Mequon Clinical Associates, SC

ADULT HISTORY

DATE:_____

INSTRUCTIONS: Your therapist would like you to answer these questions. This will help him or her better understand your situation.

Name: _____ D.O.B. _____/_____/_____

In case of an emergency, please give the name and telephone number of your nearest relative:

Name: _____ Phone: _____

PSYCHOLOGICAL HISTORY

What problem(s) caused you to come to therapy at Mequon Clinical Associates?

_____

_____

_____

When did problem begin? _____

Has the problem been constant since its beginning? Yes ___ No ___

What is the worst symptom you've had? _____

Is problem ever absent? Yes ___ No ___ If yes, when? _____

Who made the decision to come to therapy? _____

Check if you have had any of these problems or symptoms lately:

___ Anxiety	___ Changes/problems in eating	___ Headaches	___ Loss of hope
___ Tearfulness	___ Changes/problems in sleeping	___ Fatigue/tiredness	___ Excessive worry
___ Nervousness	___ Chronic Pain	___ Sexual difficulties	___ Impulsive behavior
___ Depression	___ Difficulty concentrating	___ Irritability	___ Violent behavior
___ Fears	___ Loss of interest in usual activities	___ Other _____	

Have there been any recent illnesses or deaths among your family or close friends? ___ Yes ___ No
Explain: _____

Have there been any recent major losses among your family or close friends? ___ Yes ___ No
Explain: _____

Have there been any recent crises or major changes in your life? ___ Yes ___ No
Explain: _____

Have you ever intentionally hurt yourself or made a suicide attempt? ___ Yes ___ No
Explain: _____

Have you ever taken medication for anxiety, depression, sleep, or other emotional conditions? ___ Yes ___ No
Explain: _____

Have you been in counseling or psychotherapy before? ___ Yes ___ No
If so, for what issues? _____
What was the therapist's name and when did this occur? _____

Have you had any hospitalizations for emotional problems? ___ Yes ___ No
Explain: _____

Please name any people or organizations who you feel provide help and support to you. _____

_____

MEDICAL HISTORY

List any current medical conditions and disabilities: _____

_____

Are you taking any medications? ___ Yes ___ No
If yes, list current medications and daily dosages: _____

_____

List past medical conditions (include surgeries): _____

_____

Name of your physician(s) and telephone numbers & addresses: _____

_____

Have you had a medical exam within the past year? ___ Yes ___ No
List any significant findings: _____

DRUG AND ALCOHOL USE

Please describe the drug and alcohol use of your family. Use the number which best states how often each person uses each drug. For your children, please write in the name of the child at the top of the column.

0 = Never; 1= less than once a month; 2 = 1-4 days a month; 3 = almost daily; 4 = daily; 5 = used in past, not using now

SUBSTANCE	SELF	PARTNER/SPOUSE	CHILD	CHILD	YOUR PARENTS
Caffeine	____	____	____	____	____
Nicotine	____	____	____	____	____
Beer/Wine/Liquor	____	____	____	____	____
LSD	____	____	____	____	____
Marijuana	____	____	____	____	____
Inhalants	____	____	____	____	____
Sedatives	____	____	____	____	____
Amphetamines	____	____	____	____	____
Cocaine/Crack	____	____	____	____	____
Others (specify)	____	____	____	____	____

Are you concerned about your drug or alcohol use?	___ Yes	___ No
Is someone who cares about you concerned about your use of drugs or alcohol?	___ Yes	___ No
Do you ever feel guilty about your use of drugs or alcohol?	___ Yes	___ No
Are you concerned about the drug or alcohol use of someone in your family?	___ Yes	___ No
Did you grow up in a home in which a parent abused drugs or alcohol?	___ Yes	___ No
Has anyone in your family been in treatment for drug or alcohol abuse?	___ Yes	___ No

If yes, list who and for what treatment: _____

FINANCIAL / LEGAL HISTORY

Do you have serious financial concerns?	___ Yes	___ No
If yes, explain: _____		
Have you ever been arrested?	___ Yes	___ No
If yes, explain: _____		
Have you ever been involved with Protective Services?	___ Yes	___ No
If yes, explain: _____		

SCHOOL, MILITARY & WORK HISTORY

Are you currently enrolled in school? ___ Yes ___ No
If yes, what is field of study? _____
What is your highest grade completed? _____
Have you served in the Military? ___Yes ___No
If yes, which branch? _____ When? _____ Overseas? _____ Combat? _____
What is your occupation? _____
Are you currently employed? ___Yes ___No What is length of time at current job? _____
If not employed, how long were you employed at last job held? _____

Mequon Clinical Associates, SC

Patient Name:_____ DOB:_____
Please print

Other Adult:_____ Relation to patient:_____

Address:_____ Phone:_____

_____ Email:_____

_____ Referred by:_____

Reminder Preference (please check only one box):

☐ Phone Call (Home #) ☐ Phone Call (Cell #) ☐ Email ☐ Text Message

FINANCIAL POLICY

Payment is expected at the time of service. You are ultimately financially responsible for all services you or members of your household receive from Mequon Clinical Associates.

Consent to Treatment/Privacy Policy

I hereby consent to treatment as agreed upon by my MCA Provider and myself, and I understand my rights as a patient. I have received and understand the written Notice of Privacy Practices provided by Mequon Clinical Associates.

_____initials

Private Pay

If you will be paying for visits privately (i.e., not through an insurance company), clinic policy requires payment at time of service. Please be prepared to make payment upon arrival for your session.

_____initials

Health Insurance

I authorize insurance payment of medical benefits to Mequon Clinical Associates for services described on the itemized claim form. I also authorize the release of information necessary to process this claim. Payment of benefits should be paid directly to Mequon Clinical Associates. **I recognize and accept personal responsibility for all services rendered and will make payment in full of any self-pay charges, co-payments or deductibles, and for any balance outstanding after payment or denial of such insurance benefits.**

Client / Financially Responsible Party Signature: _____

Outstanding Patient Balances

After insurance is billed any portion not covered will be billed to the patient. Any balance that is billed to the patient must be paid in full no later than 60 days from the billing date. The clinic charges a $30 fee to you for any returned checks, which is payable before or at the time of your next scheduled visit.

_____initials

Cancelled Appointments

I understand that any appointments cancelled or missed without 24 hours notice may be charged a minimum fee of $75 and **my insurance does not cover this fee.**

_____initials

Failure and/or Inability to Pay

In the event it becomes necessary to assign your account to a collection agency, you are responsible for any/all costs of collection which may include attorney fees and other costs incurred.

_____initials

I have read and understand the above financial policy.

Client / Financially Responsible Party Signature: _____

Date: _____ **Please Print Name:** _____

NAME _____

DATE _____

Zung Self-Rating Anxiety Scale (SAS)

For each item below, please place a check mark (✓) in the column which best describes how often you felt or behaved this way during the past several days. Bring the completed form with you to the office for scoring and assessment during your office visit.

Place check mark (✓) in correct column.	A little of the time	Some of the time	Good part of the time	Most 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 all right and nothing bad will happen.				
6 My arms and legs shake and tremble.				
7 I am bothered by headaches neck and back pain.				
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 like it.				
13 I can breathe in and out easily.				
14 I get feelings of numbness and tingling in my fingers & toes.				
15 I am bothered by stomach aches 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.				

Source: William W.K. Zung. A rating instrument for anxiety disorders. Psychosomatics. 1971

The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

Over the past 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 asleep, 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're 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

Column Totals _____ + _____ + _____

Add Totals Together _____

10. If you checked off any problems, how difficult have those 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