

New Directions
The Treatment Center for Anxiety and Depression
OUTPATIENT INFORMATION SHEET

DATE: _____ ACCT. # _____

SOCIAL SECURITY NUMBER: _____

NAME YOU LIKE TO BE CALLED: _____

PATIENT'S NAME: _____

LAST FIRST MIDDLE MAIDEN

ADDRESS: _____

STREET OR BOX NUMBER CITY COUNTY STATE ZIP

HOME PHONE NUMBER: (_____) _____ BUSINESS PHONE: (_____) _____

BIRTHDATE: _____ AGE: _____ SEX: M F MARITAL STATUS: SGL M SEP D W

BIRTHPLACE: _____ PLACE OF EMPLOYMENT: _____

PERSON TO CONTACT IN EMERGENCY: _____ PHONE: (_____) _____

NEAREST RELATIVE (Other than spouse): _____ RELATION: _____

ADDRESS: _____ HOME PHONE: (_____) _____ BUSINESS PHONE: (_____) _____

SPOUSE: _____ HOME PHONE: (_____) _____ BUSINESS PHONE: (_____) _____

PLEASE LIST PRIOR PSYCHIATRIC TREATMENT: (when, where, and with whom)

PLEASE LIST ALL PRESENT MEDICATIONS: (name, strength, and dosage)

NAME OF PERSON REFERRING YOU: _____

(circle one) doctor attorney minister counselor employer friend

ADDRESS: _____

I voluntarily consent to outpatient psychiatric care encompassing diagnostic and medical treatment by my physician, his assistants or his designees, as may be necessary in his judgement. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of treatments or examinations.

Witness _____ Date _____ Signature of Patient _____

(If patient is unable to consent or is a minor, complete the following.)

Patient is _____ unable to consent because _____

_____ a minor

I hereby consent on his behalf and in his stead, this _____ day of _____, 20____.

Witness _____ Signature of closest relative or legal guardian _____

FINANCIAL RESPONSIBILITY

IN ORDER TO CONTROL COST OF BILLING WE REQUEST PAYMENT IN FULL AT TIME OF SERVICE. IF WE FILE YOUR INSURANCE THEN WE REQUIRE YOUR CO-PAYMENT AT EACH VISIT. MISSED APPOINTMENTS AND CANCELLATIONS WITH LESS THAN 24 HOURS NOTICE WILL BE BILLED.

PLEASE COMPLETE INFORMATION ON BACK.

If person responsible is not the patient, please complete the following:

Responsible party's name: _____

Relationship to patient: _____ SS# _____ Phone # _____

Address: _____

Witness: _____ Date: _____ Signature _____

DO YOU WISH OUR OFFICE TO FILE? Y _____ N _____

IF SO, PLEASE COMPLETE ALL INFORMATION

Primary Insurance Company: _____ Secondary Insurance Company: _____

Policyholder Name: _____ Policyholder Name: _____

Policyholder's Social Security Number: _____ Policyholder's Social Security Number: _____

Relationship to patient: _____ Relationship to patient: _____

Employer if group coverage: _____ Employer if group coverage: _____

Policy number: _____ Policy number: _____

Group Number: _____ Group Number: _____

Policyholder's Date of Birth: _____ Policyholder's Date of Birth: _____

DOES YOUR INSURANCE REQUIRE AN AUTHORIZATION FOR MENTAL HEALTH SERVICES?

Yes _____ No _____

DO YOU HAVE THE AUTHORIZATION FOR TODAY'S VISIT WITH YOU?

Authorization # _____ from _____ to _____

PLEASE READ AND SIGN

I AUTHORIZE NEW DIRECTIONS TREATMENT CENTER TO RELEASE INFORMATION AS MAY BE NEEDED TO INSURANCE COMPANIES AND CLAIMS PROCESSORS FOR PROCESSING INSURANCE CLAIMS. I UNDERSTAND THAT ALL FEES ARE DUE AND PAYABLE BY ME AND SHOULD THE INSURANCE COMPANY DENY PAYMENT, THEN THE RESPONSIBILITY LIES SOLELY WITH ME TO PAY IN FULL. SHOULD COLLECTION PROCEEDINGS BE REQUIRED, I GIVE MY PERMISSION FOR INFORMATION TO BE RELEASED TO CREDIT BUREAUS, COLLECTION AGENCIES AND ATTORNEYS FOR THE PURPOSE OF FACILITATING COLLECTION. I FURTHER AGREE TO PAY ADDITIONAL COSTS INVOLVED IN THE COLLECTION PROCESS.

I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS TO WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INSURANCE AND OTHER HEALTH PLANS TO NEW DIRECTIONS TREATMENT CENTER.

THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.

ASSIGNMENT OF INSURANCE BENEFITS

I AGREE TO THE ASSIGNMENTS AND FINANCIAL RESPONSIBILITIES OF THIS FORM. I HAVE READ AND UNDERSTOOD THEM.

_____ Date _____

Signed (Patient, or parent if under 18 years of age)



The Treatment Center For Anxiety and Depression

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 (336) 768-8281 • FAX (336) 768-5685

NAME _____ DATE ____/____/____ HEIGHT _____ WEIGHT _____
 DATE OF BIRTH ____/____/____ JOB _____ HOW LONG? _____ YRS

PREVIOUS PSYCHIATRIC TREATMENT

DATE	CLINICIAN	REASON	LENGTH OF TREATMENT	HOSPITALIZED?

CURRENT SYMPTOMS

APPETITE

- TOO MUCH
- TOO LITTLE
- WEIGHT GAIN _____ LBS
- WEIGHT LOSS _____ LBS
- BINGING
- VOMITING
- LAXATIVE ABUSE
- PREOCCUPIED WITH WEIGHT OR BODY APPEARANCE

SLEEP

- TOO MUCH
- TOO LITTLE
- I FEEL LITTLE NEED FOR SLEEP
- NEED MORE SLEEP
- DIFFICULTY FALLING ASLEEP
- LOUD SNORING
- DIFFICULTY STAYING ASLEEP
- DAYTIME SLEEPINESS
- LEG MOVEMENTS OR FEELINGS INTERFERE WITH SLEEP
- SLEEPINESS INTERFERES WITH DRIVING

MOOD

- ELEVATED
- SAD OR DEPRESSED
- CHANGEABLE
- HOW OFTEN? _____
- BETTER IN AM
- BETTER IN PM
- BETTER IN SUMMER
- BETTER IN WINTER
- ANGRY/IRRITABLE/EXPLOSIVE
- SUICIDAL PLANS
- WISHES FOR DEATH
- SUICIDAL THOUGHTS
- PAST SELF INJURY/ATTEMPT
- THOUGHTS OF DEATH

ENERGY

- TOO MUCH
- TOO LITTLE
- VERY CHANGEABLE

ANXIETY

- ATTACKS OF PANIC OR FEAR
- SHORTNESS OF BREATH
- DIFFICULTY SWALLOWING
- NUMBNESS OR TINGLING
- RAPID HEART RATE
- DIZZINESS/BALANCE LOSS
- WORRY THAT A DISASTER WILL HAPPEN TO ME OR FAMILY
- TROUBLING OR UNWANTED THOUGHTS /URGES /ACTIONS
- REPETITIVE BEHAVIOR
- FEELING UNREAL
- WORRY OVER HEALTH
- FEAR OF LOSING CONTROL
- FEAR OF HEIGHT
- FEAR OF BEING CLOSED IN
- OTHER FEARS _____

ACTIVITY

- EXCESSIVE
- CAUSES ME PROBLEMS
- EXCESSIVE MONEY SPENT
- EASILY DISTRACTED
- COMES AND GOES
- POOR CONCENTRATION
- SOMETIMES OUT OF CONTROL
- CAN NOT COMPLETE TASKS

IS THERE ANY VIOLENCE IN YOUR HOME? NO YES _____

FAMILY HISTORY

PSYCHIATRIC PROBLEMS, ALCOHOL ABUSE, DRUG ABUSE, OR LEGAL PROBLEMS

MOTHER _____ FATHER _____
 BROTHERS _____ SISTERS _____
 GRANDPARENTS _____
 AUNTS AND UNCLAS _____
 FIRST COUSINS _____
 CHILDREN _____

GENERAL HEALTH

LAST PHYSICAL EXAM DATE _____ RESULTS _____

CURRENT MEDICAL PROBLEMS	DOCTOR	ANY MEDICINES PRESCRIBED
_____	_____	_____
_____	_____	_____
_____	_____	_____

PREVIOUS MEDICAL HOSPITALIZATIONS

ALLERGIES TO MEDICINES OR FOOD

DATE _____ _____ _____	<input type="checkbox"/> NONE _____ <input type="checkbox"/> ALLERGIC TO: _____ _____
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ALCOHOL USED NUMBER OF DRINKS PER WEEK _____ USAGE OR PROBLEMS IN THE PAST? _____

ANY NON-PRESCRIPTION DRUG USE? _____ USAGE OR PROBLEMS IN THE PAST? _____

LEGAL PROBLEMS NO YES _____

HEART AND LUNGS

- CHEST PAIN
- IRREGULAR RHYTHM
- HEART ATTACKS
- TROUBLE BREATHING
- HARD TO LIE FLAT
- BLOOD CLOTS

GLANDULAR TROUBLE

- THYROID PARATHYROID
- PITUITARY ADRENAL
- THYMUS LYMPH
- OVARIES TESTES
- CHANGE IN SKIN OR HAIR TEXTURE
- INTOLERANCE TO: HEAT COLD

BONES AND JOINTS

- ARTHRITIS GOUT
- OSTEOPOROSIS
- OTHER _____

BOWELS

- REGULAR IRREGULAR
- BLOOD IN STOOL
- CONSTIPATION DIARRHEA
- MOVEMENTS EVERY _____ DAYS
- OTHER _____

SKIN

- ANY CHANGES? _____
- SWELLING IN HANDS, FEET, OR LEGS
- SKIN DISEASES OR PROBLEMS? _____

KIDNEYS AND BLADDER

- INFECTIONS STONES
- TROUBLE STARTING STREAM
- TROUBLE STOPPING STREAM
- WETTING AT NIGHT OR DURING DAY
- SEXUALLY TRANSMITTED DISEASE
- PROSTATE PROBLEM

HEARING AND VISION

- HEARING PROBLEMS OR CHANGES?
- CHANGES IN VISION?
- GLAUCOMA
- PAIN IN EYES OR EARS
- OTHER _____

NERVOUS SYSTEM

- SEVERE HEADACHES
- HOW LONG? _____ HOW OFTEN? _____
- SEIZURES OR FITS FAINTING SPELLS
- NUMBNESS WEAKNESS
- UNCONSCIOUS AFTER HEAD INJURY
- OTHER _____

WOMEN'S HEALTH

- POST PARTUM DEPRESSION
- IRREGULAR PERIODS
- MENSTRUAL PROBLEM: _____
- BREAST PROBLEMS _____
- BIRTH CONTROL PILLS
- LAST MENSTRUAL PERIOD: _____
- TERMINATED PREGNANCY

FAMILY MEDICAL HISTORY

MOTHER'S AGE _____ HEALTH _____ FATHER'S AGE _____ HEALTH _____

OTHER _____

PATIENT SIGNATURE _____ DATE ____/____/____	REVIEWED _____ DATE ____/____/____ REVIEWED _____ DATE ____/____/____
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