Date_______________

APPS MENTAL HEALTH
NEW CLIENT QUESTIONNAIRE (ADULT)

Name:____(First, Middle, Last)
DOB:_______________________ SS#____________________________ Gender: M F Unspecified
Legal Guardian's Name (if applicable): ____
Address: ____
City:______________________________ State:____________ Zip: ___________________________
Home Phone: ____ May we leave a message at this number Y N
Work Phone: ____May we leave a message at this number Y N
Cell Phone: ____May we leave a message at this number Y N
Email: ____May we contact you via email? Y N
Secondary E-mail____May we contact you via email? Y N
May we send text reminders or messages? Y N Occupation_______________________________________
EMPLOYER____How long have you been employed there?____
Highest Level of Education Completed:_____________________Degree Obtained_________________________
Primary Care Doctor Name:___________________________ Phone#________________ Fax# _____________
Address:____ Date of Last Office Visit:______________
Emergency Contact Name:_________________________________ Relation:_________________________
I give permission to speak with ______________________________ in an emergency at my providers discretion.
Phone:___________________________Address:____
Spouse Full Name________________________________DOB_____________Employer______________________
Referred By:___________________________________ Phone______________________________________
Optional - Ethnicity:________Race:__________ Religion:__________ Language_________ Gender__________
Therapist name:_________________________**Phone-**_________________**Fax#**____________________
How often are therapy appointments?_______________________________**Please Sign Release Y or N**

INSURANCE INFORMATION:

Primary Insurance Carrier: ____
ID#_______________________ Group#____________________ Insurance Holder name:___________________
Relation:______________________ Insurance Holder Date of Birth:____________Active Date ______________
SSN of policy holder:____-_____-_____Address of primary insurance holder:__________________________
Name of Behavioral Health Insurance:_____________________________Phone#__________________________
Do you have a copay? $__________ Do you have a deductible?$______ Have you met the deductible? Y or No Do you need a Referral for full coverage? Y or N Send Claims to Address:______________________________

Secondary Primary Insurance Carrier-____
ID#_______________________ Group#____________________ Insurance Holder Name:__________________
Relation:______________________ Insurance Holder Date of Birth:_________ Active Date ______________
SSN of policy holder:___-___-___Address of primary insurance holder:______________________________
Name of Behavioral Health Insurance:_____________________________Phone#__________________________
Do you have a copay? $__________ Do you have a deductible?$______ Have you met the deductible? Y or No
Do you need a Referral for full coverage? Y or N- Send Claims to Address:___________________________

____ ______________________________

Signature Date

____

Printed Name

Patient Name ______________________________ Date of Birth________________

Your signature below indicates that you have **read and understood** the information in this clinician and patient agreement, and agree to abide by **all** terms indicated in the document during our professional relationship. As well as CRISP acknowledgment.

______________________________ ______________________________

Client/Responsible Party Signature Printed Name Date

______________________________ ______________________________

Client/Responsible Party Signature Printed Name Date

Address for billing and or office correspondence:
(This authorizes me to send identifying information to this address)

Phone Number(s) for Office Contact

(This authorizes my office to contact you at this/these number(s). Messages will indicate a first name of the caller and a number for return contacts from you. Please do not include numbers where you prefer not to be contacted or have messages left for you.)

------------------------------ ------------------------------

Email address Cell phone number

Appointment reminders are made in the form of text, email or telephone calls. **Please be advised that NO email or text messaging correspondence is considered confidential and may be recovered by other parties at any time. You may lose your right to confidentiality by corresponding with me by email and by receiving correspondence from me by email.**

Your signature above indicates your approval of receiving email and/or cell phone text messaging from me, knowing the limits of confidentiality.

PATIENT NAME ______________________ DATE OF BIRTH ____________ DATE ________

***** PLEASE BE SURE TO FILL OUT A RELEASE FOR EACH MEDICAL PROFESSIONAL & THERAPIST THAT YOU HAVE HAD TREATMENT WITH. ALSO, ANY HOSPITAL YOU HAVE BEEN ADMITTED TO OR RECEIVED TREATMENT:***

CURRENT MEDICATIONS:

NAME OF MEDICATION	DOSE (mg)	FREQUENCY	PRESCRIBED BY	DIAGNOSIS	

NAME OF MEDICATION	DOSE (mg)	FREQUENCY	PRESCRIBED BY	DIAGNOSIS	

NAME OF MEDICATION	DOSE (mg)	FREQUENCY	PRESCRIBED BY	DIAGNOSIS	

NAME OF MEDICATION	DOSE (mg)	FREQUENCY	PRESCRIBED BY	DIAGNOSIS	

NAME OF MEDICATION	DOSE (mg)	FREQUENCY	PRESCRIBED BY	DIAGNOSIS	

NAME OF MEDICATION	DOSE (mg)	FREQUENCY	PRESCRIBED BY	DIAGNOSIS	

NAME OF MEDICATION	DOSE (mg)	FREQUENCY	PRESCRIBED BY	DIAGNOSIS	

PREVIOUS HOSPITALIZATIONS: (NAME OF HOSPITAL--REASON FOR ADMISSION & ADMISSION DAYS) ______________________________

____

PAST MENTAL HEALTH MEDICATIONS(APPROX DATES MEDICATION WAS TAKEN AND WHY STOPPED)______________________________

____

ALLERGIES TO MEDICATIONS(AND REACTION)-______________________________

____

____

CONSENT FOR RELEASE OF INFORMATION

CB Benway, CRNP, PMH
13327 Wisdom Way
Hagerstown, Maryland 21742
appsmentalhealth@gmail.com
Telephone: 240-970-7300 *Fax: 240-231-9755

INFORMED CONSENT FOR ONLINE THERAPY/ MEDICATION MANAGEMENT SERVICES

This form is designed to allow you to give informed consent for the use of video technology for online therapy and medication management. Read it thoroughly for understanding and ensure all of your questions are answered before signing to give consent.

I understand that therapy and medication management conducted online is technical in nature and that problems may occasionally occur with internet connectivity. Difficulties with hardware, software, equipment, and/ or services supplied by a 3rd party may result in interruptions. Any problems with internet availability or connectivity are outside the control of the provider and the provider makes no guarantee that such services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session can not be completed via online video conferencing, I agree to call my provider back at 240-970-7300 (office telephone number). Immediately. Or other arrangements will be made.

I AGREE TO TAKE FULL RESPONSIBILITY FOR THE SECURITY OF ANY COMMUNICATIONS OR TREATMENT ON MY OWN COMPUTER OR DEVICE AND IN MY OWN PHYSICAL LOCATION. I understand I am solely responsible for maintaining the strict confidentiality of my user ID and password and not allow another person to use my User ID to access these services. I also understand that there will be no recording of any of the online or telephone sessions and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

Patient/ Client Signature	Printed Name	DATE
Parent, Guardian/ Legal Representative Signature	Printed Name	DATE
Provider Signature or Witness Signature	Printed Name	DATE

Name: Date:

ID#: DOB:

GAD-7

Over the <u>last 2 weeks</u>, 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. 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 is 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 ○

___ + ___ + ___

(For office coding: Total Score ______ **)**

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

ID#: ____________

DOB: ____________

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

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Patient Name Date

Patient ID DOB

CAGE Substance Abuse Screening Tool

Directions: Ask your patients these four questions and use the scoring method described below to determine if substance abuse exists and needs to be addressed.

CAGE Questions

1. Have you ever felt you should cut down on your drinking? Y ○ N ○
2. Have people annoyed you by criticizing your drinking? Y ○ N ○
3. Have you ever felt bad or guilty about your drinking? Y ○ N ○
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)? Y ○ N ○

OR

CAGE Questions Adapted to Include Drug Use (CAGE-AID)

1. Have you ever felt you ought to cut down on your drinking or drug use? Y ○ N ○
2. Have people annoyed you by criticizing your drinking or drug use? Y ○ N ○
3. Have you felt bad or guilty about your drinking or drug use? Y ○ N ○
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)? Y ○ N ○

Scoring: Item responses on the CAGE questions are scored 0 for "no" and 1 for "yes" answers, with a higher score being an indication of alcohol problems. A total score of two or greater is considered clinically significant. The score to the right is the maximum number of Yes answers for each group of questions. ☐

The normal cutoff for the CAGE is two positive answers, however, the Consensus Panel recommends that the primary care clinicians lower the threshold to one positive answer to cast a wider net and identify more patients who may have substance abuse disorders. A number of other screening tools are available.

CAGE is derived from the four questions of the tool: Cut down, Annoyed, Guilty, and Eye-opener

CAGE Source: Ewing 1984

ID#:
DOB:

THE MOOD DISORDER QUESTIONNAIRE

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

Patient's Name / Date	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 check one response only.* ○ No Problem ○ Minor Problem ○ Moderate Problem ○ Serious Probler		
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?	○	○

Scoring

© 2000 by The University of Texas Medical Branch. Reprinted with permission. This instrument is designed for screening purposes only and is not to be used as a diagnostic tool. Hirschfeld, Robert M.A., M.D., et al. "Development and Validation of a Screening Instrument for Bipolar Spectrum Disorder: The Mood Disorder Questionnaire." American Journal of Psychiatry 157:11 (November 2000) 1873-1875

Adverse Childhood Experience (ACE) Questionnaire

5 -100 years

Finding your ACE Score

ID# ______________ DOB ___________

Name___________________ Date_____________

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   O Yes O No ________

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   O Yes O No ________

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   O Yes O No ________

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   O Yes O No ________

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   O Yes O No ________

6. Were your parents **ever** separated or divorced
   O Yes O No ________

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   O Yes O No ________

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   O Yes O No ________

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   O Yes O No ________

10. Did a household member go to prison?
    O Yes O No ________

__________ **This is your ACE Score**

CONSENT FOR RELEASE OF INFORMATION

ADVANCED PRACTICE PSYCHIATRIC SOLUTIONS, LLC

CB Benway CRNP, PMH, Owner
13327 Wisdom Way
Hagerstown, Maryland 21742
appsmentalhealth@gmail.com
Telephone: 240-970-7300 Fax: 240-231-9755

I, ______________________________ Date of Birth______________________
(Clients Name) (Date of Birth)

hereby authorize the exchange of information between:

____
(Full name of person or provider you wish us to contact or exchange information with or get information from)

____
(Their address, phone fax, and email if you have it)

____.
and CB Benway CRNP, PMH, owner as well as staff and providers of ADVANCED PRACTICE PSYCHIATRIC SOLUTIONS, LLC. This may include: (Specify records, reports, verbal conversations, all records or other data to be released).

___ALL RECORDS AND VERBAL CONVERSATIONS______________________

____

The records are required for the specific purpose of (continuity of care, a continuation of care, collaboration of care, transfer of care, records).

____COORDINATION OF CARE ______________________________

____

I understand that my authorization shall remain effective for a period of one year from the date of my signature and that all information released will be handled confidentially, in compliance with the Federal Privacy Act (P.L. 93-575), the Federal Alcohol and Drug Abuse Act (P.L. 92-282), and the Maryland Mental Health Code HG §8-601.

I also understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at any time by written dated communication to CB Benway CRNP, PMH, Owner, as well as staff and providers of & Advanced Practice Psychiatric Solutions, LLC. It is agreed that the recipient of this information will refrain from and will protect against disclosure of any information received which is not authorized by further consent of the patient of his/her parent, guardian, or authorized representative unless provided for under law or regulation.
I understand that I may not be required to sign this authorization as a condition of my ability to obtain treatment or payment or my eligibility for benefits.

______________________________ ______________________________
Clients Signature Parent or Legal Guardian

______________________________ ______________________________
Witness Date

CONSENT FOR RELEASE OF INFORMATION

ADVANCED PRACTICE PSYCHIATRIC SOLUTIONS, LLC
CB Benway CRNP, PMH, Owner
13327 Wisdom Way
Hagerstown, Maryland 21742
appsmentalhealth@gmail.com
Telephone: 240-970-7300 Fax: 240-231-9755

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___ALL RECORDS AND VERBAL CONVERSATIONS____________________
____
The records are required for the specific purpose of (continuity of care, a continuation of care, collaboration of care, transfer of care, records).
____COORDINATION OF CARE ______________________________
____
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Clients Signature	Parent or Legal Guardian
________________________	________________________
Witness	Date

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____

____

____

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____

____

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______________________	______________________
Clients Signature	Parent or Legal Guardian
______________________	______________________
Witness	Date