Please Note: So that I may maintain the most up to date and accurate information, I may request that you review and update this form annually.

**PATIENT INFORMATION DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: 🞏M 🞏F Marital Status: 🞏Single 🞏Married 🞏 Divorced 🞏Widowed 🞏Separated 🞏 Life Partner

**Please provide a copy of your Driver’s License / Photo ID**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt #: \_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_

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

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment Status: 🞏Full Time 🞏Part-Time 🞏Unemployed 🞏Student 🞏Disabled 🞏Retired Employer/School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: 🞏White 🞏Black/African American 🞏Asian 🞏American Indian/Alaska Native 🞏Native Hawaiian/Pacific Islander 🞏Declined

Ethnicity: 🞏Not Hispanic/Latino 🞏Hispanic/Latino 🞏Declined

**EMERGENCY NOTIFICATION**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**REFERRAL SOURCE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OPTIONAL AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO OTHERS**

🞏 Do Not Release Information

I authorize Margaret L. Miesch, M.D., P.A. to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, billing information and/or medical care. This authorization will remain in effect until I provide written notification to Dr. Miesch of changes or updates. I authorize Dr. Miesch to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance/benefits, billing information, test results and/or medical care.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You may release the following information to the person names above: 🞏 Appointment 🞏 Medical Care 🞏 Billing Information

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You may release the following information to the person names above: 🞏 Appointment 🞏 Medical Care 🞏 Billing Information

**MEDICATION REFILLS (Please initial)**

\_\_\_\_\_\_ Contact your pharmacy for medication refills. Your Pharmacy will fax Dr. Miesch a medication refill request which she will review. **Refill authorizations will require 2 - 4 business days**. Plan accordingly and allow sufficient time for refills to be approved.

**CURRENT PHARMACY INFORMATION**

Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy Store #: \_\_\_\_\_\_\_\_\_

Address or Cross Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIVACY PRACTICES**

Dr. Miesch is committed to securing the privacy of your health information. I will make available to you a copy of the Notice of Privacy Practices.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL AND PAYMENT GUIDELINES**

Payment is due at the time of service in the form of cash, check, Visa, Mastercard, or Discover card.

* I understand that in the event that I do not cancel my appointment within twenty-four hours of the scheduled appointment that I will be charged a cancellation fee of $100.00
* Statement about insurance – I understand that If I choose to submit my receipts to insurance for reimbursement that it my sole responsibility. I also understand that any services would be considered out of network.
* I am responsible for notify Dr. Miesch of any changes to demographics.
* Additional fees (like late fees) are due prior to my visit.

**CONSENT FOR TREATMENT, RELEASE OF INFORMATION**

* I consent to treatment necessary to the care which has been discussed and directed by the provider.
* I authorize the release of all medical records to specialists and/or consulting physicians if applicable to my care and condition.
* I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its intermediaries, its carriers, or any other insurance carrier any information needed for this or any other related claim to be processed. I permit a copy of this authorization to be use0d in place of the original and request payment of medical insurance benefits either to me or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any party who may be responsible for paying for my treatment.

I have read, fully understand and agree to the above medication refill guidelines, financial responsibility statement , payment guidelines and consent for treatment and release of medical information. I also certify that all of the information, provided is complete and accurate.

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CANCELLATION AND NO SHOW POLICY

I understand that sometimes situations arise in which you must cancel your appointment. However, I request that if you must cancel your appointment, that you provide at least 24 hours’ notice. This will allow time for me to schedule another patient who may be waiting for an appointment.

Office appointments that are cancelled without at least 24 hours’ notice will be subject to a $100.00 Late Cancellation Fee. Additionally, patients who do not show up for their office visit without calling prior to the appointment will be considered a “No Show.” This will also result in a No Show fee of $100.00. The Late Cancellation / No Show fees are the sole responsibility of the patient and must be paid in full prior to the patient’s next appointment.

I understand that sometimes there are unavoidable circumstances where you may be forced to cancel without providing at least 24 hours’ notice. There may be instances when the late cancellation and no show fee are waived. I firmly believe that a good provider/patient relationship is based up understand and good communication.

*After reading this policy, I understand and agree to pay a Late Cancellation/No Show fee if I am unable to give 24 hours’ notice of having to cancel my appointment.*

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

Name Signature Date

**Coordination of Care**

Margaret L. Miesch, M.D., P.A. wishes to coordinate care with your primary care physician and/or your referring health care provider if applicable to your treatment and condition. This could include appointment dates, diagnosis, treatment goals, progress, and discontinuation of treatment. Please complete the information below so that we may have your authorization to coordinate care with your other health care providers.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, born on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

Print Name Date of Birth

authorize Margaret L. Miesch, M.D., P.A. to coordinate care with the following providers. I give my consent to release information by phone, email, fax, or letter.

**Primary Care Physician:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Therapist Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Health Provider Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, the undersigned, understand that I may revoke this consent at any time to the extent that action has been taken in reliance upon it and that in any event this consent shall expire when I terminate series with Margaret L. Miesch, M.D., P.A.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Margaret Miesch, MD

8105 Rasor Blvd, Ste 124

Plano, TX 75024

Office: (214) 631-3663

**Credit Card Authorization**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Holder Name: **(as it appears on card)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle: MASTERCARD VISA

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3 Digit Security Code (on back of card) \_\_\_\_\_\_\_\_\_\_\_\_

I authorize Margaret Miesch, MD to charge my credit card for missed appointments or for appointments cancelled with less than 24 hours notice, except when determined by Dr. Miesch to be an emergency.

Cardholder Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT DATA SHEET

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CURRENT PROBLEMS** | **NONE** | **MILD** | **MODERATE** | **SEVERE** |
| Depressed Mood | 1 | 2 | 3 | 4 |
| Hopelessness | 1 | 2 | 3 | 4 |
| Suicidal Thoughts | 1 | 2 | 3 | 4 |
| Disturbed Sleep | 1 | 2 | 3 | 4 |
| Appetite Change | 1 | 2 | 3 | 4 |
| Significant Change in Weight | 1 | 2 | 3 | 4 |
| Poor Concentration | 1 | 2 | 3 | 4 |
| Mood Swings | 1 | 2 | 3 | 4 |
| Elate Mood | 1 | 2 | 3 | 4 |
| Obsessive Thoughts | 1 | 2 | 3 | 4 |
| Tense/Anxious | 1 | 2 | 3 | 4 |
| Fearfulness | 1 | 2 | 3 | 4 |
| Compulsive Behavior | 1 | 2 | 3 | 4 |
| Hallucinations | 1 | 2 | 3 | 4 |
| Memory Problems | 1 | 2 | 3 | 4 |
| Hostility/Anger | 1 | 2 | 3 | 4 |
| Violence/Aggression | 1 | 2 | 3 | 4 |
| Drug/Alcohol Problems | 1 | 2 | 3 | 4 |
| Confusion | 1 | 2 | 3 | 4 |
| Recent Loss/Trauma | 1 | 2 | 3 | 4 |
| Change in Sex Drive | 1 | 2 | 3 | 4 |
| Decreased pleasure | 1 | 2 | 3 | 4 |
| Bathing, Dressing, Grooming | 1 | 2 | 3 | 4 |
| Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 1 | 2 | 3 | 4 |

History of Sexual or Physical Abuse: 🞏 Yes 🞏 No

Ongoing Sexual or Physical Abuse: 🞏 Yes 🞏 No

|  |  |
| --- | --- |
| **CURRENT MEDICATIONS** | **DOSAGE AND FREQUENCY** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |
| --- | --- |
| **PREVIOUS MEDICATIONS** | **DOSAGE AND FREQUENCY** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

MEDICATION ALLERGIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Review of systems: (Check all that apply)**

**GENERAL HEALTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

❑ Appetite loss ❑ Chills ❑ Sweating ❑ Fever ❑ Night sweats ❑ Malaise/Fatigue

❑ Weight gain ❑ Weight loss ❑ Generalized ❑Weakness

**RESPIRATORY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

❑ Cough ❑ Coughing blood ❑ Shortness of breath ❑ Snoring ❑ Wheezing ❑ Sputum production

**HEENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

❑ Congestion ❑ Ear discharge ❑ Ear pain ❑ Headaches ❑ Hearing loss ❑ Nose bleeds

❑ Tooth pain ❑ Sore throat ❑ Ear ringing

**EYES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

❑ Blurred vision ❑ Double vision ❑ Pain ❑ Sensitivity to light ❑ Redness

❑ Vision loss – L ❑ Vision loss – R ❑ Visual disturbances ❑ Visual halos

**SKIN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

❑ Changes in nails ❑ Discoloration of skin ❑ Dryness ❑ Flushing

❑ Itching ❑ Poor wound healing ❑ Rash ❑ Skin cancer

❑ Suspicious legions

**CV: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

❑ Chest Pain ❑ Painful breathing with exertion ❑ Irregular heartbeats ❑ Leg swelling

❑ Near-fainting ❑ Fainting ❑ Shortness of breath ❑ Heart palpitations

**ENDOCRINE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

❑ Intolerance of cold ❑ Intolerance of heat ❑ Excessive drinking ❑ Excessive eating

**HEME LYMPH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

❑ Swollen lymph nodes ❑ Easy bruising ❑ Easy bleeding

**GASTROINTESTINAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

❑ Abdominal bloating ❑ abdominal pain ❑ Anorexia ❑ Poor appetite

❑ Restricting intake of food ❑ Excessive passing of gas ❑ Heartburn ❑ Vomiting blood

❑ Bowel habit change ❑ Bowel incontinence ❑ Constipation ❑ Diarrhea

❑ Excessive appetite ❑ Passing red blood with stools ❑ Nausea ❑ Vomiting

❑ Passing dark blood with stools

**MUSCULOSKELETAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

❑ Arthritis ❑ Falls ❑ Gout ❑ Joint pain ❑ Joint swelling ❑ Muscle cramps

❑ Muscle weakness ❑ Muscle pain ❑ Neck pain ❑ Back pain ❑ Stiffness

**GENITOURINARY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

❑ Bladder incontinence ❑ Decreased sex drive ❑ Pain on urination ❑ Flank pain (side pain)

❑ Increased frequency of urination ❑ Genital sore ❑ Blood in urine ❑ Pelvic Pain

❑ Decrease in the force of urinary stream ❑ Incomplete emptying of the bladder ❑ Urgency to urinate

❑ Heavy menstrual periods ❑ Missed menstrual periods ❑ Non-menstrual bleeding

**NEUROLOGICAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

❑ Concentration difficulty ❑ Coordination disturbances ❑ Day time sleepiness ❑ Dizziness

❑ Light headedness ❑ Loss of balance ❑ Numbness ❑ Tingling

❑ Tremors ❑ Seizures ❑ Vertigo – sensation of whirling and loss of balance

**ALLERGY/IMMUNOLOGY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

❑ Environmental allergies ❑ HIV exposure ❑ Hives ❑ Persistent infections

**PSYCHIATRIC: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

❑ Depression ❑ Hallucinations ❑ Insomnia ❑ Memory loss ❑ Nervous/anxious

❑ Substance abuse ❑ Suicidal ideation ❑ Thoughts of violence

❑ Hypervigilance - enhanced state of sensory sensitivity accompanied by exaggerated intensity of behaviors

Have you ever been in a psychiatric hospital in the past? 🞏 Yes 🞏 No

If yes, please list the facility and the dates of treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever attempted suicide? 🞏 Yes 🞏 No

IF yes, please describe the nature of the vent and the date(s) of occurrence \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

Who is your primary care physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last physical \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List of allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List any medical problems you currently have and significant illnesses in the past:

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

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List surgeries, reason, and year:

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

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**PAIN SCREEN (If applicable)**

Pain level \_\_\_\_\_\_\_\_ Pain Goal \_\_\_\_\_\_\_\_\_ Duration of Pain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location of Pain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Interventions in past 8 hours \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes the pain better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WOMEN ONLY**

Who is your gynecologist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last period \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are your periods regular? Y N

List any gynecological problems you have had \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Method of Contraception \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many pregnancies have you had? \_\_\_\_\_\_

How may children do you have? \_\_\_\_\_\_\_\_\_\_ Are you currently pregnant? Y N

Are you planning to become pregnant the near future? Y N

**FAMILY PSYCHIATRIC HISTORY**

(List any blood relative who has had emotional problems, such as depression, manic depression, alcoholism, drug abuse, suicide, schizophrenia, and anxiety problems)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Problem** | **Relative** | **Maternal Side** | **Paternal Side** | **Hospitalization** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ |
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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ |

List any physical problems that run in your family

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Problem** | **Relative** | **Maternal Side** | **Paternal Side** | **Hospitalization** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ |
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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ |

List everyone who lives in your home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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**SUBSTANCE ABUSE**

I drink alcohol: 🞏 Never 🞏 Less than once/mth 🞏 1-4 times/mth 🞏 2-3 times per wk 🞏 Daily

I usually drink: 🞏 None 🞏 1-2 drinks/sitting 🞏 🞏 2-4 drinks/sitting 🞏 5+ drinks/sitting

I become intoxicated: 🞏 Never 🞏 Less than once/mth 🞏 1-4 times/mth 🞏 2-3 times/mth 🞏 Daily

Last used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How much? : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have had the following problems related to my use of alcohol:

 🞏 Binges 🞏 Hangovers 🞏 Physical Withdrawal

 🞏 Arrests 🞏 Passing Out 🞏 Increased Tolerance

 🞏 Assaults 🞏 Job Problems 🞏 Concern about drinking

 🞏 Seizures 🞏 Sleep Problems 🞏 Interpersonal Problems

 🞏 Blackouts 🞏 Medical Problems 🞏 Inability to stop after one drink

My drinking is: 🞏 Occasional/Social 🞏 A problem 🞏 A Dependency 🞏 An Addiction

I want to stop drinking: 🞏 No 🞏 Sometimes 🞏 Very Much

I have been involved in the following treatment for drug and/or alcohol:

🞏 None 🞏 AA/12 Steps 🞏 Inpatient Program 🞏 Outpatient Program 🞏 Residential Program

In the past 6 months, I have used:

🞏 None 🞏 Marijuana 🞏 Sedatives 🞏 Caffeine (Cups per day: \_\_\_\_)

🞏 Cocaine 🞏 Opiates 🞏 Hallucinogens 🞏 Tobacco (# per day: \_\_\_\_\_)

🞏 Inhalants 🞏 Stimulants

I have misused prescriptions: 🞏 Yes 🞏 No

**NOTICE OF PRIVACY PRACTICES**

***This Notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.***

**UNDERSTANDING YOUR HEALTH INFORMATION**

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made in order to manage the care you receive. Dr. Miesch understands that the medical information that is recorded about you and your health is personal. The confidentiality of your health information is also protected under both state and federal law.

This Notice of Privacy Practices describes how Dr. Miesch may use and disclose your information and the rights that you have regarding your health information.

**YOUR HEALTH INFORMATION RIGHTS**

Although your health information is the physical property of the facility or practitioner that compiled it, the information belongs to you, and you have certain rights over that information. You have the right to:

* Request, in writing, a restriction on certain uses and disclosures of your health information. However, agreement with the request is not required by law, such as when it is determined that compliance with the restriction cannot be guaranteed.
* Request by written authorization to inspect or obtain a copy of your health record as provided by law;
* Request, in writing, that your health record be amended as provided by law, if you feel the health information we have about you is incorrect or incomplete. You will be notified if the request cannot be granted.
* Request that we communicate with you about your health information in a specific way or a specific location. Reasonable requests will be accommodated;
* Obtain a paper copy of the Notice of Privacy Practices on request.

**PROVIDER RESPONSIBILITIES**

Dr. Miesch has certain responsibilities regarding your health information, including the requirement to:

* Maintain the privacy of your health information;
* Provide you with the Notice that describes Dr. Miesch’s legal duties and privacy practices regarding the information that I maintain about you, should you request it;
* Abide by the terms of the Notice currently in effect.
* Inform you that the clinic(s) must keep your medical records for a time period required by law and then may dispose of them as permitted by law.

Dr. Miesch reserves the right to change these information privacy policies and practices and to make the changes applicable to any health information that she maintains.

**Uses and Disclosure of the Health Information without Authorization**

There are certain uses and disclosures of your health information that are necessary and permitted by law in order to treat you, and to support other involved providers. The following categories describe ways that Dr. Miesch’s practice uses or discloses your information, and some representative examples are provided in each category.

**Your health information will be used for treatment.**

For example: Disclosures of medical information about you may be made to medical providers or others who are involved in taking care of you. This information may be disclosed to other physicians who are treating you or to other healthcare facilities involved in your care. Information may be shared with pharmacies, laboratories or radiology centers for the coordination of different treatments.

**Continuity of Care:** In order to provide for the continuity of your care, your information may be shared with other healthcare providers such as home health agencies. Information about you may be disclosed to community services agencies in order to obtain their services on your behalf.

**Disclosures Requiring Verbal Agreement**

Unless you give notice of an objection, and in accordance with your agreement, medical information may be released to a family member or other person who is involved in your medical care or who helps pay for your care. Information about you may be disclosed to notify a family member, legally authorized representative or other person responsible for your general condition. This may include disclosures of information about you to an organization assisting in a disaster relief effort, such as the American Red Cross, so that your family can be notified about your condition. You will be given an opportunity to agree or object to these disclosures except as due to your incapacity or in emergency circumstances.

**Disclosures Required by Law or otherwise Allowed without Authorization or Notification**

The following disclosures of health information may be made according to state and federal law without your written authorization or verbal agreement:

* When a disclosure is required by federal state or local law, judicial or administrative proceedings, or for law enforcement. Examples would be reporting gunshot wounds or child abuse, or responding to court orders;
* For public health purposes, such as reporting information about births, deaths, and various diseases, or disclosures to the FDA regarding adverse events related to food, medications, or devices;
* For health oversight activities, such as audits, inspections or licensure investigations;
* To organ procurement organizations for the purpose of tissue donation and transplant;
* For research purposes, when the research has been approved by an institutional review board that has reviewed the research proposal and established guidelines to provide for the privacy of your health information; or the disclosure is that of a limited data set, where personal identities have been removed.
* To coroners and funeral directors for the purpose of identification, the determination of the cause of death, or to perform their duties as authorized by law.
* To avoid a serious threat to the health or safety of a person or the public;
* For specific government functions, such as protection of the President of the United States;
* For worker’s compensation purposes;
* To military command authorities as required for members of the armed forces;
* To authorized federal officials for national security and intelligence activities as authorized by law;
* To correctional institutions or law enforcement officials concerning health information of inmates, as authorized by law.

**Breach Notification**

In certain instances, you have the right to be notified in the even that I discover an inappropriate use or disclosure of your health information. Notice of any such use or disclosure will be made as required by state and federal law.

**Required Uses and Disclosures**

Under the law I must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine my compliance with federal privacy law.

**Uses and Disclosures Requiring Authorization**

Any other uses or disclosures of your health information not addressed in this Notice or otherwise required by law will be made only with your written authorization. You may revoke such authorization at any time. Specific examples of uses and disclosures requiring authorization include: use of psychotherapy notes, marketing activities, and some types of sale of your health information.

**Privacy Complaints**

You have the right to file a complaint if you believe your privacy right has been violated. This complaint may be addressed Dr. Miesch, or to the Secretary of the Department of Health and Human Services. There will be no retaliation for registering a complaint.