



Patient Demographics

General Information:

Today's Date:		Date of Birth:	
Name:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address:		SSN:	
City:	State:	Zip:	
Home Phone:	Work Phone:	Cell Phone:	
Email:		Preferred Contact Method: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	
Race:		Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other	
Employer:			

Financially Responsible Party Information:

Responsible Party: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		Date of Birth:	
Responsible Party Name:			
Responsible Party Address:			
Phone:		<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	

Insurance Information:

Policy holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		Subscriber Date of Birth:	
Subscriber Name:		Subscriber Employer:	
Insurance Company Name:			
ID#:		Group#:	

Emergency Contact:

Name:			
Relationship:		Phone: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	

Pharmacy Information

Preferred Pharmacy:			
Address:		Phone:	
City:	State:	Zip:	

By signing I verify the information on this page is correct to the best of my knowledge. I understand quoted benefits are not a guarantee of payment and I am responsible for any portion not covered by insurance. I authorize the release of any medical or other information needed to process insurance claims. I also authorize payment of medical benefits to this practice for services rendered.

Print Name _____ Signature _____

If not signed by patient, please indicate relationship to patient (i.e., parent, Power of Attorney, etc.)

Relationship _____ Date _____

Witnessed by _____ Date _____



FINANCIAL STATEMENT OF UNDERSTANDING

- Initial _____ Payment is expected on the day of your appointment. Your insurance contract requires that we collect your copay for services. A \$15.00 fee will be charged if payment is not made on the date of service
- Initial _____ All balances should be paid within 20 days of the date of service
- Initial _____ Missed Appointment Fee: We require at least 24 hours' notice to cancel an appointment. We provide a 24 hour live answering service, courtesy confirmation calls, and can take your call during business hours. If we are not notified of your missed appointment:
 - You will be responsible for the missed appointment fee
 - \$45.00 for a therapy appointment
 - \$50.00 for a medical appointment
 - You will not be rescheduled until the fee for the missed appointment is paid.
 - We cannot bill your insurance for the missed appointment fee.
- Initial _____ You are required to keep three consecutive visits with your provider before we are able to complete any FMLA, or Disability forms. Please review our Disability Form Fee Notice if you have a request. Fees for these forms can range from \$25.00 - \$75.00 and must be paid prior to the forms being reviewed and completed.
- Initial _____ There is a \$45.00 fee for returned checks. If not paid in full within 10 days your account will be turned over to the Worthless Check Unit in Rock Hill, which will result in additional fees.
- Initial _____ Requests for medical records are charged a base fee of \$15.00. If records are provided to include greater than 30 pages, an additional \$.65 per page is charged. If records are provided to exceed 50 pages, an additional \$.50 per page is charged.
- Initial _____ Upon request prescriptions can be mailed, a \$15.00 fee will be required prior to mailing.
- Initial _____ It is your responsibility to meet all requirements for EAP Authorizations as set forth in your EAP contract.
- Initial _____ It's your responsibility to provide correct insurance information at the time of service. If incorrect information results in insurance denial, balances will be your responsibility.

I understand the above statement of fees and policies.

Patient/Authorized Person Signature

Date

Authorized Person Relationship to Patient *(if applicable)*

Witness

Date



ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Concerning the use of my personal medical information, I ALLOW the following family members and/or friends as written below on my behalf:

1) _____

Print Full Name of Person

to schedule/reschedule/cancel appointments

to pick up written prescriptions or samples

to discuss billing information

to discuss insurance information

2) _____

Print Full Name of Person

to schedule/reschedule/cancel appointments

to pick up written prescriptions or samples

to discuss billing information

to discuss insurance information

3) _____

Print Full Name of Person

to schedule/reschedule/cancel appointments

to pick up written prescriptions or samples

to discuss billing information

to discuss insurance information

• Initial _____ I have been presented with a copy of The Saluda Counseling Center’s Notice of Privacy Practices, I understand this notice and that my information may be used only as permitted under federal and state law.

Patient/Authorized Person Signature

Date

Printed Name

Authorized Person Relationship to Patient (*if applicable*)

Witness Signature

Date



Medical Intake Patient Information

Thank you for completing this form. The information you provide will help create a treatment plan tailored to meet your needs. The purpose of this questionnaire is to get a complete picture of your marital and/or family background. By obtaining this information, we can save valuable interview time. Therefore, answering these routine questions as fully and as accurately as you can is appreciated. All case records are strictly confidential. NO One is permitted to see your case record without your written permission (except in situations deemed potentially life-threatening or if court ordered). If you have questions about questionnaire, please feel free to ask at any time. If you do not wish to answer a question, you may write, "I do not wish to answer."

Patient Name _____ Today's Date: _____

Address _____ City _____ State _____

Zip _____ Home Phone: _____ Cell Phone: _____

Gender: Male Female Age: _____ Date of Birth: _____

Employer: _____ Occupation: _____

Marital Status: Single Married Divorced Widowed Separated Engaged Living Together

Spouse's Name: _____ Date of Birth: _____ Age: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Telephone: _____

Name of Children	Date of Birth	Grade	Lives with you? <input type="checkbox"/> Yes <input type="checkbox"/> NO
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> NO
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> NO
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> NO
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> NO
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> NO

Briefly describe what problems or difficulties you are presently experiencing:



Please check any of the following which apply and indicate the family member involved such as spouse, child, father, mother, brother, sister, you, etc:

Event:	Family Member Involved
<input type="checkbox"/> Death in family	_____
<input type="checkbox"/> Divorce	_____
<input type="checkbox"/> Trouble with law	_____
<input type="checkbox"/> Financial trouble	_____
<input type="checkbox"/> Serious illness	_____
<input type="checkbox"/> Mental illness	_____
<input type="checkbox"/> Job or school difficulty	_____
<input type="checkbox"/> Drugs	_____
<input type="checkbox"/> Alcohol	_____
<input type="checkbox"/> Interpersonal problems	_____
<input type="checkbox"/> Sexual abuse/assault	_____
<input type="checkbox"/> Physical abuse/assault	_____
<input type="checkbox"/> Depression	_____
<input type="checkbox"/> Suicide/homicide	_____
<input type="checkbox"/> Serious accident	_____
<input type="checkbox"/> Other	_____

Have you ever used: (check all that apply)

- | | | | | |
|---|--|---|------------------------------------|--|
| <input type="checkbox"/> alcohol | <input type="checkbox"/> sedatives | <input type="checkbox"/> barbiturates | <input type="checkbox"/> tobacco | <input type="checkbox"/> heroin |
| <input type="checkbox"/> LSD | <input type="checkbox"/> caffeine | <input type="checkbox"/> methadone | <input type="checkbox"/> PCP | <input type="checkbox"/> cocaine/crack |
| <input type="checkbox"/> stimulants | <input type="checkbox"/> tranquilizers | <input type="checkbox"/> pain medications | <input type="checkbox"/> marijuana | |
| <input type="checkbox"/> inhalants, glue, Freon, butane, gasoline | | | | |

Has anyone in your family ever been concerned about your abuse of drugs or alcohol? Yes
 No

Patient Name _____ Date of Birth: _____



Do you have any allergies? YES NO, if yes please list:

1. _____
2. _____
3. _____

Have you been in the hospital overnight in the last 5 years? Yes No, if yes please list:

- | Hospital | From | To | Reason |
|----------|------|----|--------|
| 1. _____ | | | |
| 2. _____ | | | |

Are there any disease or illnesses which seem to run in your family such as diabetes, heart disease, or high blood pressure?

1. _____
2. _____
3. _____

Have you ever seen a psychiatrist, psychologist, or counselor before? Yes No, if yes please list:

- | Name | From | To | Problem |
|----------|------|----|---------|
| 1. _____ | | | |
| 2. _____ | | | |

Have you ever had to take any nerve pills, tranquilizers, antidepressants, or sedatives before? Yes No, if yes please list:

- | Drug | Dose | Reason |
|----------|------|--------|
| 1. _____ | | |
| 2. _____ | | |
| 3. _____ | | |

Are you currently taking any of these medications list above? Yes No, if yes please list:

- | Drug | Dose | Reason |
|----------|------|--------|
| 1. _____ | | |
| 2. _____ | | |
| 3. _____ | | |

Have you been in the hospital for nerve problems, depression, or anxiety? Yes No, if yes please list:

- | Hospital | Date | Doctor | Problem |
|----------|------|--------|---------|
| 1. _____ | | | |
| 2. _____ | | | |

- | Drug Received at Hospital | Dose | Reason |
|---------------------------|------|--------|
| 1. _____ | | |
| 2. _____ | | |
| 3. _____ | | |



Sleep, anxiety, or inability to concentrate may be treated with controlled substances such as Xanax or Ritalin. When these drugs are misused there are possible dangers of accidents, seizures, accidental overdoses, and toxic effects (such as when these medication are used in large doses, mixed with alcohol, marijuana and illegal drugs, and even medications prescribed for blood pressure, pain, and allergies). These medications, when misused, can interfere with the metabolism of other medications and cause potentially dangerous inter-reactions. To prevent problems, the following policies will be followed.

Controlled substances will not be prescribed or refilled on weekends. A 48 hour notice is required to obtain records, call the pharmacy, or for prescriptions to be written for any medication, and this cannot be done on the weekend. If a sedative drug is needed, a non-controlled medication such as Neurontin or an anticonvulsant will be prescribed. If a patient loses or has a prescription stolen for controlled substance or the actual medication, he or she may be discharged from the practice. If there is evidence of overuse, misuse, failure to keep appointments, or inability of a patient to control their use, no further prescriptions for controlled substances will be given. Instead an anticonvulsant such as Neurontin may be prescribed to prevent withdrawal. Losing two prescriptions or repeated request for early refills may result in a patient being discharged from the practice.

Controlled medications are clearly labeled as such on the prescription label, and you should ask your physician or your pharmacist if you have any questions. No prescriptions for opiate-like pain medications will be prescribed. A patient should contact their primary care physician or a pain center for such medications.

Signature _____

Date _____ Witness by _____

Patient Name _____ Date of Birth: _____



What Problem bothers you the most at the present time? _____

Please check the symptoms which currently bother you or have bothered you in the last six months. Circle more than one if they apply.

Sleep Disturbance	YES	NO
If yes, difficulty going to sleep	YES	NO
Awakening throughout the night	YES	NO
Early morning awakening	YES	NO
Are you blue, sad, despondent	YES	NO
Do you lack energy	YES	NO
Are you interested in your usual pastimes	YES	NO
Have you lost Weight	YES	NO
If yes, how many pounds _____		
Have you lost interest in sex	YES	NO
Do you experience pleasure	YES	NO
Have you thought that you are more energetic than usual	YES	NO
Have you experienced a decrease in concentration	YES	NO
Do your thoughts run quickly from topic to topic	YES	NO
Are you experiencing racing thoughts	YES	NO
Do you have thoughts or fear others	YES	NO
Do you have trouble speaking in public to groups	YES	NO
Do you have a racing pulse	YES	NO
Do you have episodes of shortness of breath	YES	NO
Have you ever thought you would go crazy or lose control	YES	NO
Do you have difficulty crossing bridges over water	YES	NO
Do you have difficulty in elevators	YES	NO
Do you have difficulty flying	YES	NO
Do you have difficulty standing on a balcony or high rise	YES	NO
Are you ever compelled to do something that seems silly	YES	NO
Do you experience a thought that you cannot seem to get out your mind	YES	NO
Do you find yourself consuming huge amounts of sweets or starches at once	YES	NO
Do you collect things	YES	NO
Do you double check doors, appliances, or lock when leaving your home	YES	NO

Patient Name _____ Date of Birth: _____



COMORBID STATES QUESTIONNAIRE

Please check the statements that apply

- 1. My brain never shuts off.
- 2. I think about the same things over and over without coming to a conclusion.
- 3. My thoughts go so fast that I can't keep up with them when I talk.
- 4. I can think of many things at the same time.
- 5. If I panic, my mind gets full of thought.
- 6. I often lose my chain of thought.
- 7. When I lay down at night, I sometimes can't stop thinking about my problems.
- 8. If I awaken at night I sometimes can't stop thinking about my problems.
- 9. I often feel as though something bad is going to happen.
- 10. I often feel "on guard" for no reason.
- 11. I sometimes feel as though I am watching myself when I say and do things.
- 12. I sometimes lose control of what I am saying or doing
- 13. Sometimes I get so anxious it is as if I am watching myself and say and do things I really don't want to say or do but have no control over myself.
- 14. I sometimes can read the same page over and over again and still don't know what I read.
- 15. I can from one room to another and forget why I went there.
- 16. I have difficulty feeling my emotions.
- 17. I have trouble feeling closeness or love.
- 18. I have trouble responding emotionally and physically during sex.
- 19. I often feel empty inside.
- 20. I have trouble knowing what the right thing for me to do is.
- 21. When I get scared my hearing and sight get more sensitive.
- 22. When I get scared the noises in the room get louder and louder.
- 23. When I get scared I hear everything about me loudly and everything gets intense and sometimes it more than I can stand.
- 24. I hate loud clocks.
- 25. I am easily startled.
- 26. It is often my fault when things go wrong.
- 27. I often feel sad.
- 28. I have little energy.
- 29. I feel numb inside when good things happen.
- 30. When I feel sad I have an empty ache in my chest.
- 31. I am easily irritated.
- 32. I lose control of my temper.
- 33. My feelings can go from happy to sad to happy or peaceful to rage in a flash.
- 34. I am sometimes mad without knowing why.
- 35. I feel nervous without knowing why.
- 36. I keep getting anxious about the same things over and over.
- 37. I have trouble talking in front of groups of people.
- 38. When I get anxious my mind goes blank.
- 39. I am more anxious than I was five years ago.
- 40. When I get nervous I feel as if I have electricity in my body.
- 41. Thoughts pop into my mind from nowhere.
- 42. I can't seem to get over some of the things that have happened.
- 43. My hands and feet get cold when I am scared.



- 44. My hands are often getting wet with sweat.
- 45. I sweat more than most people.
- 46. When I am embarrassed oftentimes I turn beet red and sweat a lot.
- 47. I sometimes get rashes on my neck and chest that don't itch and go away.
- 48. My blood pressure goes up when I am scared.
- 49. I can often feel my heart pounding.
- 50. I often have diarrhea when I am anxious.
- 51. Doctors often ask me about my thyroid.
- 52. I have small pupils.
- 53. I have night sweats.
- 54. I have migraine headaches.
- 55. When I am tense I "lock" my jaw.
- 56. I grind my teeth at night.
- 57. I feel clumsy a lot of the time.
- 58. I feel clumsy a lot of the time.
- 59. I get comments on how big my eyes are.
- 60. I have trouble going to sleep and staying sleep.
- 61. I wake up several times at night.
- 62. I sleep well for several hours then sleep poorly for the rest of the night.
- 63. I sleep too much.
- 64. I come out of sleep quickly.
- 65. I have always been overactive.
- 66. My symptoms started after puberty.
- 67. My symptoms started after my child's birth.
- 68. My symptoms started or worsened after a stressful period in my life.
- 69. I cannot take steroids or birth control pills.
- 70. I was prescribed stimulants as a child, and they were helpful.
- 71. Stimulants made me feel more anxious.
- 72. Antidepressants made me feel better.
- 73. Antidepressants helped me for a while then lost their effect.
- 74. Antidepressants make me more anxious.
- 75. Antidepressants made the emptiness inside me worse.
- 76. I sometime drink alcohol to make me feel better.
- 77. I sometimes use marijuana to help with the anxiety.
- 78. Marijuana slows my racing thoughts.
- 79. I have had a high sex drive for periods of my life.
- 80. I have had times in my life when I felt really good.
- 81. I get irritable before my periods.
- 82. I have thoughts of committing suicide.
- 83. I have cut myself before and not felt pain.
- 84. I have had troublesome "hot flashes".
- 85. I seem to be more "cold natured" than most people.
- 86. I have been told I have "restless syndrome"
- 87. I often find myself shaking one or both legs when I sit still.
- 88. I have a hard time sitting still. I am more comfortable moving and doing something.



CHECKLIST: REVIEW OF SYSTEMS

General: Fatigue Fever or chills Weakness Trouble sleeping
 Change in appetite Weight loss or gain amount _____

Psychiatric: Nervousness Depression Stress Memory loss Hallucinations

Skin: Rashes Itching Dryness Color Changes
 Hair and Nail changes

Head: Headache Head Injury

Ears: Decreased hearing Ringing in ears (tinnitus) Earache Drainage

Eyes: Vision Glasses or contacts Pain Redness Blurry/double vision
 Flashing light Specks Glaucoma Cataracts
 Date of last eye exam _____

Nose: Stuffiness Discharge Itching Hay fever Nosebleeds
 Sinus pain

Throat: Teeth Gums Bleeding Dentures Soreness
 Dry Mouth Hoarseness Date of last dental exam _____

Neck: Lumps Swollen glands Pain Stiffness

Respiratory: Cough Sputum Wheezing Painful breathing
 Coughing up blood (hemoptysis) Shortness of breath (dyspnea)

Cardiovascular: Chest pain or discomfort Tightness Palpitations Swelling(edema)
 Shortness of breath w/activity (dyspnea) Difficulty breathing lying down (orthopnea)
 Sudden awakening from sleep w/shortness of breath (Paroxysmal Nocturnal Dyspnea)

Gastrointestinal: Heartburn Nausea Vomiting Constipation Diarrhea

Urinary: Frequency Urgency Burning or pain Blood Incontinence

Vascular: Calf pain with walking (Claudication) Leg Cramping

Musculoskeletal: Muscle or joint pain Stiffness Back pain Trauma Swelling of joints

Neurologic: Dizziness Fainting Seizures Weakness Numbness
 Tingling Tremor

Hematologic: Ease of bruising Ease of bleeding

Endocrine: Heat or cold intolerance Sweating Frequent urination Thirst

Patient Name _____ Date of Birth: _____