Carolinas HealthCare System
Carolinas Psychiatry & Behavioral Wellness

*Patient Name:*_____

*Date of Birth:*_____

DEMOGRAPHIC INFORMATION

Patient Legal Name: Social Security #:

Gender: Age: Date of Birth:

Address:

City, State, Zip:

Phone: Email:

Marital Status: ☐Single ☐Married/Domestic Partner ☐Divorced ☐Separated ☐ Widowed

Emergency Contact:_____
Relationship:_____

Phone:_____

EMPLOYMENT & INSURANCE

Employment Status: ☐Full Time ☐ Part Time ☐ Retired ☐ Disabled

Employer Name:_____Occupation:_____

Employer Address:_____

Insurance #1 (Primary)

Policy Holder Name:_____ Policy Holder's Number:_____

Name of Plan:_____ Policy #_____

Insurance Company:_____ Insurance Company Phone: _____

Insurance # (Secondary)

Policy Holder Name:_____ Policy Holder's Number:_____

Name of Plan:_____ Policy #_____

Insurance Company:_____ Insurance Company Phone: _____

Responsible Party Information (complete if other than patient):

Name of Responsible Party: _____

Relationship to Patient: _____

Address: _____ City:_____ State:____ Zip:_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security #: _____ Employer Name: _____

Employer Address:_____

City: _____ State: _____ Zip:_____

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*Patient Name:*_____

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CURRENT HOUSEHOLD SITUATION		
Name	**Relationship**	**Date of Birth or Age**
1.		
2.		
3.		
4.		
5.		

REASON FOR YOUR VISIT/ CONCERNS

Please list your reason for you visit:

Have you ever been seen by a Psychiatrist or Counselor Before? ☐ Yes ☐ No
If Yes, please list:

Have you ever had a problem with Drugs or Alcohol? ☐ Yes ☐ No
If Yes, please explain:

Have you ever been in a treatment facility for substance abuse? ☐ Yes ☐ No
If Yes, please list of the dates of treatment:

MEDICAL INFORMATION (current/past)

Current and Past Medical Illnesses:

Past Psychiatric Treatment (if any):

Please list any allergies to medication/food/environment:

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Current Medications: ☐ No ☐ Yes, please list:

Are you concerned about any of your current medications? ☐ No ☐ Yes, please explain:

SIGNIFICANT FAMILY HISTORY

Please include information regarding relatives with a mental health diagnosis, treatment, or hospitalization:

PAIN SCREEN

Are you currently having pain? ☐ No ☐ Yes
If Yes, What are the Severity, Location, and Duration? Please Explain:

Please Circle any of the following symptoms you may be experiencing:

Headaches	Diarrhea	Racing Heart Beat
Chest Pain	Constipation	Changes in menstrual cycles
Shortness of Breath	Blurred Vision	Pregnancy
Nausea	Runny Nose or Congestion	Difficulty urinating
Vomiting	Dizziness	Seizures
Stiffness or difficulty moving	Rashes or Bruising	Tremors
Changes in sleep	Changes in appetite or	Nose Bleeds
Pain with urination	weight	Excessive Sweating
Easy Bruising	Rashes	Change in Sex Drive
	Involuntary Movements	

ADDITIONAL COMMENTS

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Request for Treatment and Authorization

REQUEST FOR TREATMENT. I hereby consent for myself, child or family to be involved in treatment with Carolinas Psychiatry and Behavioral Wellness. I hereby grant permission for the physician/ therapist or their designee to provide or seek any necessary urgent or emergency treatment from appropriate sources should this be necessary. I understand I may withdraw this consent at any time. I choose to receive the services even if my insurance plan may not cover specific services.

Insurance Assignment and Release

I certify that I have insurance coverage with: _____
(Name of Insurance Company (ies)

and assign directly to the Charlotte-Mecklenburg Hospital Authority (CHS). All insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance**. I authorize the use of my signature on all insurance submissions. The above named facility may use my health care information and may disclose such information to the above named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed.

Notice of Privacy Practices

We are required by law to provide you with you Notice of Privacy Practices which explains how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you.

☐ I have been provided a copy of CHS' Notice of Privacy Practices.

By signing below, I affirm that I have read and understand this form in its entirety and agree to be bound by all terms and conditions herein. If I am signing on behalf of another person, I affirm that I have the legal ability to consent on that person's behalf.

Patient Name:_____ Patient DOB:_____

Parent/Legal Guardian Printed Name: _____

Patient/Parent/Legal Guardian Signature: _____

Date: _____

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Carolinas Psychiatry & Behavioral Wellness

Ongoing Communication Authorization

Patient Name:_____ DOB: _____

Preferred Phone: _____ Okay to Leave a Message? Yes No

Primary Care Provider: _____ Phone: _____

How did you hear about our practice? _____

Please list any family, friends, providers, or any other individuals that you would like for us to be able to have ongoing communication with regarding your care.

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Are you currently seeing any other behavioral health professionals? If so, please list:

Name: _____ Office: _____ Phone: _____

Name: _____ Office: _____ Phone: _____

Name: _____ Office: _____ Phone: _____

Carolinas HealthCare System

Carolinas Psychiatry & Behavioral Wellness

Dear Carolinas Psychiatry & Behavioral Wellness Patient/Caregiver,

Thank-you for choosing Carolinas Psychiatry & Behavioral Wellness as your healthcare provider. We are glad to work with you for a healthier you.

It is important for you to know the policies:

1) **Cancel/No-show Policy**:
   a. Patients must call the office at 704-801-9200 at least the day before your appointment if you will not be able to come. This allows the provider to have another patient scheduled in his/her time slot.
   b. Patients who do not show up for a scheduled appointment will be considered a "no-show".
   c. Patients with 3 or more "no-show" appointments may not be able to continue to receive services at Carolinas Psychiatry & Behavioral Wellness.

2) **Late Policy**:
   a. Patients who show up after their scheduled appointment time will be considered late.
   b. If a patient is late for their appointment, they may have to reschedule for another date/time. It is up to your healthcare team to determine if you can be seen when arriving late.

3) **Co-Payment & Deductible:**
   Depending upon the type of insurance a patient has, a co-payment or deductible is usually due at the time of your appointment. **If you have to pay a co-pay or deductible, that payment is expected at the time of check-in,** before you see the provider. Please make a plan to bring your co-pay or deductible with you for your appointment. If you do not have this at check-in, you may not be seen by the provider.

We look forward to partnering with you for your healthcare.

_____ _____

Patient, Parent, or Legal Guardian Signature Date

_____

Patient, Parent, or Legal Guardian Print Name

_____ _____

Patient Name (If different than above) Date of Birth

Patient Name: _____ Patient DOB: _____

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.

Patient Name: _____ Patient DOB: _____

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
☐	☐	☐	☐

Patient Name: _____ Patient DOB: _____

Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form (Q-LES-Q-SF)

Taking everything into consideration, during the past week how satisfied have you been with your……

	Very Poor	Poor	Fair	Good	Very Good
…..physical health?	1	2	3	4	5
…..mood?	1	2	3	4	5
…..work?	1	2	3	4	5
…..household activities?	1	2	3	4	5
…..social relationships?	1	2	3	4	5
…..family relationships?	1	2	3	4	5
…..leisure time activities?	1	2	3	4	5
…..ability to function in daily life?	1	2	3	4	5
…..sexual drive, interest and/or performance?*	1	2	3	4	5
…..economic status?	1	2	3	4	5
…..living/housing situation?*	1	2	3	4	5
…..ability to get around physically without feeling dizzy or unsteady or falling?*	1	2	3	4	5
…..your vision in terms of ability to do work or hobbies?*	1	2	3	4	5
…..overall sense of well being?	1	2	3	4	5
…..medication? (If not taking any, check here _____ and leave item blank.)	1	2	3	4	5
…..How would you rate your overall life satisfaction and contentment during the past week?	1	2	3	4	5

*If satisfaction is very poor, poor or fair on these items, please UNDERLINE the factor(s) associated with a lack of satisfaction.