Date:_____

APPS MENTAL HEALTH

NEW CLIENT QUESTIONNAIRE (ADULT)

Name:_____

DOB:_____ SS#_____-_____-_____ Gender M F Unspecified

Legal Guardian's Name (if applicable):_____

Address:_____

City:_____ State:_____ Zip code:_____

Home Phone:_____ May we leave a message at his number? Y or N

Work Phone:_____ May we leave a message at this number? Y or N

Cell Phone:_____ May we leave a message at this number? Y or N

Email:_____ May we contact you via email? Y or N

Secondary Email:_____ May we send text message reminders? Y or N

Employer:_____ How Long have you been employed there? _____

Highest Level of Education Completed:_____ Degree Obtained:_____

Spouse's Full Name:_____

Primary Care Doctor Name:_____ Phone#_____ Fax#_____

Address:_____ Date of Last Office Visit:_____

Referred By:_____ Phone#_____

Optional-Ethnicity:_____ Race:_____ Religion:_____ Language:_____ Gender:_____

EMERGENCY CONTACT:_____ **Phone:**_____ **Relation:**_____

I give permission to speak with_____ in an emergency, at my provider's discretion.

Therapist Name:_____ Phone:_____ Fax:_____

How often are therapy appoinments?_____

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: _____

Copay? _____ Deductible? _____ Have you met the deductible? Y N

Do you need a referral for full coverage? Y or N Send Claims to Address: _____

Secondary Insurance Carrier: _____

ID: _____ Group: _____ Insurance Holder name: _____

Relation: _____ Insurance Holer Date of Birth: _____ Active Date: _____

SSN of policy holder: _____ Address of primary insurance holder: _____

Name of Behavioral Health Insurance: _____ Phone: _____

Copay? _____ Deductible? _____ Have you met the deductible? Y N

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). The message 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 confidentially 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 ______________________ **DOB:** ______________________ **DATE:** ____________

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 & DMISSION DAYS)

____

____

PAST MENTAL HEALTH MEDICATIONS (APPOX DTES MEDICATION WAS TAKEN AND WHY STOPPED):

____

____

ALLERGIES TO MEDICATIONS (AND REACTION):______________________________________

____

____

CONSENT FOR RELEASE OF INFORMATION

CB Benway, CRNP, PMH
Jessica Henderson, CRNP, PMH-BC
Katie Koons, CRNP
13327 Wisdom Way
Hagerstown MD 21742
appsmentalhealth@gmail.com

Phone #: 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 cannot be completed via online video conferencing. I agree to call my provider back on 240-970-7300 (office telephone number). Immediately or other arrangements will be made.

I AGREE TO TAKE FULL RESPONIBILITY 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 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

Patient:_____

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

OR

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

1. Have you felt you ought to cut down on your drinking or drug use? Y O N O
2. Have people annoyed you by criticizing your drinking or drug use? Y O N O
3. Have you felt bad or guilty about your drinking or drug use? Y O N O
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 O N O

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 cut off 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

Patient:_____
DOB:_____

Adverse Childhood Experience (ACE) Questionnaire

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 that 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 step mother:
   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

_____ ACE SCORE

Patient:_____

DOB:_____

The Mood Disorder Questionnaire

Instruction: Please answer each question to the best of your ability

	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?	O	O
...you were so irritable that you shouted at people or started fights or arguments?	O	O
... you felt much more self-confident than usual?	O	O
...you got much less sleep than usual and found you didn't really miss it?	O	O
...you were much more talkative or spoke much faster than usual?	O	O
...thoughts raced through your head or you couldn't slow your mind down?	O	O
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	O	O
...you had much more energy than usual?	O	O
...you were much more active or did many more things than usual?	O	O
...you were much more social or outgoing than usual, for example, telephoned friends in the middle of the night?	O	O
...you were much more interested in sex than usual?	O	O
...you did things that were unusual for you or that other people might have thought were excessive, foolish or risky?	O	O
...spending money got you or your family in trouble?	O	O
2. If you checked YES to more than on of the above, have several of these Ever happened during the same period of time?	O	O

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 flights? Please check one response only.

O No Problem O Minor Problem O Moderate Problem O Serious Problem

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic depressive illness or bipolar disorder?	O	O
5. Has a heath professional ever told you that you have manic-depressive illness or bipolar disorder?	O	O

SCORE: _____

Patient:_____

DOB:_____

The Patient Health Questionnaire (PHQ-9)

Over the past 2 weeks, how often Have you been bothered by any of the Following problems?	Not At All	More Several Days	Nearly Than Half the Days	Every Day
1. Little interest or please in doing things	0 O	1 O	2 O	3 O
2. Feeling down, depressed or hopeless	0 O	1 O	2 O	3 O
3. Trouble falling asleep, staying asleep, or sleeping too much	0 O	1 O	2 O	3 O
4. Feeling tired or having little energy	0 O	1 O	2 O	3 O
5. Poor appetite or overeating	0 O	1 O	2 O	3 O
6. Feeling bad about yourself-or that you're a failure or have let yourself or your family down	0 O	1 O	2 O	3 O
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 O	1 O	2 O	3 O
8. Moving or speaking so slowly that other people could have notices. Or, the opposite- being so fidgety or restless that you have been moving around a lot more than usual	0 O	1 O	2 O	3 O
9. Thoughts that you would be better off dead or of hurting yourself in some way	0 O	1 O	2 O	3 O

_____+_____+_____

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 things at home, or get along with other people?

O Not difficult at all O Somewhat difficult O Very difficult O Extremely difficult

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Patient: _____

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 Days	Nearly Every Day
1. Feeling nervous, anxious or on edge	0 O	1 O	2 O	3 O
2. Not being able to stop or control worrying	0 O	1 O	2 O	3 O
3. Worrying too much about different things	0 O	1 O	2 O	3 O
4. Trouble relaxing	0 O	1 O	2 O	3 O
5. Being so restless that it is hard to sit still	0 O	1 O	2 O	3 O
6. Becoming easily annoyed or irritable	0 O	1 O	2 O	3 O
7. Feeling afraid as if something awful might happen	0 O	1 O	2 O	3 O

_____+_____+_____

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.

CONSENT FOR RELEASE OF INFORMATION
ADVANCED PRACTICE PSYCHIATRIC SOLUTIONS, LLC

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

Patient Name: _____ DOB:_____

I 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).

and CB Benway CRNP, PMH, owner as well as staff and providers of ADVANCED PRACTICE PSYCHIATRIC SOLUTIONS, LLC.

This may include: All records, evaluations, results, and verbal conversations and any other pertinent data for continuity of care, continuation of care, collaboration of care and/or transfer 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