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	

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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

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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Name: Date:

ID#: DOB:

GAD-7

Over the last 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. 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.

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

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________________________________ ________________________________
Clients Signature Parent or Legal Guardian

________________________________ ________________________________
Witness Date