

CURRENTLY PRESCRIBED MEDICATIONS: (medication, dosage & prescribing physician)

Have you consistently been taking these medications as prescribed? Yes No

PATIENT MEDICAL/PSYCHIATRIC HISTORY: (please check all that apply)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Abuse – Physical | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Psychosis |
| <input type="checkbox"/> Abuse – Sexual | <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> ADD | <input type="checkbox"/> Cancer | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Suicide Attempts |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Other Substance Abuse | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Violence |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Post-Traumatic Stress | <input type="checkbox"/> Weight Problem |
| <input type="checkbox"/> Head Injury/Loss of Consciousness | | <input type="checkbox"/> Stomach/Intestinal Problems | |
| <input type="checkbox"/> Other: _____ | | <input type="checkbox"/> Other: _____ | |

Do you have a history of anything NOT listed above? (please explain) _____

History of hospitalization due to a medical condition? Yes No

If yes, please describe: _____

Medication allergies: _____ Food allergies: _____

When your mother was pregnant with you, were there any complications around the pregnancy or birth? _____

How many days a week do you exercise? _____ How many minutes a week do you exercise? _____

What kind of exercise do you get? _____

For women only: Date of last menstrual period? _____

Are you currently pregnant or do you think that you might be pregnant? Yes No

Are you planning to get pregnant in the near future? Yes No Birth control method: _____

How many times have you been pregnant? _____ How many live births? _____

MENTAL HEALTH HISTORY:

No previous therapy COMCARE
 Outpatient Treatment: Type of treatment (circle all that apply) Individual Family Group
 Provider: _____
 Dates of treatment: _____
 Reason for treatment: _____
 (please document additional treatment episodes on a separate sheet)

INPATIENT PSYCHIATRIC HOSPITALIZATION:

Previously hospitalized? Yes No Multiple hospitalizations? Yes _____
 Last psychiatric facility: _____
 Date admitted: _____ Date discharged: _____
 (please document additional hospitalizations on a separate sheet)

HAVE YOU EVER RECEIVED A MENTAL HEALTH DIAGNOSIS? (i.e., depression, bipolar disorder, schizophrenia) _____

SUBSTANCE USE HISTORY: None

Alcohol With blackouts With legal problems Court ordered treatment
 Other substance use: _____
 Have you attended alcohol/drug abuse treatment: Yes No

Have you been told that you have an alcohol/drug problem: Yes No

FAMILY MEDICAL/PSYCHIATRIC HISTORY:

(please mark each that apply with "1" for immediate family and "2" for extended family)

- | | | | |
|--|---|--|---|
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| <input type="checkbox"/> ADD | <input type="checkbox"/> Cancer | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Seasonal Allergies |
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| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Post-Traumatic Stress | <input type="checkbox"/> Weight Problem |
| <input type="checkbox"/> Head Injury/Loss of Consciousness | | <input type="checkbox"/> Stomach/Intestinal Problems | |
| <input type="checkbox"/> Other: _____ | | <input type="checkbox"/> Other: _____ | |

Has any member of your family been treated with a psychiatric medication? Yes No

If yes, what medications and how effective were they? _____

FAMILY BACKGROUND & CHILDHOOD HISTORY:

Were you adopted? Yes No Where were you raised? _____

Please list your brothers and sisters and their ages: _____

What was your father's occupation? _____

What was your mother's occupation? _____

Did your parents divorce? Yes No If so, how old were you when they divorced? _____

If your parents divorced, who raised you? _____

Describe your father and your relationship with him: _____

Describe your mother and your relationship with her: _____

How old were you when you left home? _____

Were you ever physically or sexually abused? _____

Has anyone in your immediate family died? _____

Who and when? _____

GENERAL FUNCTIONING:

- | | | |
|---|--|---|
| <input type="checkbox"/> Binge eating | <input type="checkbox"/> Feelings of guilt | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Cheerful/happy most of the time | <input type="checkbox"/> Feelings of hopelessness | <input type="checkbox"/> Problems with relationships at home |
| <input type="checkbox"/> Decrease in interests/activities | <input type="checkbox"/> Hard to wake up in the morning | <input type="checkbox"/> Problems with work/school performance |
| <input type="checkbox"/> Decreased appetite | <input type="checkbox"/> History of abuse as a child | <input type="checkbox"/> Restless |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> History of abuse as an adult | <input type="checkbox"/> Sad or tearful most of the time |
| <input type="checkbox"/> Difficulty thinking | <input type="checkbox"/> Inability to complete tasks | <input type="checkbox"/> Sexual concerns |
| <input type="checkbox"/> Distinct periods of nonstop activity | <input type="checkbox"/> Inability to sustain attention | <input type="checkbox"/> Sleep too much |
| <input type="checkbox"/> Down most days | <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Suicidal attempts |
| <input type="checkbox"/> Easily distracted | <input type="checkbox"/> Intentional self harm | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Exaggerated view of abilities | <input type="checkbox"/> Intentional vomiting/purging | <input type="checkbox"/> Takes more than an hour to fall asleep |
| <input type="checkbox"/> Extreme conflict with others | <input type="checkbox"/> Irritability/anger | <input type="checkbox"/> Tense |
| <input type="checkbox"/> Extreme ups and downs in mood | <input type="checkbox"/> Night waking for longer than 30 minutes | <input type="checkbox"/> Threatened to hurt someone w/ intent |
| <input type="checkbox"/> Fast/rapid speech | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Under active/sluggish behavior |
| <input type="checkbox"/> Fearful of places, situations or people | <input type="checkbox"/> No energy | <input type="checkbox"/> Verbal threats of harm to others |
| <input type="checkbox"/> Fearlessness/engaging in reckless activities | <input type="checkbox"/> Overly fatigues during the day | <input type="checkbox"/> Weight loss/gain |
| <input type="checkbox"/> Feel rested after 3-4 hours sleep/night | <input type="checkbox"/> Physical aggression | <input type="checkbox"/> Worries about: _____ |

CONSENT AND AUTHORIZATION

By signing below, you are:

- Authorizing Wellness Solutions of Tennessee LLC (“WSTN”) or its affiliates to provide to the client with mental health services;
- Acknowledging that WSTN will provide these services in a confidential and professional manner that complies with State and Federal laws and professional standards; and
- Acknowledging that you have been informed that WSTN does not accept insurance and that you are responsible for the full amount charged by WSTN for these services subject to the information set forth in WSTN’s “Office Procedures and Policy Statement”, a copy of which you acknowledge receipt hereby.

CONSENT AND AUTHORIZATION: (MUST BE SIGNED BEFORE WE CAN PROVIDE SERVICES)

Signature: X _____ Date: _____

CREDIT CARD AUTHORIZATION

My signature below authorizes Wellness Solutions of Tennessee LLC (WSTN) to charge my credit card on file for all services rendered to me by WSTN.

CREDIT CARD AUTHORIZATION: (MUST BE SIGNED BEFORE WE CAN PROVIDE SERVICES)

Signature: X _____ Date: _____