Adult Registration Form

Patient Information

First Name: _____
Last Name:_____ Date of Birth : _____
Address: _____
City: _____ State: _____ Zip Code: _____
Gender: (Circle one) Male Female
Patient SSN: _____ Patient under 18? Yes_____ No _____
If yes, Parent or Guardian Name: _____
Patient Marital Status: (Circle one) Married Divorced Single Widowed/Widower
Emergency Contact: (Full Name and phone #)
_____
Occupation: _____ Currently Employed? Yes No
Contact Preferences:
Home Phone: _____ Email Address: _____
Work Phone: _____ Alt. Phone: _____
* Please indicate if you would like a message with detailed information, or a call-back number only, and on which phone number(s):
_____

Primary Insurance

Name of Primary Insured: _____ Insurance ID#: _____
Relationship to Patient: _____ DOB: _____
SSN: _____ Primary Insured Employer: _____
Employer Phone#: _____ Ext. _____
Insurance Company: _____ Subscriber #: _____
Group #: _____
Claims Address: _____

Additional Insurance

Circle one: Yes No
Name of insured: _____
Relationship to patient: _____ DOB: _____ SSN: _____
Primary Insured Employer: _____
Employer Phone#: _____ Ext. _____
Insurance Company: _____ Subscriber #: _____
Group #: _____
Claims Address: _____

Assignment and Release

I, the undersigned, do certify that I (or my dependent) have insurance coverage with: _____ and assign directly to Advanced Psychiatric Health, LLC and/or _____ all insurance benefits, if any, otherwise payable to me for all services rendered.

Please Initial All Spaces Below To Indicate Your Understanding:

_____ I understand that I am financially responsible for all charges not paid by insurance.

_____ I understand that I will be charged the regular appointment fee if I do not show up for an appointment, or reschedule in less that 24 hours.

_____ I understand that these fees will need to be paid before I can schedule another appointment.

_____ I hereby authorize the above named entity/individual to release all information necessary to secure benefits.

_____I authorize the use of this signature on all insurance submissions.

Patient or Primary Insured Signature: _____

Relationship to Patient: _____ Date: _____

Medical Health History

Patient Name: _____ Date Today: _____
DOB: _____ Age: _____ Height:_____ Weight:_____
Date of last physical exam: _____
Primary Care Physician: _____
Address: _____ City/State: _____ Zip: _____
Phone #: _____ Fax: _____

Symptom Checklist: (Please indicate symptoms you have currently, or have had in the last year)

General Symptoms
- ☐ Chills
- ☐ Chest pain
- ☐ Depression
- ☐ Dizziness
- ☐ Difficulty Sleeping
- ☐ Fever
- ☐ Headache
- ☐ Nervousness
- ☐ Numbness/tingling
- ☐ Sexual dysfunction
- ☐ Sweats Weakness
- ☐ Weight loss

Head & Neck
- ☐ Vision changes
- ☐ Chronic cough
- ☐ Difficulty swallowing
- ☐ Earache/Infection
- ☐ Hearing loss
- ☐ Hoarse voice
- ☐ Nosebleeds
- ☐ Ringing in ears
- ☐ Sinus problems

Bone/Joint/Muscle
- ☐ Fractures
- ☐ Joint pain
- ☐ Muscle pain

Gastrointestinal
- ☐ Bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea/
- ☐ Vomiting
- ☐ Poor appetite
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting blood

Cardiovascular
- ☐ Chest pain
- ☐ High/Low blood pressure
- ☐ Rapid heart beat
- ☐ Swelling in feet/ankles
- ☐ Varicose veins

Genitourinary
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Loss of bladder
- ☐ Loss of bowel control
- ☐ Painful urination
- ☐ Sexual dysfunction

Skin
- ☐ Bruising easily
- ☐ Change in size/color of
- ☐ moles Itching
- ☐ Rash
- ☐ Scars
- ☐ Tattoo(s)

MALES ONLY
- ☐ Breast lump
- ☐ Difficulty with erection
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Testicle lump
- ☐ Other:

FEMALES ONLY
- ☐ Abnormal Pap Smear
- ☐ Abnormal menstrual bleeding
- ☐ Breast lump
- ☐ Increased menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Last menstrual period? _____
Mammogram? _____
Are you pregnant? _____
Number of children? _____

Condition Checklist: (Please indicate conditions you have currently, or have had in the last year)

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ COPD
- ☐ Diabetes
- ☐ Drug Dependency
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV Positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Migraines
- ☐ Miscarriage
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Prostate problem
- ☐ Psychiatric care
- ☐ Rheumatic fever
- ☐ Seizure disorder
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Thyroid disorder
- ☐ Ulcers
- ☐ Vaginal infection
- ☐ Venereal disease

Medications (with dosages):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Pharmacy Name: _____ Phone #: _____

Drug allergies: (Please list drugs and reactions)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Family history (what medical problems run in your immediate family?):
_____
_____
_____

Alcohol use: NO YES If YES, how much? _____
_____
_____

Tobacco use: NO YES If YES, how much? _____
_____
_____

Other recreational drug use: NO YES If YES, what drug and how much? _____
_____
_____

Hospitalizations: (Indicate hospital name, year, and reason)
_____
_____
_____

Surgeries: (What type and what year)
_____
_____
_____

To the best of my knowledge, all information contained in this document is accurate and complete. I understand it is my responsibility to inform provider/agency if there is a change in my, or my minor child's, health status.

Signature of Patient or Parent/Guardian: _____

Date: _____

Reviewed By: _____ Date: _____

Psychiatric Health History

Patient Name: _____ Today's Date: _____

CHIEF COMPLAINT

What is the reason for your visit today? _____
_____
_____

HISTORY OF PRESENT ILLNESS

Please rate the symptoms below according to how much they affect you currently:
0 = No affect 1 = Some affect 2 = Experience 50% 3 = Experience most of the time

____ Am very depressed
____ No interest in anything
____ Feel worthless
____ Have low energy or fatigue
____ Have difficulty concentrating
____ Have poor appetite, or overeat
____ Feel restless, or slowed down
____ Trouble sleeping
____ Think about death a lot
____ Feel hopeless
____ Feel people can read my mind
____ Low self esteem
____ Am not interested in sex
____ Feel anxious or tense
____ Have anxiety/panic attacks
____ Isolate, don't go out
____ Have poor memory
____ Have paranoid feelings
____ Alcohol/Drug cravings
____ Can't keep commitments
____ Multiple arguments/fights
____ Count, check, or clean things repetitively
____ Have recurrent, frightening dreams
____ Disturbed by certain images
____ Avoid certain people or places
____ Am irritable or easily frustrated
____ My thoughts are going very fast
____ Have difficulty relating to others
____ Can't tune out the voices in my head
____ Recurrent physical illness
____ Can't stop certain repetitive thoughts
____ Can't stop certain behaviors
____ Trouble leaving the house

PAST PSYCHIATRIC HISTORY

Have you ever seen a mental health specialist (includes therapist/counselor, psychologist, psychiatrist)? YES NO
If YES, then:

Year	Reason	Hospitalized?			
		☐	Yes	☐	No
		☐	Yes	☐	No
		☐	Yes	☐	No
		☐	Yes	☐	No

Have you ever thought about/attempted suicide? YES NO
If yes, what did you do, and when? _____
_____

List all physical & sexual assaults, and domestic violence you have had in the past. Start with your earliest experience:

What happened, and who did it	Age	How long it continued	Told Anyone?	
			Yes	No
			Yes	No
			Yes	No
			Yes	No

Self Destructive Behaviors: *Have you ever done these things?*

	Age(s) you did them:		*Age(s) you did them:*
Banged head repeatedly		Induced Vomiting	
Binged on food		Used laxatives to lose weight	
Cut or burn yourself			

FAMILY PSYCHIATRIC HISTORY

Do you have family members with histories of mental illness? (Depression, Bipolar Disorder, Schizophrenia, Substance Abuse, Personality Disorders, psychiatric hospitalizations, or "nervous breakdowns"? YES NO

If yes, please describe:

Father	
Mother	
Siblings	
Paternal Grandparents	
Maternal Grandparents	

SOCIAL HISTORY

<u>If Yes to any questions below, please describe:</u>

Who lives in your home? _____

Where were you born and raised? _____

Did you develop normally (physically & mentally) as a child? _____

_____

Did you have problems in school? (discipline, grades, etc.) _____

_____

Did you have any legal problems as a child? _____

_____

Did you ever set fires for fun, skip school, or hurt animals on purpose? _____

_____

What did you do all day yesterday? _____

Sexual Orientation: Straight Bi Gay Lesbian Transgender Questioning

Occupation:

Where do you work? _____ How long? _____

Describe your work history: _____

Social:
Do you attend church/temple/synagogue regularly? YES NO
Religion: _____
Name hobbies & leisure activities: _____

Education:
Highest grade completed: _____ Graduate from high school? _____ GED? _____
Grades: In elementary school: A B C D F In junior high: A B C D F In high school: A B C D F
Graduate Degrees/Major: _____

Legal:
Have you ever been arrested? YES NO
If yes, what charges? _____
Have you been incarcerated? YES NO
If yes, describe when, where, and why: _____
_____
_____

Have you ever been involved in the following?

- ☐ Personal injury legal proceedings
- ☐ Sexual harassment complaints
- ☐ Any professional/administrative complaints
- ☐ Worker's compensation claims
- ☐ Termination or suspension from jobs or professional societies
- ☐ Bankruptcy

Additional Comments: _____
_____
_____

Patient Signature: _____ Date: _____

Reviewed By: _____ Date: _____

AUTHORIZATION FOR RELEASE OF RECORDS

Patient Name: _____ Date: _____

Recipient of Medical Records:

Advanced Psychiatric Health, LLC
400 W US HWY 24, Suite 250
Woodland Park, CO 80863

Office: (719) 434-2050
Fax: (719) 434-2423
Email: Info@coloradoAPH.com

Provider of Medical Records:

Name: _____ Type of Provider: _____

Address: _____ Phone: _____

_____ Fax: _____

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct Provider of Medical Records listed above to disclose my health information during the term of this Authorization to the Recipient listed above.

Purpose: I understand the specific purpose of the Authorization is to preserve the continuity of care regarding my treatment and to allow Recipient listed above to obtain a better understanding of my condition(s).

Information to be disclosed: This Authorization permits the Provider listed above to disclose the following medical records: (Initial the appropriate choice)

_____ All of my health information that the Provider has in their possession, including information relating to any medical history, mental or physical condition, and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes/other information, drug, alcohol, or other controlled substances information, billing information, correspondence and records from other health providers that the Provider may hold.

_____ Only the following records or types of health information: (Provide dates of treatment, types of treatment, or other designation)

_____

_____

Term: This Authorization will remain in effect for one (1) year from the date signed.

Revocation: I understand that the Authorization will remain in effect until it expires in one year, or I provide a written notice of revocation to the Provider at the listed mailing address. The revocation will be effective immediately upon the Provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Provider in reliance on this Authorization before the Provider received my written notice of revocation.
Photocopy: A photocopy, fax, or electronic copy of the Authorization shall be considered as effective and as valid as the original.

Patient Signature: _____ Date: _____

Reviewed By: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS YOUR HEALTH INFORMATION. PLEASE READ IT CAREFULLY.

Our office is required to maintain the privacy of your health information. By law, we may use or disclose your health information in the following circumstances:

1.) We may disclose your health information to other healthcare providers involved in your care in order to provide coordinated services for your.
2.) We may disclose your health information to a family member of another person responsible for your care in case of an emergency to reduce or prevent a serious threat to your health and safety, or the health and safety of another person.
3.) We may release some or all of your health information when required by Law.
4.) We may use or disclose your health information for the purpose of billing and obtaining payment from the payer of your health care.

Your rights regarding your health information:

1.) You have the right to transfer copies of your health information to another entity after your provide us with a written authorization.
2.) You have the right to see and receive a copy of your health information. We may charge you a reasonable fee for the copies, or you can access your own information via the instructions given on your first visit.
3.) You have the right to request an amendment to your health information. Please provide us this request in writing. We may not make changes according to your request, however, you may provide a statement in writing and we can include it in your file.
4.) If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. Please contact our office first se we can resolve your complaint to the best of our ability. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
5.) You have the right to provide written authorization for other uses and disclosures not identified by this Notice.
6.) You have the right to revoke all signed authorizations, including, but not limited to, this Notice.

If you have any questions regarding this Notice or our health information privacy policies, please contact our office.

Acknowledgement: I, _____, have reviewed this Notice of Privacy Practices.

Patient Signature: _____ Date: _____