

MEQUON CLINICAL ASSOCIATES, SC

ADULT HISTORY

Date: _____

INSTRUCTIONS: Your therapist would like you to answer these questions to help him/her better understand your situation.

Name & Preferred Name: _____ D.O.B. ____/____/____

Gender: _____ Race/Ethnicity: _____ Sexuality: _____

In case of an emergency, please give the name and telephone number of someone to contact:

Name: _____ Phone: _____

PSYCHOLOGICAL HISTORY

What problem(s) caused you to come to therapy at Mequon Clinical Associates?

When did problem begin? _____

Has the problem been constant since its beginning? Yes ___ No ___

What is the worst symptom you've had? _____

Is problem ever absent? Yes ___ No ___ If yes, when? _____

Who made the decision to come to therapy? _____

Check if you have had any of these problems or symptoms lately:

- | | | | |
|--------------------------------------|---|--|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Changes/problems in eating | <input type="checkbox"/> Headaches | <input type="checkbox"/> Loss of hope |
| <input type="checkbox"/> Tearfulness | <input type="checkbox"/> Changes/problems in sleeping | <input type="checkbox"/> Fatigue/tiredness | <input type="checkbox"/> Excessive worry |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Sexual difficulties | <input type="checkbox"/> Impulsive behavior |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Irritability | <input type="checkbox"/> Violent behavior |
| <input type="checkbox"/> Fears | <input type="checkbox"/> Loss of interest in usual activities | <input type="checkbox"/> Other _____ | |

Have there been any recent illnesses or deaths among your family or close friends? ___ Yes ___ No

Explain: _____

Have there been any recent major losses among your family or close friends? ___ Yes ___ No

Explain: _____

Have there been any recent crises or major changes in your life? ___ Yes ___ No

Explain: _____

Have you ever intentionally hurt yourself or made a suicide attempt? ___ Yes ___ No

Explain: _____

Have you ever taken medication for anxiety, depression, sleep, or other emotional conditions? ___ Yes ___ No

Explain: _____

Have you been in counseling or psychotherapy before? ___ Yes ___ No

If so, for what issues? _____

What was the therapist's name and when did this occur? _____

Have you had any hospitalizations for emotional problems? ___ Yes ___ No

Explain: _____

Please name any people or organizations who you feel provide help and support to you. _____

MEDICAL HISTORY

List any current medical conditions and disabilities: _____

Are you taking any medications? ___ Yes ___ No

If yes, list current medications and daily dosages: _____

List past medical conditions (include surgeries): _____

Name of your physician(s) and telephone numbers & addresses: _____

Have you had a medical exam within the past year? ___ Yes ___ No

List any significant findings: _____

DRUG & ALCOHOL USE

Please describe the drug & alcohol use of your family. Use the number which best represents frequency of use. For your children, please write in the name of the child at the top of the column.

0 = Never 1 = less than once a month 2 = 1-4 days a month 3 = almost daily 4 = daily 5 = used in past but not currently using

SUBSTANCE	SELF	PARTNER/SPOUSE	CHILD	CHILD	YOUR PARENTS
Caffeine	___	___	___	___	___
Nicotine	___	___	___	___	___
Beer/Wine/Liquor	___	___	___	___	___
LSD	___	___	___	___	___
Marijuana	___	___	___	___	___
Inhalants	___	___	___	___	___
Sedatives	___	___	___	___	___
Amphetamines	___	___	___	___	___
Cocaine/Crack	___	___	___	___	___
Others (specify)	___	___	___	___	___

Are you concerned about your drug or alcohol use? ___ Yes ___ No

Is someone who cares about you concerned about your use of drugs or alcohol? ___ Yes ___ No

Do you ever feel guilty about your use of drugs or alcohol? ___ Yes ___ No

Are you concerned about the drug or alcohol use of someone in your family? ___ Yes ___ No

Did you grow up in a home in which a parent abused drugs or alcohol? ___ Yes ___ No

Has anyone in your family been in treatment for drug or alcohol abuse? ___ Yes ___ No

If yes, list who and for what treatment: _____

FINANCIAL / LEGAL HISTORY

Do you have serious financial concerns? ___ Yes ___ No

If yes, explain: _____

Have you ever been arrested? ___ Yes ___ No

If yes, explain: _____

Have you ever been involved with Protective Services? ___ Yes ___ No

If yes, explain: _____

SCHOOL, MILITARY & WORK HISTORY

Are you currently enrolled in school? ___ Yes ___ No

If yes, what is field of study? _____

What is your highest grade completed? _____

Have you served in the Military? ___ Yes ___ No

If yes, which branch? _____ When? _____ Overseas? _____ Combat? _____

What is your occupation? _____

Are you currently employed? ___ Yes ___ No What is length of time at current job? _____

If not employed, how long were you employed at last job held? _____

Mequon Clinical Associates, SC

Patient Name: _____ **DOB:** _____
Please print

Other Adult: _____ **Relation to patient:** _____

Address: _____ **Phone:** _____

_____ **Email:** _____

_____ **Referred by:** _____

Reminder Preference (please check only one box):

- Phone Call (Home #) Phone Call (Cell #) Text Message

FINANCIAL POLICY

Payment is expected at the time of service. You are ultimately financially responsible for all services you or members of your household receive from Mequon Clinical Associates.

Consent to Treatment/Privacy Policy

I hereby consent to treatment as agreed upon by my MCA Provider and myself, and I understand my rights as a patient. I have received and understand the written Notice of Privacy Practices provided by Mequon Clinical Associates.

_____ initials

Private Pay

If you will be paying for visits privately (i.e., not through an insurance company), clinic policy requires payment at time of service. Please be prepared to make payment upon arrival for your session.

_____ initials

Health Insurance

I authorize insurance payment of medical benefits to Mequon Clinical Associates for services described on the itemized claim form. I also authorize the release of information necessary to process this claim. Payment of benefits should be paid directly to Mequon Clinical Associates. **I recognize and accept personal responsibility for all services rendered and will make payment in full of any self-pay charges, co-payments or deductibles, and for any balance outstanding after payment or denial of such insurance benefits.**

Client / Financially Responsible Party Signature: _____

Outstanding Patient Balances

After insurance is billed any portion not covered will be billed to the patient. Any balance that is billed to the patient must be paid in full no later than 60 days from the billing date. The clinic charges a \$30 fee to you for any returned checks, which is payable before or at the time of your next scheduled visit.

_____ initials

Cancelled Appointments

I understand that any appointments cancelled or missed without 24 hours notice may be charged a minimum fee of \$75 and my insurance does not cover this fee.

_____ initials

Failure and/or Inability to Pay

In the event it becomes necessary to assign your account to a collection agency, you are responsible for any/all costs of collection which may include attorney fees and other costs incurred.

_____ initials

I have read and understand the above financial policy.

Client / Financially Responsible Party Signature: _____

Date: _____ **Please Print Name:** _____

The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	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 asleep, 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're 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

Column Totals _____ + _____ + _____

Add Totals Together _____

10. If you checked off any problems, how difficult have those 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

NAME _____

DATE _____

Zung Self-Rating Anxiety Scale (SAS)

For each item below, please place a check mark (✓) in the column which best describes how often you felt or behaved this way during the past several days. Bring the completed form with you to the office for scoring and assessment during your office visit.

Place check mark (✓) in correct column.	A little of the time	Some of the time	Good part of the time	Most of the time
1 I feel more nervous and anxious than usual.				
2 I feel afraid for no reason at all.				
3 I get upset easily or feel panicky.				
4 I feel like I'm falling apart and going to pieces.				
5 I feel that everything is all right and nothing bad will happen.				
6 My arms and legs shake and tremble.				
7 I am bothered by headaches neck and back pain.				
8 I feel weak and get tired easily.				
9 I feel calm and can sit still easily.				
10 I can feel my heart beating fast.				
11 I am bothered by dizzy spells.				
12 I have fainting spells or feel like it.				
13 I can breathe in and out easily.				
14 I get feelings of numbness and tingling in my fingers & toes.				
15 I am bothered by stomach aches or indigestion.				
16 I have to empty my bladder often.				
17 My hands are usually dry and warm.				
18 My face gets hot and blushes.				
19 I fall asleep easily and get a good night's rest.				
20 I have nightmares.				

Source: William W.K. Zung. A rating instrument for anxiety disorders. Psychosomatics. 1971