CLIENT INFORMATION

Patient's Name _____
Last Name First Name Middle Initial

Responsible Party (if a minor)_____

Mailing Address_____ Apt. # _____

City_____ State _____ Zip Code _____

Phone: Home _____ Cell _____ Work _____

Email Address: _____

Sex: Female _____ Male _____ Date of Birth_____ Age _____

Single _____ Married _____ Divorced _____ Widowed _____ Seperated _____

Please list children and their ages: (if applicable)

Patient Employer_____

Address _____ City _____ State _____ Zip _____

Occupation _____ Phone _____

Drivers License # _____

How or from whom did you hear of Restoration Counseling?

Physician Church/Pastor Friend Web Search Other

In Case of Emergency, contact _____ Phone _____

Physician _____ Phone _____

PARENT/SPOUSE INFORMATION

Spouse/Parent _____ Phone _____

Employer _____ Phone _____

Occupation _____ Social Security # _____

RELEASE OF INFORMATION

I authorize Restoration Counseling to obtain/release/exchange information with my Primary Care Physician or other healthcare practitioners for the purpose of service coordination and continuity of care.

Physician's/Other practitioners name _____

Address _____

Phone _____ Fax _____

Check here <u>if you do not</u> authorize this release of information _____

COMMUNICATION BETWEEN YOU AND RESTORATION COUNSELING

Occasionally it will be necessary for our office to contact you regarding appointments or other matters about counseling. This permission form will help us know when and how to contact you in ways which are comfortable for you.

By giving permission for us to contact you in one or more of the ways listed below, you are agreeing for us to leave messages and information. We will always try to be discrete in any messages we leave, but we cannot guarantee confidentiality once the message is left.

Which is your preferred contact phone number? (circle one)

Home _____

Cell _____

Work _____

If you need to make, change, cancel an appointment or have questions about your patient records or account, please call the Restoration Counseling office @ 904-412-2876.
Client Name: _____ Date: _____

Client or Guardian Signature: _____

PATIENT HEALTH QUESTIONNAIRE

All information is kept confidential in adherence with current HIPPA regulations

Name: _____

Date: _____

People commonly encounter problems in the following categories. Please indicate how you are affected by each by circling the number that most accurately reflects your feeling.

Not a Problem	Slight Problem	Moderate Problem	Serious Problem	Severe Problem
0	1	2	3	4

1. Feeling sad, depressed or unhappy	Select
2. Feeling discouraged or hopeless	Select
3. Feeling bad about yourself	Select
4. Little interest or pleasure from things I usually enjoy	Select
5. Feeling guilty, worthless, or helpless	Select
6. Crying spells	Select
7. Restless, irritable or agitated	Select
8. Feeling tired or having little energy	Select
9. Trouble falling or staying asleep, or sleeping too much	Select
10. Poor appetite or overeating	Select
11. Trouble making decisions	Select
12. Difficulty with concentration	Select
13. Less interest in sex	Select
14. Thoughts that you would be better off dead, or of hurting yourself in some way.	Select
1. Anxious/nervous/worried	Select
2. Stressed/overwhelmed	Select
3. Intense fear, panic/discomfort	Select
4. Panic or fear with physical symptoms (such as pounding heart heart, sweating, shaking, nausea, dizzy, fear of losing control, etc.)	Select
5. Anxiety about being in certain situations (such as in a crowd, traveling, standing in line, etc.)	Select
6. Anxiety or fear related to being in social situations or having to Perform (such as public speaking, test taking, etc.)	Select
7. Fear, anxiety, or avoiding specific situations (such as flying, Heights, animals, etc.)	Select
8. Worrying about health problems	Select
1. Having unwanted thoughts over and over again	Select
2. Repeating specific acts over and over (such as hand washing, Checking, etc.) or mental acts (such as counting, repeating words)	Select

Not a Problem	Slight Problem	Moderate Problem	Serious Problem	Severe Problem
0	1	2	3	4

1. Euphoria (feeling high) 2. Sudden changes in mood for no apparent reason 3. Decreased need for sleep 4. More talkative than usual 5. Racing thoughts 6. Acting impulsive (such as buying sprees, drinking more, sexual activity, etc.) 7. Excessive irritability or agitation 8. Angry outbursts 9. Property destruction	Select Select Select Select Select Select Select Select Select
1. Making careless mistakes at school, work or other activities 2. Difficulty sustaining attention during tasks 3. Difficulty following through or finishing things 4. Difficulty in organizing tasks or activitites 5. Easily distracted 6. Losing things or forgetful 7. Hyperactivity (can't sit still) 8. Poor impulse control	Select Select Select Select Select Select Select Select
1. Hearing things 2. Seeing things 3. Experiencing confusion 4. Memory lapses/forgetting 5. Feeling of unreality or being outside of self 6. "Missing time" 7. Suspiciousness (questioning other people's motives)	Select Select Select Select Select Select Select

I have been experiencing these problems for:

☐ **< 1 month** ☐ **1-6 months** ☐ **7-12 months** ☐ **> 1 year**

Check the following that have caused concern or difficulties during the last 6 months:

☐ Taking care of personal grooming needs
☐ Getting along with spouse/parents/children
☐ Meeting financial obligations
☐ Meeting home responsibilities
☐ Enjoyment of work
☐ Preparing meals for family/self
☐ Taking care of children/others
☐ Enjoying of hobbies
☐ Getting along with co-workers/others
☐ Meeting work responsibilities

Current Life Stressors

☐Relationship issues (arguments, separation, divorce)
☐Health issues (illness or injury)
☐Financial issues (owe money, loss of job, unemployment)
☐Abuse (physical, mental, emotional, sexual)
☐Legal difficulties (law suit, traffic, criminal charges)
☐Substance abuse (alcohol/drugs/food)

If you checked off any of the above 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 at all ____ Somewhat ___Very ___ Extremely

Briefly describe why you are seeking help at this time:

_____

_____

_____

Please check below if you have had any of the following medical conditions:

☐Arthritis	☐Diabetes	☐PMS
☐Stomach Ulcers	☐Head injury	☐Asthma
☐Hyperthyroidism	☐Seizures	☐Other Respiratory Problems
☐Hypothyroidism	☐Heart attack	☐Cancer
☐Kidney problems	☐Angina	☐Menstrual Problems
☐Colitis/Crohn's	☐High blood pressure	☐Pregnancy (____ times)
☐Chronic pain	☐Urinary retention	☐Miscarriage (____ times)
☐Lupus	☐Migraines	☐Hysterectomy
☐Tuberculosis	☐Chronic headaches	☐Surgery:_____

☐Other:_____

Please list all current medications:

Medication	Strength	Frequency	Date Started	Prescribed by

Please list all previous psychotropic medications you have ever taken:

Medication	Strength	Frequency	Date Started	Prescribed by

Medication Allergies: No ___Yes ___ (Describe: _____)

Please list all previous counseling/psychiatric treatment including any psychiatric hospitalizations

Dates	Reason	Counselor/Doctor

Yes ___ No___ Has any family member ever had a problem with drugs and/or alcohol? If so, who and what?

_____

_____

Yes ___ No ___ Has any family member ever had any history of depression, anxiety, other mental problems, or suicide? If so, who and what?

_____

_____

Yes ___ No ___ Never ___ 1. Do you have thoughts about suicide now?
Yes ___ No ___ Never ___ 2. Have you ever thought about suicide?
Yes ___ No ___ Never ___ 3. Have you ever attempted suicide?
Yes.___ No ___ Never ___ 4. Do you have access to guns/weapons?

Yes ___ No ___ Never ___ 1. Are you thinking about hurting someone now?
Yes ___ No ___ Never ___ 2. Have you ever thought about hurting someone else?
Yes ___ No ___ Never ___ 3. Have you ever hurt someone else?

Please answer the following questions:

Do you drink alcoholic beverages? ☐ Yes ☐ No ☐ Never

If never, please skip to the next section.

If yes, how many alcoholic drinks do you have in the average
Day _____ Week _____Month _____ Year _____

If yes to the above, please answer the following:

Yes ___ No ___ Have you ever sought help for alcohol or drug use?

Yes ___ No ___ In the past year, have you ever drunk alcohol or used drugs more than you meant to?

Yes ___ No ___ Have you ever neglected some of your usual responsibilities because of using alcohol or drugs?

Yes ___ No ___ Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?

Yes ___ No ___ Have anyone ever objected to your drinking or drug use?

Yes ___ No ___ Have you ever found yourself preoccupied with wanting to use alcohol/drugs?

Yes ___ No ___ Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger or boredom?

Yes ___ No ___ Has your drinking or drug use ever caused legal problems (DUI's, Violence)?

Check if you have taken any of the following drugs:

Yes ___ (which ones) No ___

If No, please skip to the next section.

☐Marijuana/Pot ☐Cocaine/Crack ☐Inhalants

☐Amphetamines/Speed ☐Barbituates/Sedatives/Downers ☐Designer drugs, Ecstasy

☐Heroin/opiates ☐Intravenous drug use ☐Tranquilizers (Xanax, Valium)

☐PCP/Angel Dust ☐Pain medicine ☐LSD/hallucinogens

☐Have you ever taken prescribed medication inappropriately? Yes ___ No ___

Sleep Difficulties (Check all that apply):

☐None ☐Wets bed ☐Nightmares

☐Falling asleep ☐Walks in sleep ☐Bad dreams

☐ Falling back to sleep ☐ Snores

☐ Tired upon waking ☐ Stops breathing during sleep

☐ Early morning awakening ☐ Falls asleep when emotional

Usually, the time that I…

Go to bed: _____ A.M. _____ P.M.

Wake up: _____ A.M. _____ P.M.

Smoking:

☐ None

Packs per day ☐ 1 ☐ 2 ☐ 3 ☐ Other

Age began:

Caffeine (cups per day):

☐ Coffee: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ More

☐ Tea: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ More

☐ Soda/Other: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ More

Are you sensitive to caffeine? Yes ___ No ___

Please answer the following questions:

Yes ___ No ___ Is there any history of violence, verbal or sexual abuse in your family?

Yes ___ No ___ Have you ever been physically abused?

Yes ___ No ___ Have you ever been sexually abused?

Yes ___ No ___ Have you ever experienced or witnessed a traumatic event (accidents, crime, major illness)?

I VERIFY THAT ALL INFORMATION ABOVE IS TRUE AND ACCURATE.

_____ **(Signature)** _____ **(Date)**