My Mental Health, LLC

Patient Information

Patient Name: _____
Last First Middle Initial

Prior Last Names: _____ Race: African American Asian Caucasian Hispanic Native American Other

Social Security Number: _____ - _____ - _____ Date of Birth: _____/_____/_____

Sex: M or F Marital Status: Single Married Divorced Widow Separated

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell / Other: _____

Insurance Information

Name of Primary Insurance: _____ Policy ID Number: _____

Subscriber Name: _____ Subscriber DOB: _____ / _____ / _____

Relation to patient: _____

Group Number: _____ Subscriber Employer / Group Name: _____

Subscriber work status: FT PT Retired

(Please fill out Secondary insurance if applicable)

Name of Primary Insurance: _____ Policy ID Number: _____

Subscriber Name: _____ Subscriber DOB: _____ / _____ / _____

Relation to patient: _____

Group Number: _____ Subscriber Employer / Group Name: _____

Subscriber work status: FT PT Retired

Emergency Contact Information:

Person to notify / Next of Kin: _____
Last First MI

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Relationship to patient: _____

Protected Health Information:

For confidentiality reasons, family member phone calls about treatment will not be returned. I must request my family and or specified individual to join me as part of my appointment if I wish to include them in my care. I know and agree to the charges provided to me by My Mental Health LLC if they do join me during my appointment.

Therefore I, _____, give *My Mental Health LLC*. Permission to make and disclose the following with the person listed below:

□ Scheduling / Canceling appointments
□ Medication questions
□ Speak with the provider regarding patient (*Only in appointment*)

Name: _____ Phone: _____

Relation: _____

Current Medication and Allergies:

1. What daily / weekly medications are you currently taking?

_____

_____

2. Have you or are you currently taking any psych medication? *(if 'Yes' please list below)* □ YES □ NO

_____

_____

3. Do you have allergies to medication? *(if 'Yes' please list below)* □ YES □ NO

_____

_____

Current Concerns – Please **CIRCLE** one or more of the following items:

Anxiety/Worry/Nervousness	Thoughts of harming yourself
Sadness/Depression	Thoughts of harming others
Anger/Temper	Low self-esteem
Irritability	Paranoia/Suspiciousness
Sleep Difficulty	Hearing voices/noises
Change in appetite/weight	Seeing visions
Loss of pleasure in activities	Panic attacks
Concentration difficulties	Racing thoughts
Memory lapses	Recurring, unwanted thoughts
Low motivation	Alcohol or other substance use
Mood swings	Loneliness
Impulsivity	Risk-taking behavior
Nightmares	Flashbacks
Binge eating	Restrictive eating

Other: _____

Sources of stress – Please **CIRCLE** one or more of the following items:

Health	Family	Finances
Work	Relationships	Loss
School	Physical appearance/body image	Housing

Other: _____

Psychiatric History:

1. Have you ever been evaluated by a psychiatrist before? Yes No
2. Have you ever been in psychotherapy (talk therapy) before? Yes No
3. Have you ever been hospitalized on a psychiatric unit? Yes No
4. Have you ever attempted to end your life? Yes No
5. Have you ever been aggressive or violent towards others? Yes No
6. Have you ever been treated for an alcohol or drug abuse problem? Yes No
7. Have you ever been prescribed medication for a mental health condition? Yes No
8. Does any family member have a mental illness? Yes No

(If yes, please specify relative in the space provided)

□ Bipolar disorder: □ Post-traumatic Stress disorder:

□ Major depression: □ Schizophrenia:

□ Anxiety disorder: □ ADHD:

□ Panic disorder: □ Drug/Alcohol dependence:

□ Obsessive Compulsive Disorder (OCD):

Psychosocial History:

1. Place of birth: _____
2. Any history of birth complications or developmental delays? □ Yes □ No

   If yes, please specify: _____
3. My childhood was (please circle):

   Very Happy Happy Fair Unhappy Very unhappy
4. History of abuse (please circle):

   None Verbal Emotional Physical Sexual
5. With whom do you live? _____
6. Do you have any children? □Yes □No *(If yes, list ages:* _____)
7. Religion/Spiritual beliefs: _____
8. Military service: _____
9. Occupation: _____
10. Past employment: _____
11. Highest level of education? _____
12. History of arrests or other legal issues? □ Yes □ No

Substance Use History: Please **CIRCLE** one or more of the choices provided

Caffeine	Current	Past	Never
Alcohol	Current	Past	Never
Nicotine	Current	Past	Never
Marijuana	Current	Past	Never
Cocaine	Current	Past	Never
Amphetamines/Stimulants	Current	Past	Never
Hallucinogens (PCP, LSD, mushrooms)	Current	Past	Never
Opiates (Heroin, oxycodone)	Current	Past	Never
Sedatives (Valium, Xanax)	Current	Past	Never

Alcohol History:

1. How many drinks can you hold without feeling drunk? _____
2. Have you ever felt that you should cut down on your drinking? ☐ Yes ☐ No
3. Have close friends or family members ever told you about things you said or did while you were drinking that you could not remember? ☐ Yes ☐ No
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? ☐ Yes ☐ No
5. Have you ever had a DWI? ☐ Yes ☐ No

I verify that all information provided above is complete and accurate to my knowledge.

X_____ ____/_____/_____
Patient signature Date

Suicide Risk Assessment:

Have you ever had feelings or thoughts that you didn't want to live? ☐ Yes ☐ No

If YES, please check and answer the following. If NO, please skip.

- Do you currently feel that you do not 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? _____
- On a scale of 1-10 (ten being the strongest) how strong is the desire to kill yourself currently? _____
- Would anything make it better? _____
- Have you ever thought about how you would kill yourself? _____
- Is the method you would use readily available? _____
- Have you planned a time for this? _____
- Is there anything that would stop you from killing yourself? _____
- Do you feel hopeless and/or worthless? _____
- Have you ever tried to kill or harm yourself before? _____

PATIENT HEALTH QUESTIONAIRE (PHQ -9)

Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "X" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly Everyday
1. Little interest or pleasure in doing things	0	1	2	3
2. Felling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping to much	0	1	2	3
4. felling 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 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	0	1	2	3
Total				

Add Columns _____ + _____ + _____+ _____ = _____

Healthcare professional: For interpretation of TOATAL, please refer to accompanying scoring card)

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