# Miller Care Group
# Michael S Miller DO FACOS, CWS, PC

Dear New Patient:

We would like to welcome you the the Miller Care Group. Our staff looks forward to caring for your medical needs.

During this initial visit one of our staff members will copy your picture ID and insurance card. **If you do not have an ID, we will not be able to see you at this time.**

Per our Patient Financial Policy, you will be required to pay your office visit co-pay at the time of your visit. Our office accepts All Major credit/debit cards and cash. We no longer accept checks as a form of payment. Our office accepts Medicare, Indiana Medicaid, Anthem BCBS, most Healthy Indiana Plans (HIP 2.0) as well as many other commercial insurance plans. However, if insurance fails to pay for services rendered, you will be responsible for payment of any and all charges incurred.

It is the patients responsibility to verify with your insurance carrier that the provider you are seeing is in your network. If you have questions about your coverage, please contact your insurance carrier.

**Remember, your insurance plan is between you and your insurance carrier. Any unpaid balance will be your responsibility.**

**Our office charges $40.00 for missed or failed appointments. A missed or failed appointment is defined as not calling to change an appointment 24 hours before or not showing up for a scheduled appointment. The $40.00 fee is not billable to insurance and must be paid before being seen again.**

Thank you for giving us the opportunity to treat you. We look forward to helping you with all of your medical needs. We appreciate your interest in our practice.

Please feel to contact us with any questions or concerns you may have.

Yours in Health

Dr. Michael Miller and the Health Care team Miller Care Group

Miller Care Group Intake Sheet.

First ______________________ M______________________________.

Last____________________________________________________________

Sex M/F SSN__________________________

DOB___________________

Phone Number_____________________________________________

Secondary Phone Number _____________________________________

Address__________________________________

City________________ State______________ Zip____________

**Marital Staus: Single Married Divorced Separated Widowed**

**Spouse Name**________________________________________________

**Spouses Ph Number w/Area Code**________________________________

**Email Address**__________________________________________

**Employer**____________________________________________________

**Occupation**__________________________________________________

**Primary Care Physician**________________________________________

**Phone Number**__________________________________________

**Pharmacy**__________________________________________________

**Phone Number**______________________________________________

**Insurance**_________________________________________________________________

**Policy Number**_________________________________________________________________

**Phone Number**_____________________________________________________________

**Emergency Contact w/Ph Number**______________________________________________________________________

Miller Care Group
317-429-0061
8355 Rockville Rd Suite 120
Indianapolis, IN 46234

## CONSENT/AUTHORIZATION FOR PROCEDURE/TREATMENT FORM

I AUTHORIZE ______________________________________________
Provider Name
to perform the treatment/procedures described below. I have been informed of the reasons for the treatment/procedures along with the expected benefits, risks, possible alternative methods of treatment, and possible consequences involved in the following:

___ Mental and Behavioral Counseling

___ Psychiatric Care

___ Advance Wound Care & Lymphedema

___ Palliative Medical Care

___ Telehealth Visits

______________________________________________

______________________________________________

The treatment/procedures were explained to me in detail, and all of my questions were fully answered. Understanding this, I authorize

______________________________________________
Provider Name
to perform the above treatment.

Patient Name:______________________________________________

Patient Signature:______________________________________________

Date:______________________________________________

# Miller Care Group Financial Policy

## Michael Miller DPO, FACOS, FAPWCA, WCC

Thank you for choosing Miller Care Group for your specialty health care provider. We are committed to building a successful physician and patient relation with you and your family. Please understand that payment for services is part of that relationship. Our reception staff is trained to inform you of the financial policies of this practice. This document must be rea and signed by each patient. It will remain in effect for all services rendered during your time as a patient here at our practice.

**Information:** A current registration will be on file on the patient file during the time the patient is considered active. Patient registration will be updated yearly and will include numbers for the patient including home, mobile, work, and emergency. A signature by the responsible party is required. On an annual basis or as needed we will ask for a copy of your insurance card for your file.

***Your insurance policy is a contract between you and your insurance company. We cannot bill your insurance company unless you give us your insurance card to put on file. Failure to provide correct information will result in a denied claim, which in return will be your entire responsibility.***

**Insurance Claims:** I am authorizing Miller Care Group (MCG), to furnish information to insurance carries concerning the illness or medical treatment of dependents or myself. I hereby assign to the provider all insurance payments for medical services rendered to myself and or my dependents, except those services which I have already paid for prior to the filing of the insurance claim. I also acknowledge responsibility for payment or all medical fees regardless of any insurance I may have to assist me in the responsibility.

**Primary Insurance:** Miller Care Group (MCG) will file your medical claim upon proof of insurance (I.E. Insurance Cards). As part of your insurance contract full payment for "your part" of the charges is expected from you at the time of services are rendered. "Your Part" of charges incurred on the date of service. Be prepared to pay you co-pay at the time of service. If you have insurance coverage, but cannot provide documentation of the insurance policy, payment I due in full at the time services are rendered.

Please be aware that some, and in rare cases, all, of the services provided may be non-covered services, and not considered payable under your insurance plan. You need to contact your insurance carrier prior to your appointment for your coverage benefits.

**Secondary Insurance:** Claims will be filed with secondary insurance if adequate information is given at the time of service.

**Patient Financial Responsibility:** If no insurance is to be filed by MCG or if MCG is not a participating provider in your insurance network, and you do not have out of network benefits, full payment is due at the time of service unless other arrangements have been made. A finance charge of 1% monthly will be applied to any balance left unpaid after 60 days of receipt of insurance payment.

**Minors and Dependents:** Children under the age of 18 will be require the signature of a responsible adult party on the registration form. An adult is required to accompany children under the age of 18 to all office visits.

**Method Of Payment:** Acceptable methods of payment are cash, Credit Card (Visa, Mastercard, Discover, Amex.) Debit. We do **NOT** accept personal checks.

**Accounts Past Due:** Payment is due on the day services are rendered. Payment for any additional treatment supplies, are due the day they are received. Noncompliance may result preparation of account for small claims court, collection agency, and or credit bureau reporting but is not subject to dismissal from practice. If your account is turned over for collections, the person financially responsible for the account will be responsible for the cost of collections, which includes, but not limited to, late fees, collection agency fees, court cost and interest and fines. A patient may remit in full to the collection agency all outstanding charges owed on the account, includes amounts previously placed with the collection service. Under these circumstances, a physician may reserve the right to re-establish the patient to active status in the practice.

**Missed Appointments:** Appointments missed and not cancelled prior to 24 hours will be charged a **"NO SHOW'** fee **$40.00.** If a new patient missed two (2) consecutive appointments, no additional appointments will be made, If an established patient misses/cancels with less than 24 hours' notice four (4) times, the patient may be discharged from the practice.

Your signature below indicates that you accept and understand this policy. Further, your signature authorizes Miller Care Group to release such medical information necessary to process your insurance claims (if any). You hereby authorize payment of medical benefits to MCG when an assigned claim is filed.

I have received a copy of Miller Care Group Financial Policy

Printed Patient Name: Signature of patient (Responsible Party): Date"

____________________ _________________________ _________

***Miller Care Group is legally known as Michael S Miller, DO, FACOS, PC, LLC**

# HEALTH HISTORY

## FAMILY HEALTH HISTORY

HAS ANYONE IN YOUR FAMILY HAD.

| | MOTHER | FATHER | SIBLINGS | NONE |
|---|---|---|---|---|
| DIABETES | | | | |
| HEART PROBLEMS | | | | |
| STROKE | | | | |
| HIGH BLOOD PRESSURE | | | | |

## MEDICATIONS

| MEDICATION NAME | DOSAGE | FREQUENCY | ROUTE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## SURGICAL HISTORY

## ALLERGIES: PLEASE LIST

______________________________________________

______________________________________________

______________________________________________

## CURRENT USE OF THE FOLLOWING DRUGS PLEASE CIRCLE

None

Cocaine

Morphine

Methamphetamine

Marijuana

Heroin

Do you have a history of drug dependency? Is so, please list the drugs you had an addiction to.

______________________________________________

______________________________________________

## SOCIAL HISTORY

Alcohol Use: Please circle appropriate

None
Abstainer (fewer than 12 drinks per year)
Light Drinker(1-13 drinks per month)
Moderate Drinker(more than 14 drinks per month)
Heavy Drinker(more than 2 drink/day)
Binge Drinker(drinks occasionally w/5+ drinks per session)
History of Alcoholism

## ARE YOU A SMOKER? PLEASE CIRCLE

NON-SMOKER
PREVIOUS SMOKER
1-3 CIGARETTES PER DAY
UP TO 1 PACK PER DAY
2 OR MORE PACKS PER DAY

# NOTIFICATION OF INSURANCE CHANGES

IT IS THE RESPONSIBILITY OF THE PATIENT OR PATIENTS FAMILY TO INFORM OUR OFFICE OF CHANGES TO HEALTH INSURANCE COVERAGE.

FAILURE TO INFORM OUR STAFF OF A CHANGE IN INSURANCE WILL RESULT IN CHARGES BEING DENIED FOR PAYMENT OR PAYMENT REDUCED AND THE PATIENT OR PATIENTS FAMILY BEING RESPONSIBLE FOR 100% PAYMENT OF THE DENIED CHARGES.

ALL INSURANCE IS SUBJECT TO VERIFICATION.

I UNDERSTAND THAT I AM RESPONSIBLE FOR KEEPING MY INSURANCE INFORMATION CURRENT WITH DR. MICHAEL MILLER/MILLER CARE GROUP. I UNDERSTAND THAT IF MY INSURANCE INFORMATION CHANGES AND I DO NOT INFORM THE STAFF THAT I WILL BE RESPONSIBLE FOR ALL CHARGES INCURRED.

________________________________________

PATIENTS PRINTED NAME

________________________________________

PATIENTS SIGNATURE

________________________________________

DATE

MILLER CARE GROUP
INDY TRANSITIONS
DR. MICHAEL S MILLER
8355 ROCKVILLE RD SUITE 120
INDIANAPOLIS, IN 46234
PHONE 317-429-0061 FAX: 317 222-1953

In compliance with the BitterPill.in.gov policy and the Affordable Care Act, as well as the ICD-10 implementation, proper coding has been increased in scope. All results of our urine drug testing required by Indiana House Bills 246 and 844 will be coded for any and all findings. This may involve perceived higher risk to insurers inclusive of, but not limited to, all illicit drugs under the Indiana Law, as well as alcohol use, which may be inter active with any other prescribed or illicit drug findings. Insurance carriers, law enforcement, and prescribers of any controlled substance will need to know more about the results of these tests and records which must be reflected in patients medical records and these should be considered part of your permanent medical records.

These can also be reviewed and correlated with other required state reported information on controlled substances and may not be as completely private as you may think.

________________________________________
Signature

____________________________
Date

# REQUEST FOR MEDICAL RECORDS

TO: ______________________________________________

PROVIDER/HOSPITAL: ______________________________________

I ______________________________________________
PATIENT NAME (PLEASE PRINT)

AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS, TO INCLUDE:

FULL RECORD_______
LABS/RADIOLOGY_____
LIMITED RELEASE (SPECIFY INFORMATION
NEEDED)__________________________________________

PATIENT DOB:______________________________________

PATIENT SSN:______________________________________

PATIENT SIGNATURE:________________________________

PLEASE RELEASE INFORMATION TO:
DR. MICHAEL S MILLER
8355 ROCKVILLE RD SUITE 120
INDIANAPOLIS, IN 46234
FAX: 317-222-1953

EFFECTIVE OCTOBER 11, 2016

Our office will no longer process re-fill requests or requests for new prescriptions on Friday.

All prescription requests must be made at least 48 hours in advance to allow processing time for our staff.
Please be sure you have an adequate supply of your medication at all times.

Please note that requests for controlled substance prescriptions or pain medications are not considered an emergency and will are subject to the 48 hour notice. These will not be processed on Friday.

Thank You

# Patient Health Questionnaire-9
# (PHQ-9)

| Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use a check mark 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 | [illegible] | [illegible] | 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 hurting yourself in some way | 0 | 1 | 2 | 3 |
| FOR OFFICE CODING | ____ + | ____ + | ____ + | ____ |

= 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 |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

Created 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.

## LEVEL 2—Substance Use—Adult*

*Adapted from the NIDA-Modified ASSIST

Name: ______________________ Age: ____ Sex: ☐ Male ☐ Female Date: ____________

If the measure is being completed by an informant, what is your relationship with the individual receiving care? ____________

In a typical week, approximately how much time do you spend with the individual receiving care? ____________ hours/week

<u>Instructions:</u> On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that during *the past 2 weeks* you (the individual receiving care) have been bothered by "using medicines on your own without a doctor's prescription, or in greater amounts or longer than prescribed, and/or using drugs like marijuana, cocaine or crack, and/or other drugs" at a slight or greater level of severity. The questions below ask how often you (the individual receiving care) have used these medicines and/or substances <u>during the past 2 weeks.</u> Please respond to each item by marking (✓ or x) one box per row.

| During the past **TWO (2) WEEKS**, about how often did you use any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed? | | | | | | | Clinician Use |
|---|---|---|---|---|---|---|---|
| | | Not at all | One or two days | Several days | More than half the days | Nearly every day | Item Score |
| a. | Painkillers (like Vicodin) | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| b. | Stimulants (like Ritalin, Adderall) | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| c. | Sedatives or tranquilizers (like sleeping pills or Valium) | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| *Or drugs like:* | | | | | | | |
| d. | Marijuana | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| e. | Cocaine or crack | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| f. | Club drugs (like ecstasy) | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| g. | Hallucinogens (like LSD) | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| h. | Heroin | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| i. | Inhalants or solvents (like glue) | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| j. | Methamphetamine (like speed) | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | |
| | | | | | | **Total Score:** | |

Courtesy of National Institute on Drug Abuse.
This instrument may be reproduced without permission by clinicians for use with their own patients.

# DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: ______________________ Age: ____ Sex: ☐ Male ☐ Female Date: ________

If this questionnaire is completed by an informant, what is your relationship with the individual? ____________
In a typical week, approximately how much time do you spend with the individual? ____________ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the past TWO (2) WEEKS.

| | During the past TWO (2) WEEKS, how much (or how often) have you been bothered by the following problems? | None Not at all 0 | Slight Rare, less than a day or two | Mild Several days | Moderate More than half the days | Severe Nearly every day | Highest Domain Score (clinician) |
|---|---|---|---|---|---|---|---|
| I. | 1. Little interest or pleasure in doing things? | 0 | 1 | 2 | 3 | 4 | |
| | 2. Feeling down, depressed, or hopeless? | 0 | 1 | 2 | 3 | 4 | |
| II. | 3. Feeling more irritated, grouchy, or angry than usual? | 0 | 1 | 2 | 3 | 4 | |
| III. | 4. Sleeping less than usual, but still have a lot of energy? | 0 | 1 | 2 | 3 | 4 | |
| | 5. Starting lots more projects than usual or doing more risky things than usual? | 0 | 1 | 2 | 3 | 4 | |
| IV. | 6. Feeling nervous, anxious, frightened, worried, or on edge? | 0 | 1 | 2 | 3 | 4 | |
| | 7. Feeling panic or being frightened? | 0 | 1 | 2 | 3 | 4 | |
| | 8. Avoiding situations that make you anxious? | 0 | 1 | 2 | 3 | 4 | |
| V. | 9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)? | 0 | 1 | 2 | 3 | 4 | |
| | 10. Feeling that your illnesses are not being taken seriously enough? | 0 | 1 | 2 | 3 | 4 | |
| VI. | 11. Thoughts of actually hurting yourself? | 0 | 1 | 2 | 3 | 4 | |
| VII. | 12. Hearing things other people couldn't hear, such as voices even when no one was around? | 0 | 1 | 2 | 3 | 4 | |
| | 13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking? | 0 | 1 | 2 | 3 | 4 | |
| VIII. | 14. Problems with sleep that affected your sleep quality over all? | 0 | 1 | 2 | 3 | 4 | |
| IX. | 15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)? | 0 | 1 | 2 | 3 | 4 | |
| X. | 16. Unpleasant thoughts, urges, or images that repeatedly enter your mind? | 0 | 1 | 2 | 3 | 4 | |
| | 17. Feeling driven to perform certain behaviors or mental acts over and over again? | 0 | 1 | 2 | 3 | 4 | |
| XI. | 18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories? | 0 | 1 | 2 | 3 | 4 | |
| XII. | 19. Not knowing who you really are or what you want out of life? | 0 | 1 | 2 | 3 | 4 | |
| | 20. Not feeling close to other people or enjoying your relationships with them? | 0 | 1 | 2 | 3 | 4 | |
| XIII. | 21. Drinking at least 4 drinks of any kind of alcohol in a single day? | 0 | 1 | 2 | 3 | 4 | |
| | 22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco? | 0 | 1 | 2 | 3 | 4 | |
| | 23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]? | 0 | 1 | 2 | 3 | 4 | |

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Miller Care Group
8355 Rockville Road Ste 120
Indianapolis IN 46234
Phone: 317-429-0061 Fax: 317-222-1953

Psychosocial Questionnaire and Assessment

Client Name: ______________________ Therapist: ______________________
Client Age: __________ Date of Birth: __________ Date of Intake__________

Describe the problem or situation that brought you to counseling:
______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________

When did you first notice the problem? ______________________
How often is the problem occurring? ______________________

Please indicate the problems that you are experiencing:

| | | | | | |
|---|---|---|---|---|---|
| Anger | ____ | Excitability | ____ | Mania | ____ |
| Alcohol problems | ____ | Fatigue | ____ | Numb feelings | ____ |
| Anxiety | ____ | Gambling problems | ____ | Obsessive | ____ |
| Appetite disturbance | ____ | Hallucinations | ____ | Panic attacks | ____ |
| Avoiding people | ____ | Heart palpitations | ____ | Phobias/fears | ____ |
| Compulsive behavior | ____ | Hopeless feelings | ____ | Recurrent thoughts | ____ |
| Depressed mood | ____ | Hyperventilating | ____ | Relationship problems | ____ |
| Disorganized thoughts | ____ | Impulsivity | ____ | Self harm | ____ |
| Distractible | ____ | Irritability | ____ | Sexual problems | ____ |
| Dizziness | ____ | Judgment errors | ____ | Sleep problems | ____ |
| Drug problems | ____ | Loneliness | ____ | Suicidal thoughts | ____ |
| Eating habits | ____ | Memory problems | ____ | Worry | ____ |
| Elevated mood | ____ | Mood changes | ____ | Other (specify) | ____ |

Briefly explain if/how the problems are effecting your life (Work, school, relationships, etc.):
______________________________________________
______________________________________________
______________________________________________
______________________________________________

List stressful situations, events, experiences and other relevant information over the past 12 months that may be contributing to the problem(s):

_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________

Please describe any trauma (extremely stressful events) that you can recall experiencing at any time of your life. This may include experiencing or witness to physical, emotional, psychological and/or sexual abuse, being involved in very high stress situations for long periods of time, involved in accidents, witness to sudden death, military combat situations, etc.:

_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________

What are your personal strengths (skills, talents, gifts, traits, etc.)?

_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________

Who do you turn to for support (specific individuals, groups, church, etc.)?

_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________

What are your goals for therapy?

_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________

**Family of Origin:**

Who were (are) your primary caregivers? ______________________________
_______________________________________________

**Describe your relationship with your caregivers:**

_______________________________________________
_______________________________________________
_______________________________________________

**Do you have Siblings? Please give names and ages and a brief description of the quality of therelationship:**

_______________________________________________
_______________________________________________
_______________________________________________

Has anyone in your family of origin (parents, grandparents, siblings, etc.) ever suffered from mental health problems? Please indicate who and the extent of the known problem:

______________________________________________

______________________________________________

______________________________________________

Other relevant family of origin history: ______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

Marital and Current Family/Relationship Dynamics:

Single __________

Married __________ Spouse's name and length of marriage______________________________

Divorced__________ Name(s) of former spouse(s) and dates of marriage(s) ______________

______________________________________________

Widowed__________ Please indicate length of marriage, spouses name and date of death___

______________________________________________

Current committed relationship, not married________________ Cohabitating? ____________

Please indicate name of partner and length of relationship______________________________

Children (names and ages) ______________________________________________

______________________________________________

**Medical History**

Do you have a primary care physician? No______ Yes __________

Name and Location of primary physician: ______________________________________________

______________________________________________

Any other physicians involved with your care? ______________________________________________

______________________________________________

Please describe any significant physical health problems:

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

Current mediations, doses, other treatments and purpose:

______________________________________________

______________________________________________

______________________________________________

## Psychological/Mental Health History

Please describe any past mental health diagnosis, approximate dates when diagnosed, previous hospitalizations, psychiatric treatment etc.

______________________________________________
______________________________________________
______________________________________________
______________________________________________

Current psychiatric or psychotherapeutic treatments and providers involved

______________________________________________
______________________________________________
______________________________________________

Current medications including doses and prescribing physician:

______________________________________________
______________________________________________
______________________________________________

## Chemical Use History

Please check the following substances that you have used in the past 1 year.

Alcohol _____ Marijuana ______ Cocaine/Crack _____Meth _____Inhalants ___ Stimulants_____
Hallucinogens _____ Heroin/Opiates ______ Prescription pain medications or other narcotics (indicate) _________________ Other___________________________

How many times per week/month do you use alcohol?____________________

How many times per week/month do you use other drugs? (please list drug and frequency)____________________________________

How many servings do you have at a time? ____________________

Have your ever felt like you should cut down on your drinking or drug use? ____________

Have people ever annoyed you by criticizing your drinking or drug use? ____________

Have you ever felt guilty about your drinking or drug use? ____________________

Have you ever had a drink or used drugs first thing in the morning in order to get started for the day, steady your nerves, or get rid of a hangover or residual drug effect? ____________

Have you ever been in trouble with the law as a result of your chemical use? ____________

Have you ever been treated for chemical abuse/dependency? Yes ________ No __________

If yes, indicate dates and facilities____________________________________

Is there a family history of chemical abuse/dependency? Yes __________ No ___________

If yes, please specify____________________________________

## Education History

How many years of formal education do you have? ____________________

High School Diploma ______ B.A. /B.S. degree(s) ____________________

Graduate degree(s)_________________________Other:____________________

Are you currently in school? _______ What school do you attend? ____________

Is the current problem effecting your academic performance? Yes ________ No __________

If yes, please describe: ________________________________________
______________________________________________

Have you been diagnosed with a learning disability (describe)? ____________________
______________________________________________

Have you been diagnosed with ADD/ADHD?____________________________________

## Work History

Are you currently working? Yes__________ No__________

What type of work do you do? ______________________________

Past work experiences ______________________________

______________________________

Have there been any recent changes to your employment status? ______________

Has the current problem affected your work performance? If yes, please describe.

______________________________

______________________________

______________________________

## Military History

Have you ever been in the military? Yes ________ No__________ Active? ______________

What branch? _________ Please describe any combat experience and location: __________

______________________________

Type of discharge________________________ Rank at discharge________________

## Recreation

Describe activities that you do as a form of recreation or relaxation: ______________

______________________________

______________________________

______________________________

Describe activities and interests that you wish to further develop: ______________

______________________________

______________________________

______________________________

## Spiritual/Religious

Do you associate with a particular spiritual or religious denomination or group?

No ______ Yes______ (please specify) ______________________________

Is the current problem affecting your spiritual life? No _____Yes_____ (explain) __________

______________________________

Would you like to incorporate your spiritual beliefs in therapy? No_______ Yes __________

Please describe how we may help integrate your faith into therapy______________

______________________________

______________________________

______________________________

# Adverse Childhood Experience (ACE) Questionnaire
## Finding your ACE Score ra hbr 10 24 06

**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?
   Yes No
   If yes enter 1 ________

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?
   Yes No
   If yes enter 1 ________

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?
   Yes No
   If yes enter 1 ________

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?
   Yes No
   If yes enter 1 ________

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?
   Yes No
   If yes enter 1 ________

6. Were your parents **ever** separated or divorced?
   Yes No
   If yes enter 1 ________

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?
   Yes No
   If yes enter 1 ________

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No
   If yes enter 1 ________

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No
   If yes enter 1 ________

10. Did a household member go to prison?
    Yes No
    If yes enter 1 ________

**Now add up your "Yes" answers: ________ This is your ACE Score**