Kan Health Behavioral

Phone (713) 298-1031

Email: info@kanbehavioral.com

PATIENT REGISTRATION:

First: _____ Middle: _____ Last: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Employer: _____ Social Security #: _____

Birth Date: _____ Age: _____ Gender: _____ Marital Status: _____

Race: _____ Email: _____

EMERGENCY CONTACT: NAME _____ **PHONE:** _____

Legal Guardian Information (If patient is less than 18 years old)

Legal Guardian Name: _____ Relationship to Patient: _____

Home #: _____ Cell #: _____ Work #: _____

Financial and Policy Holder Information

Primary Insurance

Insurance Company: _____ Contract #: _____ Group #:

Effective Date: _____ Policy Holder Name: _____

Policy Holder SS#: _____ Birth Date: _____ Relationship to Patient: _____

Policy Holder Address: _____ City, State & Zip: _____

Policy Holder Phone #: _____ Sex: ☐M or ☐F

Secondary Insurance

Insurance Company: _____ Contract #: _____ Group #: _____

Effective Date: _____ Policy Holder Name: _____

Policy Holder SS#: _____ Birth Date: _____ Relationship to Patient: _____

Policy Holder Address: _____ City, State & Zip: _____

Policy Holder Phone #: _____ Sex: ☐M or ☐F

Date_____

Name_____ Age_____
Address_____
Home phone_____ Work phone_____ Cell phone_____

What issue(s) bring(s) you to the Psychiatry Clinic?

_____
_____
_____
_____

What has been stressing you of late (e.g. Family, job, recent loss of loved ones, financial issues)?

_____
_____
_____
_____

Are you currently having any of the following problems (please circle)?

Depression? Loss of interest in activities? Feeling hopeless, worthless? Poor energy? Poor self-esteem? Change in appetite? Increased or decreased? Fatigue? Poor focus? Problems going to sleep? Thoughts of not being alive? Periods of euphoria or unusually good mood? Having very high energy for no reason? Going days without needing to sleep? Thoughts racing? Talking too fast? Acting impulsively (spending, speeding)?	Worrying excessively? Having tense muscles? So anxious you feel you cannot rest? Having panic attacks? Traumatic events that come back in nightmares, flashbacks? Feeling awkward in public? Thoughts that replay? Repetitive or compulsive behaviors? Phobias or fears? Grunts, tics, or jerks? Inattentiveness at work or school? If so, since what age? Hyperactive or fidgety?	Hearing voices? Seeing things? Feelings people were trying to watch or harm you? Concerns about alcohol use? Drug use? Concerns about eating too much? Eating too little? Memory problems? Getting lost easily? Forgetting how to do tasks? Problems finding words? Problems caring for yourself (cooking, dressing)?

Past Psychiatric Care

Have you been ever diagnosed with a mental health condition by a medical provider (e.g. Depression, bipolar, schizophrenia, ADHD)? If so, please list.

_____

_____

Have you ever been seen by a psychiatrist or therapist/counselor? Please list and describe.

Date(s) seen? By whom?	For what problem?	What treatment (meds, ECT, therapy)?

Have you ever been hospitalized for psychiatric care? Please list and describe.

Date(s)	Where and for what?	What treatment (meds, ECT, therapy)?

Have you ever been treated with any of the following medications? Circle all that apply and list any good or bad effects of the medications.

Med	Good/bad effects	Med	Good/bad effects	Med	Good/bad effects
Abilify		Haldol		Ritalin	
Ambien		Klonopin		Saphris	
Adderall		Invega		Serax	
Anafranil		Lamictal		Seroquel	
Antabuse		Latuda		Serzone	
Ascendin		Lexapro		Soma	
Atarax		Librium		Sonata	
Ativan		Lithium		Stelazine	
Buspar		Lunesta		Strattera	

Campral		Luvox		Suboxone/ subutex	
Celexa		Marplan		Symmetrel	
Chloral hydrate		Mellaril		Tegretol	
Clonidine		Methadone		Thorazine	
Clozaril		Miltown		Tofranil	
Cogentin		Nardil		Topomax	
Concerta		Norpramine		Traxene	
Cymbalta		Orap		Trazodone	
Dalmane		Pamelor		Trileptal	
Depakote		Parnate		Valium	
Dexedrine		Paxil		Vibryd	
Doral		Prosom		Vistraril	
Effexor		Pristiq		Vivitrol	
Elavil		Prolixin		Wellbutrin	
Fanapt		Remeron		Xanax	
Geodon		Restoril		Zoloft	
Halcion		Risperdal		Zyprexa	

Any other psychiatric medications you have taken?

_____

Past Medical Care

Do you have a primary care doctor? Name_____ Last Seen?_____

What medical illnesses do you have?

_____

_____

_____

What surgeries have you had?

_____

_____

_____

Please list all medications you are currenly taking, including over-the-counter medications, herbals, and supplements.

Medication	Dosage	# times per day	For what condition	Who prescribes it

Describe any allergies you have (e.g. to medications, foods).

_____

_____

Are you currently having or have you recently had any of these physical symptoms?

Fevers	Headache	Constipation	Hot/cold flashes
Chills	Chest pain	Acid reflux	Decreased sex drive
Night sweats	Shortness of breath	Joint pains	Problems reaching orgasm
Unexplained weight loss/gain	Heart palpitations	Muscle pains or tension	Easy bruising or bleeding
Weakness in arms/legs	Cough	Pain or difficulty urinating	Rashes
Numbness in arms/legs	Sore throat	Dental problems	
Episodes of passing out	Nausea or vomiting	Changes in vision	
Problems walking	Diarrhea	Changes in hearing	

For women-
Last menstrual period? _____ Usually regular? Yes/no
Do you use any birth control? Yes/no If yes, please list. _____
Have you been pregnant before? Yes/no If yes, how many times? _____
Miscarriages? Yes/no
Elective abortions? Yes/no
Any depression or unreal thoughts around pregnancies? Yes/no

Substance Use History

How often have you used the following substances?

	Last time used?	Approximately how often (# of times per week, month or year)?	How much do you use in a sitting if/when you do use?
Tobacco			
Alcohol			
Marijuana or K2/"spice"			
Cocaine			
Opiates (e.g. Heroin, morphine, Percocet,			

oxycodone, Tylenol #3, Dilaudid/hydromorphone)			
Tranquilizers/sedatives (e.g. Xanax, Ativan, Klonopin, Valium)			
PCP or LSD			
Mushrooms			
Others			

Family History

Please list blood relatives who have been diagnosed with the following conditions.
Alcoholism _____
Anxiety disorders _____
Bipolar disorder _____
Cancer _____
Depression _____
Diabetes _____
Drug abuse _____
Heart disease/high blood pressure/arrhythmias _____
Osteoporosis _____
Seizures _____
Schizophrenia _____
Strokes _____
Suicides _____
Thyroid disease _____

Social History

Where do you live? _____
Who lives with you? _____

How far did you go in school/highest level of education? _____

What is your current job/occupation? _____
What jobs have you had in the past?
_____
_____

Are you married? Yes/no If so, for how long? _____

Have you been married in the past? Yes/no # of times? _____
Do you have children? Yes/no If so, how many, what are their ages?_____

What do you do in your free time to relax?

_____

Do you have any religious beliefs? Yes/ No
How important are your religious/spiritual beliefs to your life?_____

Have you had any legal issues (arrests, charges, time in jail)? If so, please describe.

_____
_____
_____

Have you ever been the victim of a violent crime? Yes/No
Have you ever been a victim of physical abuse? Emotional? Sexual abuse or rape? If so, please explain.

_____
_____
_____
_____

Safety

Do currently have thoughts of hurting yourself? Yes/no Please explain.

_____

Have you tried to hurt yourself in the past? If so, please explain.

_____
_____
_____

Do you currently have thoughts of hurting anyone else? Yes/no Please explain.

_____

Have you tried to hurt anyone in the past? If so, please explain.

_____
_____
_____

Do you own any guns or knives? _____

CHECKLIST: Review of Systems

Patient Name: _____ Date of visit: _____

CONSTITUTIONAL:
Yes No
☐ ☐ Weight Loss
☐ ☐ Fatigue
☐ ☐ Fever

EYES:
Yes No
☐ ☐ Glasses/Contacts
☐ ☐ Eye Pain
☐ ☐ Double Vision
☐ ☐ Cataracts

EAR,NOSE,THROAT:
Yes No
☐ ☐ Difficulty Hearing
☐ ☐ Ringing in Ears
☐ ☐ Vertigo
☐ ☐ Sinus Trouble
☐ ☐ Nasal Stuffiness
☐ ☐ Frequent Sore Throat

CARDIOVASCULAR:
Yes No
☐ ☐ Murmur
☐ ☐ Chest Pain
☐ ☐ Palpitations
☐ ☐ Dizziness
☐ ☐ Fainting Spells
☐ ☐ Shortness of Breath
☐ ☐ Difficulty lying Flat
☐ ☐ Swelling Ankles

ENDOCRINE:
Yes No
☐ ☐ Loss of Hair
☐ ☐ Heat/Cold Intolerance

RESPIRATORY:
Yes No
☐ ☐ Cough Easy
☐ ☐ Coughing Blood
☐ ☐ Wheezing
☐ ☐ Chills

GASTROINTESTINAL:
Yes No
☐ ☐ Heartburn/Reflux
☐ ☐ Nausea/Vomiting
☐ ☐ Constipation
☐ ☐ Change in BMs
☐ ☐ Diarrhea
☐ ☐ Jaundice
☐ ☐ Abdominal Pain
☐ ☐ Black or Bloody BM

GENITOURINARY:
Yes No
☐ ☐ Burning/Frequency
☐ ☐ Nighttime
☐ ☐ Blood in Urine
☐ ☐ Erectile Dysfunction
☐ ☐ Abnormal Discharge
☐ ☐ Bladder Leakage

ALLERGIC/IMMUNOLOGIC:
Yes No
☐ ☐ Hives/Eczema
☐ ☐ Hay Fever

PSYCHIATRIC:
Yes No
☐ ☐ Anxiety/Depression
☐ ☐ Mood Swings
☐ ☐ Difficult Sleeping

HEMATOLOGY/LYMPH:
Yes No
☐ ☐ Easy Bruising
☐ ☐ Gums Bleed Easily
☐ ☐ Enlarged Glands

MUSCULOSKELETAL:
Yes No
☐ ☐ Joint Pain/Swelling
☐ ☐ Stiffness
☐ ☐ Muscle Pain
☐ ☐ Back Pain

SKIN:
Yes No
☐ ☐ Rash/Sores
☐ ☐ Lesions
☐ ☐ Itching/Burning

NEUROLOGICAL:
Yes No
☐ ☐ Loss of Strength
☐ ☐ Numbness
☐ ☐ Headaches
☐ ☐ Tremors
☐ ☐ Memory Loss

FEMALES ONLY:
Date Last Mammogram_____
Normal_____Abnormal_____
Date last PAP_____
Normal_____Abnormal_____
Age Onset Periods_____
Age Onset Menopause_____
Periods Regular?
Yes_____No____
Number
Pregnancies_____

Patient Health Care Questionnaire

Name _____ **Date** _____

Provider _____ **Patient ID #** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

add columns: ____ + ____ + ____

TOTAL: ____

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- **Not difficult at all** _____
- **Somewhat difficult** _____
- **Very difficult** _____
- **Extremely difficult** _____

The Epworth Sleepiness Scale (ESS)

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the **most appropriate number** for each situation:

0 = would **never** doze
1 = **slight chance** of dozing
2 = **moderate chance** of dozing
3 = **high chance** of dozing

SITUATION	CHANCE OF DOZING (0–3)
Sitting and reading	
Watching television	
Sitting inactive in a public place (e.g. a theater or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
TOTAL SCORE	

SCORE RESULTS:

1-6	Congratulations, you are getting enough sleep!
7-8	Your score is average
9 and up	Very sleepy and should seek medical advice

Johns, M.W. (1991). A new method for measuring daytime sleepiness: The Epworth sleepiness scale. *Sleep, 14*, 540-545.

Mood Disorder Questionnaire (MDQ)

Name: _____ Date: _____

Instructions: Check (✓) the answer that best applies to you.
Please answer each question as best you can.

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

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry.* 2000;157:1873-1875.

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

PRIVACY OF PROTECTED HEALTH INFORMATION

I consent to the use of disclosure of my protected health information by **KAN BEHAVIORAL** (hereinafter referred to as "**KBH**") for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct healthcare operations of KBH

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. KBH is not required to agree to the restrictions that I may request. However, if KBH agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that KBH has taken action in reliance on this consent.

My protected health information means health information, including my demographic information collected from me and created or received by my physician, another healthcare provider, health plan, my employer, or a healthcare clearinghouse. This protected health information relates to my past, present, and future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review KBH 's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of KBH. The Notice of Privacy Practices also describes my rights and KBH's duties with respect to my protected health information.

If you have asked us to file health insurance for you, we send only the minimum information required to obtain payment from your insurance company. We do not release any information to anyone about your treatment nor do we acknowledge that you are a patient here (even to your immediate family or other healthcare providers) without your expressed written consent. If you wish us to communicate with anyone about your treatment, please ask for a release of information form.

KBH reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent by email or asking for one at the time of my appointment.

Initial _____ **Date** _____

Kan Behavioral Health

EXCEPTION TO PRIVACY, PRIVILEGED COMMUNICATIONS AND CONFIDENTIALITY

Any unusual circumstances information that the client discloses may be released without consent to the appropriate parties involved if:

- There exists a danger of harm to the client or someone else
- The client needs to be involuntarily hospitalized due to the debilitating effects of mental illness or substance abuse
- The client is required to undergo a court-ordered examination
- The client discloses information about abuse, neglect, or exploitation of a minor
- The client discloses information about abuse, neglect, or exploitation of an aged or disabled adult
- The client's mental or emotional condition is used as a legal defense
- A civil, criminal, or disciplinary action arises from a complaint filed on behalf of the client against a mental health professional in which case the disclosure and release of information shall be limited to that action

I hereby give my consent for service to be provided under these conditions.

KAN BEHAVIORAL HEALTH INFORMED CONSENT FOR TREATMENT

- I understand the concepts and conditions of informed consent, privacy and confidentiality.
- I understand that I can discuss these concepts and conditions and to ask for clarification of parts which I am concerned about or do not fully understand.
- I understand that I will be informed of the goals, expectations, procedures, benefits, and possible risks involved in the evaluation and counseling/treatment.
- I understand that the process of counseling, psychotherapy, and evaluation is an interview process requiring self-disclosure, self-exploration, and responsible action. It has the overall purpose of promoting understanding and change. Sometimes this process can be stressful and emotionally uncomfortable. At other times, it can be very fulfilling. I also understand that there are no guarantees of positive outcome for the therapy/treatment.
- I have the right to refuse or withdraw from any counseling, psychotherapy, or evaluation procedure unless otherwise specified by law.
- I have the right to question any procedure, intervention, rationale, or discussion that is unclear or that I do not understand.
- I understand that all communication will be private, legally privileged, and confidential unless otherwise specified by the specific laws presented below or unless I provide my written consent with a specified release of information. I understand that if my provider is a resident or inter, then the treatment will be discussed with a supervising professional.
- I understand that this consent may be withdrawn by me at any time without prejudice and has to be completed in writing.

Initial _____ **Date** _____

AUTHORIZATION FOR CONTACTING PATIENT

Should a circumstance arise when it becomes necessary for the office to call you for any reason (such as to verify or change your appointment), every effort will be made to notify you in a timely manner. Please indicate your preference for being contacted.

☐ Telephone Yes No (Circle One) HOME # _____
☐ Telephone Yes No (Circle One) WORK # _____

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Signature Date

INFORMATION FOR CLIENTS

Our Practice

We are a group of licensed mental health professionals in private practice. We see clients by appointment only. Appointments are scheduled according to the individual doctor/therapist recommendation. If there is an emergency during office hours, which requires immediate attention, please contact the office by phone. If an appointment cannot be kept, please contact the receptionist at least 24 hours in advance. There will be a ***$50 service charge for late cancellations and a $50 service charge for no shows.*** You are responsible for this fee and your insurance companies **WILL NOT** pay for this fee. If unforeseen circumstances arise and you are able to give notice that is less than 24 hours we will do our best to fill the vacancy. If we are able to do so, you will not be charged. The more notice you can give the better we are to accommodate other patients who need to be seen.

Confidentiality

Communications between the provider and the patient are strictly confidential and protected under Maryland Law and by the ethics of our profession. In order to communicate with others about your case, your provider must have permission in writing. Our registration form and our Notice of Privacy Practices explain the limits of confidentiality.

After Hour Emergencies

Our telephone number is **(713) 298-1031** If you need to speak with your doctor or therapist, please make your calls brief. Calls of more than 5 minutes will be billed at the provider's hourly rate. Calls are answered 24 hours each day, 7 days a week. After office hours, you can leave a message on the voice mail or in an urgent situation; leave a message with the answering service operator who will contact your doctor/therapist/provider or the person on call. You may leave a voicemail or call during business hours for all prescription refill request or appointment change/cancellation request. **If immediate services are required or you have an emergency, please call 911 or go to the nearest Emergency Department.**