CENTER FOR
Behavioral Wellness

Jeannie Dilworth, APRN | Stacey Hansen, LMFT | Tracy Lewis, LCSW | Holly Monroe, LMFT

PATIENT REGISTRATION FORM

DATE:

PERSONAL INFORMATION:

Name: _____ Date of Birth: ____/____/____ Sex: ☐ Female ☐ Male

Address: _____ Town: _____ State: _____ Zip Code: _____

Phone Number: (____) _____ Is it ok to leave a voicemail at this number?: ☐ Yes ☐ No

Cell: (____) _____ Is it ok to leave a voicemail at this number?: ☐ Yes ☐ No

Work: (____) _____ Is it ok to leave a voicemail at this number?: ☐ Yes ☐ No

Email: _____ Can we email you a link to our patient portal? ☐ Yes ☐ No

Social Security #: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employment Status: ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Unemployed ☐ Disabled ☐ Child ☐ Student

If Employed: Employers Name/Address: _____

If you are a Student, are you attending: ☐ High School ☐ College Highest grade completed: _____

Primary Language: ☐ English ☐ Spanish ☐ Vietnamese ☐ Portuguese ☐ Other: _____

Race: ☐ White ☐ Black/African-American ☐ Asian ☐ American Indian/ Alaskan Native ☐ Native Hawaiian/Other Pacific Islander

☐ Declined to Specify ☐ Other: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to Specify

Preferred Pharmacy: _____ Phone Number: (____) _____

Primary Care Physician: _____ Phone Number: (____) _____

Emergency Contact: _____ Phone Number: (____) _____

Referred By: _____ Phone Number: (____) _____

Previous Psychiatric Services: _____

INSURANCE INFORMATION:

Primary Medical Insurance: _____ Policy Number: _____

Secondary Medical Insurance: _____ Policy Number: _____

☐ Copy of card given Insured Party: ☐ Self ☐ Spouse ☐ Parent

Party responsible for payment: ☐ Spouse ☐ Parent ☐ Other: _____

**Please complete this section ONLY if someone other than the client is responsible for payment:*

Name: _____ Date of Birth: ____/____/____ Sex: ☐ Female ☐ Male

Address: _____ Town: _____ State: _____ Zip Code: _____

Phone Number: (____) _____ Cell: (____) _____ Work: (____) _____

925 Sullivan Avenue South Windsor, CT 06074 Phone: 860.432.7771 Fax: 860.432.7774
5 Magauran Drive Suite 1 Stafford Springs, CT 06076 Phone: 860.851.9086 Fax:860.851.9097
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ACKNOWLEDGEMENT OF POLICY STATEMENT

I, _____, have been shown the Policy Statement for this office, and have been offered a copy of such policy to keep for my records.

_____

Signature of Client/Parent/Legal Representative Date Print Name

If not signed by the client indicate relationship of authorizing person to client:

☐ Parent or guardian of minor child
☐ Guardian or conservator of conserved client
☐ Beneficiary or personal Representative of a deceased individual

I hereby give permission for this office to leave messages on the answering service/ voicemail/ text messages or emails at:

☐ My Home (please initial) _____ ☐ My Cell (please initial) _____
☐ My Work (please initial) _____ ☐ My Email (please initial) _____

I, _____, hereby give my consent for Center for Behavioral Wellness to bill my/my child's insurance carrier for the services rendered to me/ my child/family. In addition, I agree to pay Center for Behavioral Wellness any deductibles or uncovered charges in accordance with my health care plan.

_____

Signature of Client/Parent/Legal Representative Date Print Name

If not signed by the client indicate relationship of authorizing person to client:

☐ Parent or guardian of minor child
☐ Guardian or conservator of conserved client
☐ Beneficiary or personal Representative of a deceased individual

YOU MAY REQUEST A COPY OF OUR OFFICE POLICIES FROM OUR FRONT DESK, OR OBTAIN THEM FROM OUR WEBSITE, www.centerforbehavioralwellness.com

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ADULT SELF-ASSESSMENT

Please list the reason for your visit today: _____

CURRENT MEDICATIONS:

Medication/Dose	Reason	Medication/Dose	Reason

Who is prescribing your medications?: _____

Previous Medications:

Medication/Dose	Reason	Medication/Dose	Reason

Have you received Mental Health services before?: _____

Past Surgeries: (type of surgery and approximate year) ☐ None

1. _____
2. _____
3. _____

Past Injuries: (type of injury and approximate date) ☐ None

1. _____
2. _____
3. _____

Have you had any frightening or traumatic experiences? If yes, please describe.

- Accident:
  ☐ No ☐ Yes: _____
- Medical Trauma:
  ☐ No ☐ Yes: _____
- Other:
  ☐ No ☐ Yes: _____

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Have you ever experienced sexual or physical abuse? If yes, please describe.

- Physical Abuse:
  ☐ No ☐ Yes: _____
- Sexual Abuse:
  ☐ No ☐ Yes: _____
- Sexual Assault:
  ☐ No ☐ Yes: _____
- Neglect by parent(s):
  ☐ No ☐ Yes: _____
- Neglect by relative(s):
  ☐ No ☐ Yes: _____

Have you ever been a witness to violence? If yes, please describe.

- Witness to domestic violence::
  ☐ No ☐ Yes: _____
- Witness to other violence:
  ☐ No ☐ Yes: _____

Have you ever used/abused any of the following?

Substance:	Date of last use:	Age of first use:	Method of use:	Amount/Frequency of use:	Type:
Alcohol					
Marijuana					
Tobacco					
Cocaine					
PCP					
Heroin					
Sedatives					
Amphetamines					
Prescription Drugs					
Internet					
Video Games					
Other					

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Have you ever felt the need to cut down on your drinking/substance abuse? ☐ Yes ☐ No

Have you ever felt annoyed by criticism of your drinking/substance abuse? ☐ Yes ☐ No

Have you ever felt guilty feelings about drinking/substance abuse? ☐ Yes ☐ No

Have you ever been to a detox program or drug rehab program? ☐ Yes ☐ No

If yes, when?: _____ Where?: _____

MEDICAL HISTORY:

Have you ever had any of the following health problems?	Yes	No	When
1. Loss of consciousness or head injury	☐	☐	
2. Seizures or convulsions	☐	☐	
3. Rashes or skin problems	☐	☐	
4. Meningitis	☐	☐	
5. Asthma	☐	☐	
6. Food allergies	☐	☐	
7. Drug or medication allergies	☐	☐	
8. Pneumonia	☐	☐	
9. Anemia or low blood count	☐	☐	
10. Heart Problems	☐	☐	
11. Kidney or urinary problems	☐	☐	
12. Bowel problems	☐	☐	
13. Trouble with vision	☐	☐	
14. Trouble with hearing	☐	☐	
15. Lack of weight gain	☐	☐	
16. Poisoning or medication overdose	☐	☐	
17. Serious injury	☐	☐	
18. Hospitalization	☐	☐	
19. Surgery	☐	☐	
20. Diabetes	☐	☐	
21. Sexually Active	☐	☐	
22. Last menstrual period	☐	☐	

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Are you aware of any difficulties/issues during:

☐ Birth: _____

☐ Early Childhood: _____

☐ Elementary school: _____

☐ Middle school: _____

☐ High school: _____

☐ College: _____

FAMILY ILLNESSES:

Illness	Biological Mother	Biological Mother's Family	Biological Father	Biological Father's Family	Siblings
Allergies					
Asthma or Emphysema					
Diabetes					
Heart Trouble					
Mental Retardation					
Seizure Disorder					
Depression					
Anxiety					
OCD					
Bipolar Disorder					
ADHD					
Schizophrenia					
Other Psychiatric Disorder					
Learning Difficulties					
Behavioral Problems					
Alcohol Dependency					
Drug Dependency					

LEGAL PROBLEMS:

☐ None ☐ Arrests ☐ CHINS ☐ Probation ☐ DYS ☐ Victim/ Witness ☐ Restraining Order

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REVIEW OF PHYSICAL SYSTEMS: (mark any of the following that frequently apply or are currently a concern to you)

HEAD:

- ☐ dizziness / vertigo
- ☐ blurred vision
- ☐ loss of vision
- ☐ loss of hearing
- ☐ loss of smell
- ☐ loss of taste
- ☐ eye pain
- ☐ ear pain
- ☐ ringing / buzzing
- ☐ sinus drainage

NEUROLOGIC:

- ☐ headache
- ☐ memory loss
- ☐ difficulty concentrating
- ☐ speech difficulty
- ☐ blackout / fainting
- ☐ seizures
- ☐ trouble walking
- ☐ falling
- ☐ clumsiness
- ☐ weakness
- ☐ numbness / tingling
- ☐ shaking / tremor
- ☐ cramping / twitching

MUSCULOSKELETAL:

- ☐ neck pain
- ☐ back pain
- ☐ joint pain

CARDIOVASULAR:

- ☐ chest pain
- ☐ palpitations
- ☐ irregular heart beat
- ☐ swelling of feet
- ☐ heart murmur

RESPIRATORY:

- ☐ shortness of breath
- ☐ wheezing
- ☐ coughing

GASTROINTESTINAL:

- ☐ nausea
- ☐ vomiting
- ☐ stomach pain/heartburn
- ☐ difficulty swallowing
- ☐ blood in stool
- ☐ constipation
- ☐ diarrhea
- ☐ loss of bowel control

GENITOURINARY:

- ☐ frequent urination
- ☐ painful urination
- ☐ loss of bladder control
- ☐ sexual problems
- ☐ irregular menstruation
- ☐ heavy menstruation
- ☐ excessive cramping

HEMATOLOGIC/LYMPHATIC:

- ☐ bleeding tendency
- ☐ blood clots
- ☐ easily bruises

ENDOCRINE:

- ☐ heat intolerance
- ☐ cold intolerance
- ☐ excessive thirst

SKIN:

- ☐ rash
- ☐ hair loss
- ☐ sores
- ☐ dryness/flaking

GENERAL:

- ☐ unexplained fevers
- ☐ weight loss
- ☐ weight gain
- ☐ severe fatigue
- ☐ difficulty with sleep

FOR STAFF USE:

_____

_____

_____

_____

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MEDICATION AGREEMENT & REFILL POLICY

Controlled Medications are governed by multiple Federal and State laws and monitored through multiple agencies. Monitoring agencies include the Drug Enforcement Agency (DEA), Connecticut Department of Public Health, Connecticut Board of Medicine, and the Connecticut Board of Pharmacy. Connecticut Board of Nursing Prescribers and pharmacists themselves can monitor any controlled prescription ever filled by a given client (irrespective pf payment type, including cash), by logging on to the Connecticut Prescription Monitoring Program System (aka CTPMP). If our staff has any questions regarding your healthcare, including medications, we reserve the right to contact your other treating physicians and pharmacies.

If you need a refill of your prescribed medications prior to your next scheduled appointment, notify your pharmacy to fax this office with your prescription information (Please do not call the office directly). Center for Behavioral Wellness personnel and/or your provider will be available to fill refills on weekdays during normal office hours only. Please notify your pharmacy at least 48 business hours before your medication runs out or we may not be able to respond to your request.

- Medications require prescriber monitoring. We will not refill prescriptions for clients who have not had adequate follow-up visits. The longest interval between visits while being prescribed a medication is three months and one month for a controlled medication.
- You are responsible for the any medications prescribed to you. If your prescription is lost, misplaced, stolen, or misused your medication, please understand it will not be replaced.
- We do not consider medication refills an "emergency." If you run out of medication over the weekend/holiday and forgot to request a refill, it will have to wait until normal business hours.

TERMS AND CONDITIONS: (Please read and the following important information and initial next to each item in the space provided.)

____ I agree to obtain all controlled medications from the same pharmacy. Should the need arise to change pharmacies, I will inform this providers office.

____ I agree to follow the dosing schedule prescribed to me by my prescriber.

____ I agree to never sell or exchange my medications with anyone for any reason. This is a felony and very dangerous.

____ I understand that medication refills for controlled medication require a scheduled appointment with my prescriber in the office. For this type of medication, refills cannot be called into a pharmacy and dosages will not be adjusted by phone.

____ I agree to keep all scheduled appointments. I understand that no medications will be given for canceled or no show appointments. I understand that if I am more than 15 minutes late to my scheduled appointment time, I will have to reschedule for another time.

____ I understand Center for Behavioral Wellness reserves the right to perform a drug screen, via saliva, urine or blood, as well as any random pill counts of medications prescribed by my provider, at any time while I am being treated with a controlled substance. I understand that I have 24 hours to comply with the requested drug screen. Failure to do so will result in immediate discharge from the practice.

____ I agree to conduct myself in a courteous manner in the office. I agree not to arrive at the office intoxicated or under the influence of drugs. I understand that any misconduct will lead to the termination of my treatment.

____ I understand that dealing with a forged, falsified, or altered prescription will result in a report to the police and termination from this practice.

____ I understand that failure to adhere to these policies and/or failure to comply with my providers' treatment plan may result in possible discharge from this practice. I understand that if I am discharged, it means I can no longer schedule appointments, or receive medication refills.

I, the undersigned client, attest that I have read, fully understand, and agree to all of the above requirements and instructions. I affirm that I have the full right and power to sign and be bound by this agreement.

Signature of Client/Parent/Legal Representative Date Print Name

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Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔ to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____ **=Total Score:** _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
⑤	⑤	⑤	⑤

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

PCL-C

The next questions are about problems and complaints that people sometimes have in response to stressful life experiences. Please indicate how much you have been bothered by each problem in the past month. For these questions, the response options are: "not at all", "a little bit", "moderately", "quite a bit", or "extremely".

		Not at all	A little bit	Moderately	Quite A Bit	Extremely
PCL1	Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?	1	2	3	4	5
PCL2	Repeated, disturbing dreams of a stressful experience from the past?	1	2	3	4	5
PCL3	Suddenly acting or feeling as if a stressful experience from the past were happening again (as if you were reliving it)?	1	2	3	4	5
PCL4	Feeling very upset when something reminded you of a stressful experience from the past?	1	2	3	4	5
PCL5	Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience from the past?	1	2	3	4	5
PCL6	Avoiding thinking or talking about a stressful experience from the past or avoiding having feelings related to it?	1	2	3	4	5
PCL7	Avoided activities or situations because they reminded you of a stressful experience from the past?	1	2	3	4	5
PCL8	Having trouble remembering important parts of a stressful experience from the past?	1	2	3	4	5
PCL9	Loss of interest in activities that you used to enjoy?	1	2	3	4	5
PCL10	Feeling distant or cut off from other people?	1	2	3	4	5
PCL11	Feeling emotionally numb or being unable to have loving feelings for those close to you?	1	2	3	4	5
PCL12	Feeling as if your future somehow will be cut short?	1	2	3	4	5
PCL13	Having trouble falling or staying asleep?	1	2	3	4	5
PCL14	Feeling irritable or having angry outbursts?	1	2	3	4	5
PCL15	Difficulty concentrating?	1	2	3	4	5
PCL16	Being "superalert" or watchful or on guard?	1	2	3	4	5
PCL17	Feeling jumpy or easily startled?	1	2	3	4	5

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
...you were so irritable that you shouted at people or started fights or arguments?	○	○
...you felt much more self-confident than usual?	○	○
...you got much less sleep than usual and found you didn't really miss it?	○	○
...you were much more talkative or spoke much faster than usual?	○	○
...thoughts raced through your head or you couldn't slow your mind down?	○	○
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
...you had much more energy than usual?	○	○
...you were much more active or did many more things than usual?	○	○
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
...you were much more interested in sex than usual?	○	○
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○	○
...spending money got you or your family into trouble?	○	○
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	○	○
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.* No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	○	○
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	○	○