MEQUON CLINICAL ASSOCIATES, SC

ADULT HISTORY

Date: _____

INSTRUCTIONS: Your therapist would like you to answer these questions to help him/her better understand your situation.

Name & Preferred Name: _____ D.O.B. _____/_____/_____

Gender: _____ Race/Ethnicity: _____ Sexuality: _____

In case of an emergency, please give the name and telephone number of someone to contact:

Name: _____ Phone: _____

PSYCHOLOGICAL HISTORY

What problem(s) caused you to come to therapy at Mequon Clinical Associates?

_____

_____

_____

When did problem begin? _____

Has the problem been constant since its beginning? Yes ___ No ___

What is the worst symptom you've had? _____

Is problem ever absent? Yes ___ No ___ If yes, when? _____

Who made the decision to come to therapy? _____

Check if you have had any of these problems or symptoms lately:

___ Anxiety	___ Changes/problems in eating	___ Headaches	___ Loss of hope
___ Tearfulness	___ Changes/problems in sleeping	___ Fatigue/tiredness	___ Excessive worry
___ Nervousness	___ Chronic Pain	___ Sexual difficulties	___ Impulsive behavior
___ Depression	___ Difficulty concentrating	___ Irritability	___ Violent behavior
___ Fears	___ Loss of interest in usual activities	___ Other _____	

Have there been any recent illnesses or deaths among your family or close friends? ___ Yes ___ No

Explain: _____

Have there been any recent major losses among your family or close friends? ___ Yes ___ No

Explain: _____

Have there been any recent crises or major changes in your life? ___ Yes ___ No

Explain: _____

Have you ever intentionally hurt yourself or made a suicide attempt? ___ Yes ___ No

Explain: _____

Have you ever taken medication for anxiety, depression, sleep, or other emotional conditions? ___ Yes ___ No

Explain: _____

Have you been in counseling or psychotherapy before? ___ Yes ___ No

If so, for what issues? _____

What was the therapist's name and when did this occur? _____

Have you had any hospitalizations for emotional problems? ___ Yes ___ No

Explain: _____

Please name any people or organizations who you feel provide help and support to you. _____

_____

MEDICAL HISTORY

List any current medical conditions and disabilities: _____

_____

Are you taking any medications? ___ Yes ___ No

If yes, list current medications and daily dosages: _____

_____

List past medical conditions (include surgeries): _____

_____

Name of your physician(s) and telephone numbers & addresses: _____

_____

Have you had a medical exam within the past year? ___ Yes ___ No

List any significant findings: _____

DRUG & ALCOHOL USE

Please describe the drug & alcohol use of your family. Use the number which best represents frequency of use. For your children, please write in the name of the child at the top of the column.

0 = Never 1= less than once a month 2 = 1-4 days a month 3 = almost daily 4 = daily 5 = used in past but not currently using

SUBSTANCE	SELF	PARTNER/SPOUSE	CHILD	CHILD	YOUR PARENTS
Caffeine	____	____	____	____	____
Nicotine	____	____	____	____	____
Beer/Wine/Liquor	____	____	____	____	____
LSD	____	____	____	____	____
Marijuana	____	____	____	____	____
Inhalants	____	____	____	____	____
Sedatives	____	____	____	____	____
Amphetamines	____	____	____	____	____
Cocaine/Crack	____	____	____	____	____
Others (specify)	____	____	____	____	____

Are you concerned about your drug or alcohol use? ___ Yes ___ No

Is someone who cares about you concerned about your use of drugs or alcohol? ___ Yes ___ No

Do you ever feel guilty about your use of drugs or alcohol? ___ Yes ___ No

Are you concerned about the drug or alcohol use of someone in your family? ___ Yes ___ No

Did you grow up in a home in which a parent abused drugs or alcohol? ___ Yes ___ No

Has anyone in your family been in treatment for drug or alcohol abuse? ___ Yes ___ No

If yes, list who and for what treatment: _____

FINANCIAL / LEGAL HISTORY

Do you have serious financial concerns? ___ Yes ___ No

If yes, explain: _____

Have you ever been arrested? ___ Yes ___ No

If yes, explain: _____

Have you ever been involved with Protective Services? ___ Yes ___ No

If yes, explain: _____

SCHOOL, MILITARY & WORK HISTORY

Are you currently enrolled in school? ___ Yes ___ No

If yes, what is field of study? _____

What is your highest grade completed? _____

Have you served in the Military? ___Yes ___No

If yes, which branch? _____ When? _____ Overseas? _____ Combat? _____

What is your occupation? _____

Are you currently employed? ___Yes ___No What is length of time at current job? _____

If not employed, how long were you employed at last job held? _____

Mequon Clinical Associates, SC

Patient Name:_____ DOB:_____

Please print

18+ to be filled out by client only; under 18 to be filled out by legal guardian

FINANCIAL POLICY

Payment is expected at the time of service. You are ultimately financially responsible for all services you or members of your household receive from Mequon Clinical Associates.

Consent to Treatment/Privacy Policy

I hereby consent to treatment as agreed upon by my MCA Provider and myself, and I understand my rights as a patient. I have received and understand the written Notice of Privacy Practices provided by Mequon Clinical Associates.

_____initials

Private Pay

If you will be paying for visits privately (i.e., not through an insurance company or your insurance is a Medicaid policy), clinic policy requires payment at time of service. Please be prepared to make payment upon arrival for your session.

_____initials

Health Insurance

I have been advised that Mequon Clinical Associates does not accept any Medicaid insurance (which includes HMO Medicaid and Badgercare policies) and that I will be financially responsible if I have or obtain a Medicaid policy in the future.

I authorize insurance payment of medical benefits to Mequon Clinical Associates for services described on the itemized claim form. I also authorize the release of information necessary to process this claim. Payment of benefits should be paid directly to Mequon Clinical Associates. **I recognize and accept personal responsibility for all services rendered and will make payment in full of any self-pay charges, co-payments, or deductibles, and for any balance outstanding after payment or denial of such insurance benefits.**

_____initials

Outstanding Patient Balances

After insurance is billed any portion not covered will be billed to the patient. Any balance that is billed to the patient must be paid in full no later than 60 days from the billing date. The clinic charges a $30 fee to you for any returned checks, which is payable before or at the time of your next scheduled visit.

_____initials

Cancelled Appointments

I understand that any appointments cancelled or missed without 24 hours notice may be charged a minimum fee of $75 and **my insurance does not cover this fee. If you are 15 or more minutes late for your appointment, it will be at the providers discretion to charge this fee.**

_____initials

Failure and/or Inability to Pay

In the event it becomes necessary to assign your account to a collection agency, you are responsible for any/all costs of collection which may include attorney fees and other costs incurred.

_____initials

I have read and understand the above financial policy.

Client or Legal Guardian: _____ Date: _____

Legal Guardian Name (print): _____ Legal Guardian 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

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by 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

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they 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: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu.

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day."
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety