 weeks?	Yes	No
Had trouble falling asleep or staying asleep?	Yes	No
Slept more than usual or have had trouble waking up?	Yes	No
Withdrawn from family and friends, talking less than usual?	Yes	No
Lost interest in things you usually like doing?	Yes	No
Felt tired all the time but weren't physically sick?	Yes	No
Complained of aches / pains frequently? (headaches, stomachaches, etc.)	Yes	No
Felt guilty over things you really weren't to blame for?	Yes	No
Felt worthless / helpless and thought you would be better off dead?	Yes	No
Felt you couldn't concentrate / focus on work / school / hobbies?	Yes	No
Talked or thought about or have tried to kill yourself?	Yes	No
Are you still feeling sad, blue, moody, or irritable now?	Yes	No
Are you an anxious person?	Yes	No
Have you ever had an anxiety attack without an apparent reason?	Yes	No

If YES, how often do you have these attacks? __________________________________

During an anxiety attack –

Do you have trouble catching your breath?	Yes	No
Does your heart race (beat too fast)?	Yes	No
Does your face become flush or do your hands begin to sweat?	Yes	No

Patient Name:____

HAVE YOU EVER HAD A PERIOD OF TIME (AT LEAST ONE WEEK) WHEN:

You were so overly happy "high" that you got into trouble?	Yes	No
You became more overactive than usual that others were concerned?	Yes	No
Talked faster or more constantly than usual?	Yes	No
Had thoughts that you were going very fast (racing) in your head?	Yes	No
Thought you had special powers to do remarkable things?	Yes	No
Slept a lot less than usual without appearing tired?	Yes	No
Were unable to concentrate on things as usual? (work / school / hobbies / tasks)	Yes	No
Did extravagant things you later regretted? (travel, sex, shopping spree, etc.)	Yes	No

DO YOU HAVE ANY OF THE FOLLOWING AT WORK / SCHOOL / HOME:

Often leave things unfinished?	Yes	No
Are easily distracted?	Yes	No
Have difficulty concentrating on reading / homework / office tasks?	Yes	No
Have difficulty sitting still?	Yes	No
Are restless or fidgety?	Yes	No
Are impulsive, acting without thinking?	Yes	No
Are you often misplacing or losing things?	Yes	No
Are you forgetful, needing frequent reminders?	Yes	No
Are you unusually stubborn or self-willed?	Yes	No
Have trouble conforming to rules / regulations?	Yes	No
Argue with your boss / coworkers / neighbors / friends?	Yes	No
Lose your temper easily, break or throw things at times?	Yes	No
Have you ever shoplifted or stolen anything?	Yes	No
Injured or killed a small animal / pet just for fun?	Yes	No
Ever broken or destroyed someone's property? (windows, cars, etc.)	Yes	No
Have a reputation for starting fights?	Yes	No
Ever pulled a knife or gun on someone?	Yes	No
Ever tried to steal something by threatening someone?	Yes	No
Ever tried to force another person to have sex?	Yes	No

PERSONAL HABITS /GENERAL HEALTH HISTORY

Do you smoke cigarettes regularly?	Yes	No
Number of packs per day ________		
Ever drink beer, wine or other alcoholic beverages?	Yes	No
How often? _______ How much? _______		
What is / was the most you have consumed at one time? ________________________		
Have you ever missed an appointment, school, work because of drinking?	Yes	No
Have you ever been asked to leave anywhere because of drinking? (work, school, social event)	Yes	No
Have you ever had a traffic violation because of drinking? (DUI, accident, etc.)	Yes	No
Ever sniffed glue, gasoline or fumes to get "high"?	Yes	No
Ever smoked marijuana? (pot, grass, hash, etc.)	Yes	No
Ever used amphetamines? (crystal, speed, etc.)	Yes	No
Ever used cocaine (coke, crack, etc.)?	Yes	No

Patient Name:____

PERSONAL HABITS /GENERAL HEALTH HISTORY

Ever use hallucinogens? (LSD, PCP, peyote, mescaline)	Yes	No
Ever use heroin or opiates? (horse, H, junk, etc.)	Yes	No
Ever use sedatives or tranquilizers? (downers)	Yes	No
Are you using any of the above now?	Yes	No
Have you ever had unusual or troublesome thoughts which you can't put out of your mind? (getting hurt, hurting someone, germs, bugs, etc.)	Yes	No
Have you ever had special habits or rituals that seem excessive or unnecessary? (counting things, touching, hand washing, hair pulling, etc.)	Yes	No
Do you check and recheck things excessively? (doors, locks, lights on or off, etc.)	Yes	No
Do you get very upset when things are not in their exact place?	Yes	No
Have you or do you have sudden jerky movements which are repetitive? (neck jerks, eye blinking, mouth twitches, shoulder shrugs, etc.)	Yes	No
Have you or do you make repetitive sounds over and over? (sniffs, grunts, throat clearing, barking, etc.)	Yes	No
Have you ever had repetitive habits? (body rocking, hand wringing, hair twirling, etc.)	Yes	No
Do you think that you are too fat?	Yes	No
Have you ever lost excessive weight intentionally?	Yes	No
Do you exercise with the intent to lose weight?	Yes	No
Have you lost more than 10 pounds intentionally?	Yes	No
Have you ever gone on excessive eating binges?	Yes	No
Have you made yourself vomit after meals?	Yes	No
Have you tried diet pills or laxative to lose weight?	Yes	No

HAVE YOU EVER HAD BELIEFS THAT CONFUSED YOU

Thought that someone was out to get you?	Yes	No
Thought that others could control your thoughts?	Yes	No
Have you heard voices / sounds / noises in your head?	Yes	No
Are you hearing voices / sounds / noises now?	Yes	No
Have you ever seen things / visions which others cannot?	Yes	No

SURVEY / DEPRESSION

PLEASE CHECK A RESPONSE FORE EACH ITEM 1 – 20	Some or a Little of the time	Good Part or a Lot of the time	Most or All of the time	None of the time
1. I FEEL DOWNHEARTED, BLUE AND SAD.	❍	❍	❍	❍
2. MORNING IS WHEN I FEEL THE BEST.	❍	❍	❍	❍
3. I HAVE CRYING SPELLS OR FEEL LIKE IT.	❍	❍	❍	❍
4. I HAVE TROUBLE SLEEPING THROUGH THE NIGHT.	❍	❍	❍	❍
5. I EAT AS MUCH AS I USED TO.	❍	❍	❍	❍
6. I ENJOY LOOKING AT, TALKING TO AND BEING WITH ATTRACTIVE WOMEN / MEN.	❍	❍	❍	❍
7. I NOTICE THAT I AM LOSING WEIGHT.	❍	❍	❍	❍
8. I HAVE TROUBLE WITH CONSTIPATION.	❍	❍	❍	❍
9. MY HEART BEATS FASTER THAN USUAL.	❍	❍	❍	❍
10. I GET TIRED FOR NO REASON.	❍	❍	❍	❍
11. MY MIND IS AS CLEAR AS IT USED TO BE.	❍	❍	❍	❍
12. I FIND IT EASY TO DO THE THINGS I USED TO DO.	❍	❍	❍	❍
13. I FIND IT DIFFICULT TO DO THE THINGS I USED TO DO.	❍	❍	❍	❍
14. I FEEL HOPEFUL ABOUT THE FUTURE.	❍	❍	❍	❍
15. I AM MORE IRRITABLE THAN USUAL.	❍	❍	❍	❍
16. I FIND IT EASY TO MAKE DECISIONS.	❍	❍	❍	❍
17. I FEEL THAT I AM USEFUL AND NEEDED.	❍	❍	❍	❍
18. MY LIFE IS PRETTY FULL.	❍	❍	❍	❍
19. I FEEL THAT OTHERS WOULD BE BETTER OFF IF I WAS DEAD.	❍	❍	❍	❍
20. I STILL ENJOY THE THINGS I USED TO DO.	❍	❍	❍	❍

SURVEY / ANXIETY

Choose the appropriate letter to the following questions:

A. None or little of the time
B. Some of the time
C. Good part of the time
D. Most or all of the time

1. I feel more nervous and anxious than usual. _____
2. I feel afraid for no reason at all. _____
3. I get upset easily or feel panicky. _____
4. I feel like I'm falling apart and going to pieces. _____
5. I feel that everything is alright and nothing bad will happen. _____
6. My arms and legs shake and tremble. _____
7. I am bothered by headaches, neck and back pains. _____
8. I feel weak and get tired easily. _____
9. I feel calm and can sit still easily. _____
10. I can feel my heart beating fast. _____
11. I am bothered by dizzy spells. _____
12. I have fainting spells or feel faint. _____
13. I can breathe in and out easily. _____
14. I get feelings of numbness and tingling in my fingers and toes. _____
15. I am bothered by stomachaches or indigestion. _____
16. I have to empty my bladder often. _____
17. My hands are usually dry and warm. _____
18. My face gets hot and blushes. _____
19. I fall asleep easily and get a good night's rest. _____
20. I have nightmares. _____