Medical and Mental Health Histories

Patient:_____ **Date of Birth:**_____

Psychiatric History

Are you concerned about the following? If yes, briefly explain.

Depression/Mood Elevation Symptoms ☐ No ☐ Yes_____

Anxiety Symptoms ☐ No ☐ Yes_____

Issues after a trauma ☐ No ☐ Yes_____

Eating Disorder Symptoms ☐ No ☐ Yes_____

Psychotic Symptoms (hallucinations) ☐ No ☐ Yes_____

ADHD (inattention/hyperactivity) Symptoms ☐ No ☐ Yes_____

Recent major stressors in your family (deaths, moves, marital changes, relationship issues, financial, legal, etc):

_____

What symptoms/situations brought you in to be evaluated today?

_____

_____

_____

_____

Have you received mental health treatment from a psychiatrist in the past?

☐ No ☐ Yes Name and date: _____

Name and date: _____

Have you received mental health treatment from a therapist or counselor in the past?

☐ No ☐ Yes Name and date: _____

Name and date: _____

Have you ever been hospitalized for a mental health disorder?

☐ No ☐ Yes Hospital and date: _____

Have you ever attempted to harm yourself in the past? (Suicide attempt, self harm i.e. cutting)

☐ No ☐ Yes (Please provide details)

_____

Have you been prescribed medications for a mental health disorder by a psychiatrist or other doctor in the past?

☐ No ☐ Yes (Medications):

Medication	Strength/Frequency	How long taken?	Prescribing doctor

Are you currently taking any medications prescribed by another doctor? ☐ No ☐ Yes

Medication	Strength/Frequency	How long taken?	Prescribing doctor

Have your previous psychiatric medications been helpful? Did you have any side effects? Why did you stop taking them?

Do you use any drugs, including alcohol, nicotine and/or illicit drugs? ☐ No ☐ Yes (Please provide details)

Have you ever used illicit drugs in the past? ☐ No ☐ Yes (Please provide details)

Past Medical History

Are you allergic (i.e., rashes, hives, anaphylaxis) to any medications? ☐ No ☐ Yes (drug and details of reaction)

Do you have any current health concerns? ☐ No ☐ Yes (Please provide details) _____

Have you ever been hospitalized overnight for any reason? ☐No ☐Yes (Please provide details and dates)

_____

_____

Have you had any major surgeries or accidents requiring medical treatment (fall, car accident, etc.) in the past?
☐No ☐Yes (Please provide details and dates) _____

_____

Have you ever hit your head so hard that you passed out or lost consciousness?

□ No □ Yes (Please provide details and dates) _____

Have you ever had a seizure? ☐No ☐Yes (details and dates)

_____

Have you ever had chest pain or heart problems? ☐No ☐Yes (details and dates)

_____

Have you ever passed out or fainted? ☐No ☐Yes (details and dates)

_____

Are you currently sexually active? ☐ No ☐ Yes

Do you see a primary care physician (PCP), or any other doctor, on a regular basis?

(Please provide the physician's name, practice address, and phone number, if readily available)

Primary Care Physician:_____

Other Physician (i.e., Specialist physician):_____

General Information

Do you have any history of being physically, sexually, or emotionally abused? ☐ No ☐ Yes (Please provide details)

_____

_____

Do you have any history of witnessing traumatic events, including domestic violence? ☐ No ☐ Yes (Please provide details)

_____

_____

Were you ever placed in someone else's care other than that of your parents/guardians (i.e. social service removal)?

☐ No ☐ Yes (Please provide details)

Please list everyone currently living in your home (i.e., spouse, children, roommate)

What do you like to do in your free time (hobbies or other interests)?

Employer/School:

Highest grade level/degree attained:

History of Special or Regular Education?

Any history of repeating a grade(s)? ☐ No ☐ Yes (Please provide grade(s) repeated)

Any recent change in academic or work performance? ☐ No ☐ Yes (Please provide details)

Do you have any problems with friendships or relationships? ☐ No ☐ Yes (Please provide details)

Current relationship status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you have children (biological or adopted)? ? ☐ No ☐ Yes

If yes, how many and what are their ages, names, and sex (i.e., male or female)?

Family History

Do you have any history of blood-related family members (parents, grandparents, siblings, aunts/uncles, or immediate cousins) having a history of any of the following? (Please indicate whether the family member is on your mother's or father's side of the family)

Mood Disorders (i.e., Depression, Bipolar) ☐No ☐Yes [Family member(s)]

Anxiety Disorders (i.e., "Nervous Breakdowns") ☐No ☐Yes [Family member(s)]

Schizophrenia (i.e., Hallucinations) ☐No ☐Yes [Family member(s)]

Suicide Attempts or Completions ☐No ☐Yes [Family member(s)]

Drug Abuse or Dependence ☐No ☐Yes [Family member(s))

Alcohol Abuse or Dependence ☐No ☐Yes [Family member(s))

Learning Disorders/Mental Retardation ☐No ☐Yes [Family member(s))

ADHD or Behavioral Problems ☐No ☐Yes [Family member(s))

Sudden Death Before the Age of 40 years old ☐No ☐Yes [Family member(s))

Seizures ☐No ☐Yes [Family member(s))

Other (i.e., Autism) ☐No ☐Yes [Family member(s))

Thank you for completing this form.

Date: _____ **Patient Signature:** _____

Patient Name:_____

Circle all the symptoms that apply to you

MOOD
Sadness
Tearfulness
Feeling empty
Suicidal thoughts/attempts
Anxiety
Fear
Panic attacks
Irritability
Anger
Guilt
Social anxiety
Elevated mood
Mood swings
Self-harming (ex: cutting)

SLEEP
Problems falling asleep
Problems staying asleep
Waking in the early morning
Nightmares
Waking in panic
Sleeping too much
Sleeping too little

ENERGY
Too much
Too little

APPETITE/WEIGHT
Increased appetite
Decreased appetite
Increased weight
Decreased weight
Restrictive dieting
Over-exercising
Binge-eating
Purging
Taking laxatives

MOTIVATION/INTEREST
Little/no joy in pleasurable things
No drive to accomplish tasks

IMPULSIVITY
Impulsive spending
Putting self in danger
Interrupting others
Cannot wait your turn

CONCENTRATION/FOCUS
Cannot start/stick with/complete tasks
Difficulties concentrating on:
- School/homework
- Reading
- Conversations

Mind is racing
Procrastinating

The Couch
Immediate Mental Health Care
ORA FRANKEL, MD~ DANIELLE ROGERS-CANDEE, PMHNP-BC
LINDSAY HEISTER, PMHNP-BC~ LORI HENSON, PMHNP-BC~ LAUREN LAZARUS, PMHNP-BC
2327 LIME KILN LANE • SUITE B • LOUISVILLE, KENTUCKY 40222
(502) 414-4557 • FAX 502-873-0021

We thank you for choosing *The Couch* for your immediate and continual mental health needs. Let us know if we can assist you in any way. We strive to help you feel satisfied and fully comfortable with every aspect of your care and treatment. Here at *The Couch* ,we believe that "getting help should be comfortable".

If you do not mind, please help our business continue to grow by taking a few moments to fill out a few questions. All information that you provide is protected under HIPPA law, and will not be disclosed in any manner without your direct written consent. Thank you very much for your time. If there is anything our staff can do to help you, please do not hesitate to ask.

If you were referred to The Couch, who told you about the office?

_____

If no one referred you, how did you hear about The Couch?

_____

Do you currently see a therapist or psychiatrist? ___Yes _____No

If yes, whom do you see? _____

Who is your most recent employer?_____

Would you like any of your records from today's appointment to be sent to a physician's office, therapist, or psychiatrist that you currently are a patient of?

_____Yes _____NO
(If you select "YES", please include their name on the following authorization forms)

Primary Pharmacy:_____

Pharmacy Zip Code:_____
Pharmacy Telephone Number:_____

Authorization for Release of Information

The Couch Immediate Mental Health Care
2327 Lime Kiln Lame, Louisville, KY, 40222
Phone: (502) 414-4557 Fax (502) 414-4557

Patient Name: Patient Date of Birth:

***Individual Health Information to be Provided, Received, or Disclosed*:** By signing this document, you authorize *The Couch Immediate Mental Health Care, PLLC* and the parties listed below to provide, receive, or disclose the following information about you/your child, indicated by the boxes checked below:

- ☐ Psychiatric Assessments or Evaluations
- ☐ Psychosocial History
- ☐ Physician Notes
- ☐ Medications
- ☐ Therapy Assessment/notes
- ☐ D/C Summary/Program Completion

***Reason for disclosure (This authorization not valid unless stated):* Ongoing treatment and collaboration**

- ☐ Other:_____

Parties Who May Provide, Receive, or Disclose Your/Your Child's Individual Information: *The Couch Immediate Mental Health Care, PLLC* may provide, receive, or disclose information to the following practitioners, providers, clinics, individuals, or other entities either verbally or in written in form as indicated by the boxes checked below:

- ☐ Pediatrician/Primary Care Provider (PCP)_____
- ☐ Psychiatrist/Pychologist/Therapist_____
- ☐ Family Members_____
- ☐ School_____
- ☐ Insurance Provider_____
- ☐ Other Parties or Entity_____

Expiration date: This authorization will not expire unless indicated by the check box below

- ☐ Please change the expiration period to last for:_____

I understand this Authorization can be revoked at any time according to the Notice of Privacy Practices of *The Couch Immediate Mental Health Care, PLLC.* This request must be made in writing. Treatment, payment, enrollment in any health plan, or eligibility for benefits is not conditioned on signing this Authorization.

I have read and understand this information. I have also been given the opportunity to ask questions. I understand that specific type of information to be disclosed may include HIV/AIDS, drug, alcohol, mental health, medical history, and physical treatment. I have received a copy of this form (if I requested a copy). I am the patient or authorized to act on behalf of the patient to sign this document verifying authorization for the use of the disclosure of the protected health information under the above state terms.

_____ _____
Signature of Patient (or parent/guardian) Signature of Witness

_____ _____
Relationship to patient Date

The Couch
Immediate Mental Health Care
ORA FRANKEL, MD~ DANIELLE ROGERS-CANDEE, PMHNP-BC
LINDSAY HEISTER, PMHNP-BC~ LORI HENSON, PMHNP-BC ~ LAUREN LAZARUS, PMHNP-BC
2327 LIME KILN LANE • SUITE B • LOUISVILLE, KENTUCKY 40222
(502) 414-4557 • FAX 502-873-0021

NEW PATIENT INFORMATION

INITIAL EVALUATION

Your initial evaluation will last approximately 1 hr and the cost is $265. At this visit a detailed medical history is obtained and a clinician recommends an appropriate form of treatment. This treatment may consist of medication and/or psychotherapy. If medication is appropriate, a 30 day supply may be provided. A follow-up visit is usually recommended 2-4 weeks after the initial visit.

FOLLOW-UP

A follow-up visit will last approximately 30 minutes and is $120. Your response to treatment will be evaluated and medications may be adjusted. You can choose to make an appointment or you can walk in during regular business hours. Monday – Thursday 8:30-8:00, Friday 10-5 and Saturday 1-4. Please note that walk-in appointments may result in a longer wait times.

Your response to treatment and your specific medication protocol will determine how frequently you will need to be seen. Most patients are required to follow-up every 3 months once stabilized on medications.

MEDICATION REFILL POLICY

Medications will be refilled as medically indicated. If you find that your symptoms are not controlled on your medications, contact our office before making changes on your own. Early refills can't be provided without seeing the clinician.
The clinician usually provides enough refills on your NON-CONTROLLED prescriptions to last until the next scheduled follow-up. (3-6 months depending on your specific needs) It is likely that you need to be seen if you have no remaining refills on your prescription. Please call our office for an appointment.

Medication refill requests will be responded to by 4 pm on the next business day following the request. Please request refills through your pharmacy at least 3 days before you need the medication, Non-Controlled Only.

The Couch
Immediate Mental Health Care
ORA FRANKEL, MD~ DANIELLE ROGERS-CANDEE, PMHNP-BC
LINDSAY HEISTER, PMHNP-BC~ LORI HENSON, PMHNP-BC ~ LAUREN LAZARUS, PMHNP-BC
2327 LIME KILN LANE • SUITE B • LOUISVILLE, KENTUCKY 40222
(502) 414-4557 • FAX 502-873-0021

MEDICATION REFILLS REQUIRING NEW PRESCIPTION

Certain medications, can't be refilled and will require a new prescription each month. This does not mean we need to see you each month, but you will need to call our office to request a new prescription. Call 502 -414 -4557, and select option 1. This will take your call to a voice message system where you need to leave the following: Name (please spell the last name), Date of Birth, medication name, and if there is a change in pharmacy the ZIP CODE AND NAME OF THE PHARMACY. Call our office 2 days before you are out of the medication. A new prescription will be sent to your pharmacy, if medically appropriate, the next day by 4pm. **Be aware that if you have not been seen in our office within the last 90 days a controlled substance can't be prescribed**.
DUE TO INCREASED REQULATIONS CONTROLLED SUBSTANCES WILL NOT BE REPLACED EVEN IF LOST OR STOLEN.

PRIOR AUTHORIZATION

Certain medications require prior authorization from the insurance carrier before they will pay for your medication. Your pharmacy will receive notice of the prior authorization requirement when they contact your insurance carrier for payment. At that time the pharmacy will send us notification of the requirement. Each insurance plan has its own requirements, so it is not possible to anticipate when a prior authorization will be required. We will process those requests as quickly as possible, usually within 48 hrs. A prior authorization can take 3-4 days for the carrier to process.

INSURANCE REIMBURSMENT

After each visit we can provide you with a receipt and an insurance form that you can submit to your insurance carrier for possible reimbursement of the cost of your visits. Each insurance plan has specific rules on reimbursement for out of network services. You should call the number on the back of your insurance card to ask about the process for reimbursement.

URINE DRUG SCREENS

New patients are asked to provide a urine drug screen at the initial visit. The initial screen is completed in our office. The clinician will let you know your results. This test will provide information for the clinician to determine what other medications

The Couch
Immediate Mental Health Care
ORA FRANKEL, MD~ DANIELLE ROGERS-CANDEE, PMHNP-BC
LINDSAY HEISTER, PMHNP-BC~ LORI HENSON, PMHNP-BC ~ LAUREN LAZARUS, PMHNP-BC
2327 LIME KILN LANE • SUITE B • LOUISVILLE, KENTUCKY 40222
(502) 414-4557 • FAX 502-873-0021

may be in your system prior to prescribing additional medications. On occasion, it is necessary to send your urine drug screen to an out-side lab for confirmation. If that is required, the clinician will inform you. There is an additional charge from the drug screening lab that will be billed to your insurance carrier or to you if you are uninsured.
If the clinician prescribes certain controlled substances, you can anticipate random urine drug screens. (This is another regulatory requirement.) The cost for the follow-up drug screens are $10. Additional fees may be billed if the screen needs to be sent out to a lab for confirmation.

PREGNANCY TESTS

Each female between 10-55 yrs of age will have a urine pregnancy test at the first office visit. Notify The Couch immediately if you become pregnant after being prescribed medication from The Couch. The clinician may need to modify your medication.

QUESTIONS

Please contact The Couch if you have questions regarding your medications or are in crisis. The receptionist will take detailed information to communicate to the clinician. If the crisis is outside the scope of service that can be safely addressed, you may be directed to go to the emergency department or The Brook.
All phone calls will be returned as quickly as possible. It may be necessary for you to see the clinician, as not all issues can be addressed in a telephone format.

NO SHOW CHARGES

Please note that a $120 fee will be charged for a “No Show”, so please contact us as early as possible if you will not be able to attend a scheduled appointment.