

DR# _____

CHART# _____

HOPE SPEAKS, PLLC
PATIENT INFORMATION
Please print and provide complete information.

LAST NAME: _____ FIRST NAME: _____ MI: _____

SSN: _____ DOB: _____ AGE: _____ SEX: _____

MARITAL STATUS: _____ EMPLOYER: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE: _____

INSURANCE

IS MEDICARE PRIMARY? YES: _____ NO: _____

INSURANCE CO NAME: _____ PHONE NO: _____

SUBSCRIBER NAME: _____ DOB: _____ SSN: _____

POLICY NO: _____ GROUP NO: _____

RELATIONSHIP: _____ EMPLOYER: _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize HOPE SPEAKS, PLLC to release any medical information concerning my care for the purpose of claims to federal, state, city, or town governmental agencies, third party payors of all categories, doctors, hospitals, and pharmacies.

DISABILITY: I understand that all providers of HOPE SPEAKS, PLLC DO NOT do any type of disability paperwork or any paperwork associated with disability.

CONSENT FOR MEDICAL/PSYCHIATRIC TREATMENT: I am authorizing my physician{s} and/or therapist{s} to perform and/or direct another person to perform all tests, exams, evaluations, and any other care deemed necessary or advisable for the diagnosis, evaluation, and treatment of my medical/psychiatric condition. I understand that my provider(s) at the HOPE SPEAKS, PLLC is not responsible for the care by any other health care professional.

ACKNOWLEDGEMENT FOR TREATMENT BY OTHER PROVIDERS: Dr. Shoaf and his team of providers are dedicated to providing quality healthcare to our patients. Please be aware that there will be times that you will be treated by one of the other qualified providers for your follow up appointments.

HIPAA NOTICE OF PRIVACY PRACTICES: I acknowledge that I have been given a copy of the HIPAA Notice of Privacy Practices for Hope Speaks, PLLC.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

HIPAA Notice of Privacy Practices

HOPE SPEAKS, PLLC

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this notice, please contact THE PRIVACY OFFICER.

Your medical information is personal. We are committed to protecting your medical information. We create a record of the care and services you receive at this office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this office whether made by your personal physician or one of the offices employees. This notice will tell you about the ways in which we may use and disclose your medical information. This Notice will also describe your rights and certain obligations we have regarding the use and disclosure of your medical information.

This office is required by law to:

1. make sure that medical information that identifies you is kept private.
2. give you this notice of our legal duties and privacy practices with respect to medical information about you
3. follow the terms of the notice that is currently in effect.

How this office may use and disclose your medical information

The following describes the different ways that your medical information may be used or disclosed by this office. For clarification we have included some examples. Not every possible use or disclosure is specifically mentioned. However, all of the ways we are permitted to use and disclose your medical information will fit within one of these general categories:

For Treatment: We will use medical information about you to provide you with medical treatment and services. We may disclose medical information about you to doctors, nurses, technicians and other office personnel who are involved in providing you medical treatment.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about treatment you received here so your health plan will pay us or reimburse you for the treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For health care operations: We may use and disclose medical information about you for office operations these uses and disclosures are necessary to run our office and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also disclose information to doctors, nurses, technicians, and other office personnel for review and learning purposes.

Appointment reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at this office.

Treatment alternatives and other health related benefits and services: We may use and disclose medical information to tell you about or recommend possible treatment options, alternatives, or other health related benefits and services that may be of interest to you.

Release of Information to Family/Friends: Our practice may release your medical information to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter or family member take their child for an appointment.

As required by law: We will disclose medical information about you when required to do so by federal, state, or local law. For example, disclosure may be required by Workers' Compensation statutes and various public health statutes in connection with required reporting of certain diseases, child abuse and neglect, domestic violence, adverse drug reactions, etc.

To avert a serious threat to health or safety: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be made to someone able to help prevent the threat.

Health Oversight Activities: We may disclose medical information to a governmental or other oversight agency for activities authorized by law. For example, disclosures of your medical information may be made in connection with audits, investigations, inspections and licensure renewals, etc.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may use your medical information to defend the office or to respond to a court order.

Law Enforcement: We may release medical information about you if required by law when asked to do so by a law enforcement agency.

Coroners and Medical Examiners: We may release medical information to a coroner or medical examiner to identify a deceased person or determine the cause of death.

National Security: Our practice may disclose medical information to federal official for intelligence and national security activities authorized by law. We also may disclose your medical information to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

Inmates: Our practice may disclose your medical information to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: a) for the institution to provide health care services to you, b) for the safety and security of the institution, and/or c) to protect your health and safety of other individuals.

Workers' Compensation: Our practice may release your medical information for workers' compensation and similar programs.

Your Rights Regarding Your Medical Information

You have the following rights regarding the medical information this office maintains about you.

Right to Inspect or Obtain a Copy: You have the right to inspect or obtain a copy your medical information with the exception of any psychotherapy notes. **To inspect or obtain a copy of your medical information you must submit your request in writing.** If you request a copy of the information we may charge a fee for the cost of copying, mailing or for other supplies associated with your request. We may deny your request to inspect or obtain a copy of your information in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed. For information regarding such a review contact THE PRIVACY OFFICER.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by this office. To request an amendment, your request must be made in writing and submitted to THE PRIVACY OFFICER. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request.

In Addition, we may deny your request if you ask us to amend information that:

- (a) Was not created by us.
- (b) Is not part of the medical information kept by this office.
- © Is not part of the information which you would be permitted to inspect or obtain a copy of: or
- (d) Is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures this office has made of your medical information. To request this accounting of disclosures you must submit your request in writing to THE PRIVACY OFFICER. Your request must state a time period which may not be longer than five years and may not include dates before January 1, 2013.

Right to Request Restrictions: You have the right to request a restriction or limitation on the use or disclosure we make of your medical information. **We are not required to agree to your request for a restriction.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to THE PRIVACY OFFICER.

Right to Request Confidential Information: You have the right to request that we communicate with you only in certain manner. For example, you can ask that we only contact you at specific numbers or by mail. To request confidential communications, you must make your request in writing to THE PRIVACY OFFICER. We will accommodate all reasonable le requests.

Right to a Paper Copy of this Notice: You have the right to a paper copy of this notice. To obtain a paper copy of this notice, contact THE PRIVACY OFFICER.

Right to Provide an Authorization for Other Uses and Disclosures: Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your medical information may be revoked at any time **in writing.** After you revoke your authorization, we will no longer use or disclose your medical information for the reasons described in the authorization. Please note, we are required to retain records of your care.

Revisions to This Notice

We reserve the right to revise this notice. Any revised notice will be effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of any revised notice in this office.. Any revised notice will contain the effective date of the revisions.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with this office or with the Secretary of the Department of Health and Human Services. To file a complaint with this office, contact THE PRIVACY OFFICER, Hope Speaks, PLLC, 1200 E. Collins Blvd., Suite 300, Richardson, TX. 75081, 972)669-1733. All complaints must be submitted in writing. THIS OFFICE WILL NOT PENALIZE YOU IN ANY WAY FOR FILING A COMPLAINT.

Other Uses of Medical Information

Other uses and disclosures of your medical information not covered by this Notice of Privacy Practices will be made only with your written authorization if you provide us such an authorization in writing to use or disclose medical information about you, you may revoke that authorization, in writing, at any time, If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact THE PRIVACY OFFICER, Hope Speaks, PLLC, 1200 E. Collins Blvd., Suite 300, Richardson, TX. 75081, 972)669-1733.

HOPE SPEAKS, PLLC
PATIENT FINANCIAL RESPONSIBILITY

Recognizing the need for patients to understand what is expected regarding payment of medical/mental services we have established our financial policy. Some of these items are required by law. It is our goal to remain sensitive to our patients' needs while providing quality medical care, and we encourage you to contact our office if a problem should arise regarding your account.

1. **All co-pays and co-insurance required by your insurance company must be paid at the time services are rendered.** We accept cash, checks, and Visa, MasterCard, Discover and American Express cards. There is a \$40.00 service charge on all returned checks. After receiving a returned check, HOPE SPEAKS, PLLC will only accept cash, money order, or credit card.
2. **It is the patient's responsibility to be aware of the contract benefits of his/her insurance carrier or any co-payment or deductible obligation.** If your insurance requires referrals for full benefits to be paid, it is your responsibility to verify that the referrals are in place prior to your visit.
3. **Our facility will file primary insurance claims for medical services rendered.** Claims for a secondary and third insurance will not be filed unless required by our contract. We cannot file claims correctly without accurate information from you. Proof of insurance must be presented at each visit.
4. **If you do not have insurance,** payment in full is expected at the time of service unless financial arrangements have been made in advance with our billing department.
5. **You will be responsible for any outstanding balance after your insurance company processes your claim.** If you are dissatisfied with the amount paid by your insurance company, please contact your insurance carrier.
6. **We are participating providers for Medicare.** This means that we must accept Medicare's allowed charge for the services rendered. Medicare will pay 80% of the approved amount. The patient is responsible for the remaining 20%, plus any out-of-pocket deductible. We will write off the difference between what we charge and what Medicare approves. If you have secondary insurance, we will submit the claim for the remaining balance after Medicare has paid. Please remember that although we accept assignment for Medicare, the patient, by federal law, is responsible for any portion of the approved amount not paid by Medicare or a secondary insurance.
7. **Responsibility for payment for services rendered to the child/children of divorced or separated parents** rests with the parent who seeks treatment at the time of service. Any court ordered judgment must be between the individuals involved, without including our facility.
8. **There will be a charge for all missed appointments without a 24 hour notice.** We reserve resources for your visit and would like to be available to others if you have a schedule change. If such scheduling problems arise, please contact us promptly.

It is our hope that you will find this information helpful. If you have any questions, please speak with our billing staff at 972-669-1733.

Patient's Signature OR Authorized Representative/Guardian Date

Witness's Signature Date

MEDICATION CHECKLIST

Chart# _____

Name: _____

Date: _____

Place a check mark next to any medication you are currently taking or that you may have taken in the past-even if it was for a short time. Then next to the medicine write a brief description based on your experience with the medication. Examples: good, helped, bad, side effects, made dizzy, gained weight, head aches, etc.

Anti-Depressants

- _____ Anafranil clomiprimine
- _____ Trintellix vortioxetine
- _____ Celexa citalopram
- _____ Cymbalta duloxetine
- _____ Deplin Lmethylfolate
- _____ Desyrel trazodone
- _____ Effexor venlafaxine
- _____ Elavil amitriptyline
- _____ Emsam selegiline patch
- _____ Fetzima levomilnacipran
- _____ Forfivo XL bupropion
- _____ Lexapro escitalopram
- _____ Ludomil maprotiline
- _____ Luvox fluvoxamine
- _____ Nardil phenelzine
- _____ Nuvigil armodafinil
- _____ Pamelor nortriptyline
- _____ Parnate tranlycromine
- _____ Paxil paroxetine
- _____ Pristiq desvenlafaxine
- _____ Provigil modafinil
- _____ Prozac fluoxetine
- _____ Remeron mirtazapine
- _____ Rexulti brexpiprazole
- _____ Serzone nefazodone
- _____ Sinequan doxepin
- _____ Stavzor valproic acid
- _____ Symbyax olanzapine+fluoxetine
- _____ Tofranil imipramine
- _____ Trintellix vortioxetine
- _____ Viibryd vilazodone
- _____ Vivactil protriptyline
- _____ Wellbutrin bupropion
- _____ Zoloft sertraline

Anti-Anxiety

- _____ Ativan lorazepam
- _____ Buspar buspirone
- _____ Klonopin clonazepam
- _____ Librium chlorazepoxide
- _____ Niravam alprazolam
- _____ Restoril temazepam
- _____ Serax oxazepam
- _____ Tranxene clorazepate
- _____ Valium diazepam
- _____ Vistaril hydroxyzine Pamoate
- _____ Xanax alprazolam

Mood Stabilizers

- _____ Carbatrol carbamazepine
- _____ Celontin mesuximide
- _____ Depakote divalproic acid
- _____ Dilantin phenoin Na
- _____ Equatro carbamazepine
- _____ Felbatol felbamate
- _____ Gabitril tiagabine
- _____ Keppra levetiracetam
- _____ Lamictal lamotrigine
- _____ Latuda lurasidone
- _____ Lithium
- _____ Mysoline primidone
- _____ Neurontin gabapentin
- _____ Oxtellar XR oxcarbazepine
- _____ Phenobarbital
- _____ Saphris asenapine
- _____ Stavzor valproic acid
- _____ Tegretol carbamazepine
- _____ Topamax topiramate
- _____ Trokendi XR topiramate
- _____ Trileptal oxcarbazepine
- _____ Vraylar cariprazine
- _____ Zarontin ethosuximide
- _____ Zonegran zonisimide

Anti-Psychotics

- _____ Abilify aripiprazole
- _____ Clozaril clozapine
- _____ Cogentin benzatropine
- _____ FanApt iloperidone
- _____ Geodon ziprasidone
- _____ Haldol haloperidol
- _____ Invega paliperidone
- _____ Latuda lurasidone
- _____ Loxitane loxapine
- _____ Mellaril thiondazine
- _____ Moban molindone
- _____ Navane thiothixene
- _____ Prolixin fluphenazine
- _____ Risperdal risperdone
- _____ Seroquel quetiapine
- _____ Stelazine trifluoperazine
- _____ Symbyax olanzapine+fluoxetine
- _____ Thorazine chlorpromazine
- _____ Trilafon perphenazine
- _____ Zyprexa olanzepine

Attention Deficit Stimulants

- _____ Dextroamphetamine + amphetamine salts
- _____ Adderall
- _____ Adderall XR
- _____ Concerta methylphenidate
- _____ Cylert
- _____ Daytrana methylphenidate
- _____ Dexadrine dextroamphetamine
- _____ Evekeo amphetamine sulfate
- _____ Focalin dexmethylphenidate
- _____ Focalin XR dexmethylphenidate
- _____ Metadate methylphenidate
- _____ Methylin methylphenidate
- _____ Methylphenidate
- _____ Quillivant
- _____ Ritalin methylphenidate
- _____ Vyvanse lisdexamfetamine dimelylate
- _____ Zenzedi dextroamphetamine sulfate

Attention Deficit Non-stimulants

- _____ Clonidine (ER)
- _____ Guanfacine
- _____ Intuniv guanfacine
- _____ Kapvay clonidine
- _____ Strattera atomoxetine
- _____ Vayarin

Insomnia/Sleep

- _____ Ambien zolpidem
- _____ Dalmane flurazepam
- _____ Doxepin
- _____ Edular zolpidem
- _____ Lunesta eszoplidone
- _____ Restoril temazepam
- _____ Rozerem ramelteon
- _____ Silenor doxepin hcl
- _____ Sonata zaleplon
- _____ Trazodone

**Early Cognitive Delay-
Alzheimers/Dementia**

- _____ Aricept donepezil
- _____ Cerefolin NAC
- _____ Cognex tacrine
- _____ Exelon rivastigmine
- _____ Lycoremime galantamine
- _____ Metanx (B6-B9-B12)
- _____ Namenda memantine
- _____ Razadyne galantamine
- _____ Reminyl galantamine
- _____ Vayacog

Migraine Relief/Prevention

- _____ Amerge natatriptan
- _____ Axert
- _____ Frova frovatriptan
- _____ Imtrex sumatriptan
- _____ Keppra levetiracetam
- _____ Lamictal lamotrigine
- _____ Prinivil lisinopril
- _____ Midrin
- _____ Neurontin gabapentin
- _____ Relpax eletriptan
- _____ Topamax topiramate
- _____ Treximet sumatriptan/naproxen na
- _____ Zomig zolmitriptan

Pain

- _____ Amrix
- _____ Anaprox
- _____ Butalbital
- _____ Butrans Patch
- _____ Codeine
- _____ Darvocet
- _____ Esgic
- _____ Fentanyl Patch
- _____ Fiorcet
- _____ Flexeril
- _____ Hydrocodone
- _____ Ketamine
- _____ Lorcet
- _____ Lortab
- _____ Lorzone
- _____ Lyrica
- _____ Morphine
- _____ Naprosyn
- _____ Noreco
- _____ Opana
- _____ Oxycodone
- _____ Oxycontin
- _____ Percocet
- _____ Phrenilin
- _____ Soma
- _____ Stadol
- _____ Suboxone
- _____ Subutex
- _____ Ultracet
- _____ Ultram
- _____ Vicodin
- _____ Zanaflex
- _____ Zydone

HOPE SPEAKS, PLLC

1200 East Collins Blvd. Suite 300 Richardson TX 75081 Phone 972-669-1733 Secure fax 972-644-7056

HEALTH HISTORY QUESTIONNAIRE

Date: _____ * **MEDICATION ALLERGIES:** _____

Name: _____ M / F Age _____ DOB _____ CHART# _____

Current Non-Psychiatric Medications and Dosages:

Social History: Alcohol _____ Tobacco _____ Other Drugs (list) _____

Family Health History: _____

*** Please check any symptoms or disorders that you have either past or present

Constitutional	Fever <input type="checkbox"/> Y <input type="checkbox"/> N	Weight Gain <input type="checkbox"/> Y <input type="checkbox"/> N	Renal/Urological Gynecologic	Difficulty urinating <input type="checkbox"/> Y <input type="checkbox"/> N
	Weight Loss <input type="checkbox"/> Y <input type="checkbox"/> N	Night Sweats <input type="checkbox"/> Y <input type="checkbox"/> N		History of urinary tract infection <input type="checkbox"/> Y <input type="checkbox"/> N
Head and Neck	Insomnia <input type="checkbox"/> Y <input type="checkbox"/> N	Other <input type="checkbox"/> Y <input type="checkbox"/> N	Musculoskeletal	Sexual dysfunction <input type="checkbox"/> Y <input type="checkbox"/> N
	Visual Changes <input type="checkbox"/> Y <input type="checkbox"/> N	Eye pain <input type="checkbox"/> Y <input type="checkbox"/> N		Other <input type="checkbox"/> Y <input type="checkbox"/> N
Connective Tissue Disease	Nasal bleeds <input type="checkbox"/> Y <input type="checkbox"/> N	Sore throat <input type="checkbox"/> Y <input type="checkbox"/> N	Neurological	Joint Pain <input type="checkbox"/> Y <input type="checkbox"/> N
	Hoarseness <input type="checkbox"/> Y <input type="checkbox"/> N	Pain in gums <input type="checkbox"/> Y <input type="checkbox"/> N		Back Pain <input type="checkbox"/> Y <input type="checkbox"/> N
Respiratory	Ear pain <input type="checkbox"/> Y <input type="checkbox"/> N	Hearing Loss <input type="checkbox"/> Y <input type="checkbox"/> N	Endocrine	Joint swelling <input type="checkbox"/> Y <input type="checkbox"/> N
	Other <input type="checkbox"/> Y <input type="checkbox"/> N	Other <input type="checkbox"/> Y <input type="checkbox"/> N		Other <input type="checkbox"/> Y <input type="checkbox"/> N
Cardiovascular	Lupus <input type="checkbox"/> Y <input type="checkbox"/> N	Scleroderma <input type="checkbox"/> Y <input type="checkbox"/> N	Hematological	Headaches <input type="checkbox"/> Y <input type="checkbox"/> N
	Rheumatoid/Osteo Arthritis <input type="checkbox"/> Y <input type="checkbox"/> N	Sjogren's <input type="checkbox"/> Y <input type="checkbox"/> N		Other <input type="checkbox"/> Y <input type="checkbox"/> N
Gastrointestinal	Other <input type="checkbox"/> Y <input type="checkbox"/> N	Other <input type="checkbox"/> Y <input type="checkbox"/> N	Immunological	Seizure <input type="checkbox"/> Y <input type="checkbox"/> N
	Difficulty Breathing <input type="checkbox"/> Y <input type="checkbox"/> N	Hemoptysis <input type="checkbox"/> Y <input type="checkbox"/> N		Weakness <input type="checkbox"/> Y <input type="checkbox"/> N
Gastrointestinal	Cough <input type="checkbox"/> Y <input type="checkbox"/> N	Wheezing <input type="checkbox"/> Y <input type="checkbox"/> N	Endocrine	Difficulty speaking <input type="checkbox"/> Y <input type="checkbox"/> N
	Other <input type="checkbox"/> Y <input type="checkbox"/> N	Other <input type="checkbox"/> Y <input type="checkbox"/> N		Other <input type="checkbox"/> Y <input type="checkbox"/> N
Cardiovascular	Chest Pain <input type="checkbox"/> Y <input type="checkbox"/> N	Palpitations <input type="checkbox"/> Y <input type="checkbox"/> N	Hematological	Frequent Urination <input type="checkbox"/> Y <input type="checkbox"/> N
	Feet/legs Swelling <input type="checkbox"/> Y <input type="checkbox"/> N	Other <input type="checkbox"/> Y <input type="checkbox"/> N		Fatigue <input type="checkbox"/> Y <input type="checkbox"/> N
Gastrointestinal	Difficulty Swallowing <input type="checkbox"/> Y <input type="checkbox"/> N	Vomiting <input type="checkbox"/> Y <input type="checkbox"/> N	Immunological	Excessive Thirst <input type="checkbox"/> Y <input type="checkbox"/> N
	Diarrhea <input type="checkbox"/> Y <input type="checkbox"/> N	Constipation <input type="checkbox"/> Y <input type="checkbox"/> N		Other <input type="checkbox"/> Y <input type="checkbox"/> N
Gastrointestinal	Abdominal Pain <input type="checkbox"/> Y <input type="checkbox"/> N	Indigestion/ Heart Burn <input type="checkbox"/> Y <input type="checkbox"/> N	Immunological	Hives <input type="checkbox"/> Y <input type="checkbox"/> N
	Other <input type="checkbox"/> Y <input type="checkbox"/> N	Other <input type="checkbox"/> Y <input type="checkbox"/> N		Allergy to foods <input type="checkbox"/> Y <input type="checkbox"/> N
Gastrointestinal	Other <input type="checkbox"/> Y <input type="checkbox"/> N	Other <input type="checkbox"/> Y <input type="checkbox"/> N	Immunological	Other <input type="checkbox"/> Y <input type="checkbox"/> N
	Other <input type="checkbox"/> Y <input type="checkbox"/> N	Other <input type="checkbox"/> Y <input type="checkbox"/> N		Other <input type="checkbox"/> Y <input type="checkbox"/> N

1. Have you ever been hospitalized overnight? Y N if yes why? _____
2. Have you ever had surgery? Y N if yes, Why? _____
3. Have you ever had racing of your heart or skipped heartbeats? Y N
4. Have you had high blood pressure or high cholesterol? Y N
5. Have you ever been told you have a heart murmur? Y N When was your last EKG? _____ results? _____
6. Has any family member or relative died of heart problems or of sudden death before age 50? Y N
7. Has a physician ever denied or restricted your participation in sports for any heart problems? Y N
8. Have you ever had a head injury or concussion? Y N If yes, when? _____ CT or MRI? when? _____
9. Have you ever been knocked out, become unconscious, or lost your memory? Y N if yes, When? _____
10. Have you ever had a seizure? Y N if yes, when was last EEG or MRI? _____ results? _____
11. Do you have frequent or severe headaches? Y N
12. Have you ever had numbness or tingling in your arms, hands, legs, or feet? Y N
13. Have you ever had a stinger, burner, or pinched nerve? Y N
14. Have you had any problems with your eyes or vision? Y N
15. Do you wear glasses, contacts, or protective eyewear? Y N
16. Do you want to weigh more or less than you do now? Y N
17. Do you feel stressed out? Y N
18. Have you ever had respiratory, cardiovascular, or gastrointestinal disorder? Y N if yes, What? _____
19. Have you ever had any renal, urological, musculoskeletal, neurological, or an endocrine disorder? Y N if yes, What? _____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of patient _____

Date _____

Signature of parent/guardian _____

Date _____

Initial Information Form - Your Life in Review

HOPE SPEAKS, PLLC

1200 East Collins Blvd. Ste 300, Richardson, TX 75081
Office Phone # 972-669-1733 Secure Fax # 972-644-7056

A ONE PAGE DIGEST ON EVERYTHING I WOULD WANT OTHERS TO KNOW ABOUT WHO I AM.

Please take a few moments to fill out this form as complete as possible. From this history, valuable information may be realized by examining areas such as the **PRESENTING PICTURE** (current symptoms and what precipitated them), the HISTORY OF **PRESENT PROBLEMS** (current symptoms), the **PAST HISTORY** (past issues that may be important now), and the **DYNAMIC FORMULATION** (your own attempt to put all of this information together). In brief, this is what your life has been. You can work toward changing it to what you want it to be.

Name: _____ Date: _____ Chart #: _____

Briefly describe why you are here:

I. PRESENTING PICTURE (Current symptoms and what precipitated them)

I am a _____ year old [male] or [female] from _____ (city). If I had to describe my one major symptom, it would be **Depression** **Anxiety**, **Obsessive Worries**, **Panic Attacks**, **Times of Confusion**, **Drug Abuse**, **Inattention/Hyperactivity**, **Mood Swings** **Loss of Memory**, **Other**: _____.

The major stressor(s) that precipitated my symptom is/are: **Marital Issues**, **Parent/Child Issues**, **Job Issues**, **Health Issues**, **Relationship Issues**, **Financial Issues**, **Issues of Past**: (**Guilt**, **Abuse**, **Family or Origin** (adoption issues)) **Other**: (please specify) _____ / _____

My symptom(s) began: _____ (date). My symptom(s) increased: _____ (date). My three biggest worries in life at the present time are:

1. _____ 2. _____ 3. _____

I am currently taking the following prescribed medications: (please list Psychiatric medications first)

Medicine & Dose	Date Began	Side Effects	Results (good, bad, etc)	Doctor's Name
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

I am also currently taking the following over the counter medications or vitamin/mineral supplements: _____

II. HISTORY OF PRESENT PROBLEM: Current Symptoms (check all that apply) *If symptoms were present before medicine please specify.

Occ'l	Weekly	Daily	Depression & Anxiety	Occ'l	Weekly	Daily	Depression & Anxiety (cont'd)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Increased Crying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intense Fear
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sad Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart Beat
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lack of Motivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Increased Sweating
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Pattern (More) or (Less)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Trembling
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Appetite Changes ↑ or ↓	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight Changes ↑ or ↓	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Withdrawn
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lack of Interest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nightmares
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Decreased Self Esteem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sad Affect	<u>OTHER SYMPTOMS</u>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hopeless / Helpless Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inattention
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Energy Level ↑ or ↓	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest Discomfort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Delusions/Paranoia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal (Stomach) Distress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinations (hearing voices-music that no one else hears, seeing things no one else sees)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling Dizzy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High with Racing Thoughts, Increased Speech, Decreased Sleep, and Increased Activity
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fear of Going Crazy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Isolating self from all contact with others
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Startled Response	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Amnesia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chills or Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Running Away
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Outburst of Anger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Truancy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety in General	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Memory impaired with trouble organizing & sequencing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Restlessness, Keyed Up, Fatigued, Decreased Concentration, Irritability, Muscle Tension, Decreased Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Somatization - undue health worries with adequate medical explanation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypervigilance - excessive attention & focus on all internal and external stimuli	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Agitated - Irritable (easily annoyed provoked to anger)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Obsessions / Compulsions-constant checking, washing, or counting type behaviors; unrelenting worries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance Abuse (including but not limited to drugs or alcohol)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Avoidance of stimuli associated with trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drugs you've used: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Agoraphobia - anxiety of places or inescapable situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Behavioral Problems: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specific Phobia - marked & persistent fear of social or performance situations where embarrassment may occur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Developmental Problems: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post Traumatic Stress Experience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Self-Mutilation: _____
	<input type="checkbox"/>	<input type="checkbox"/>	YES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Legal Issue(s): _____
	<input type="checkbox"/>	<input type="checkbox"/>	NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Issue(s): _____
	<input type="checkbox"/>	<input type="checkbox"/>	SUICIDE IS A DEFINITE POSSIBILITY NOW	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating Issue(s): _____
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Impulsive
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aphasia, Apraxia, Agnosia

III. PAST HISTORY

- A. Have you had similar and significant symptom(s) in the past? YES NO. If yes, when: _____
Did they recently increase? YES NO What caused the increase? _____
- B. Name 3 past stressful events in your life that precipitated the original symptom(s): _____

- C. Prior Psychiatric Hospitalization? YES NO Where: _____
Reason Hospitalized: _____ Date(s): _____
Prior Outpatient Counseling: YES NO Therapist _____ Date(s): _____
- D. Substance Abuse History? YES NO When began? _____ Substances: _____ Drug of choice: _____
Any treatment YES NO Facility: _____ Date(s) _____
- E. Birth and Early Development was Normal Abnormal if abnormal explain: _____
- F. My childhood was overall: Painful Uneventful Good
- G. History of: Abuse School Problems Abandonment Relationship Problems Disability Job Problems Legal Other: _____
- H. Family of Origin Issues:
 - 1. Father- what was he like? _____
 - 2. Mother- what was she like? _____
 - 3. Brothers / Sisters - how many of each? _____
 - 4. Where did you fit in birth order? _____
 - 5. What type of relationship did you have with you siblings? _____
 - 6. School History - what type of grades? _____ How many years? _____
College? (where/degrees): _____
 - 7. Marriages - How many? _____ What types of stress in marriage(s)? _____
 - 8. Children - How many? _____ Ages and sex of each? _____
- I. Psychiatric History - Name of past Psychiatrist and/or Therapist: _____
- J. Name of referral source to the clinic: _____
- K. Job History & Current Job: _____
- L. Religious History: _____

M. Past & Current History Summary:

I grew up in _____ (state). I grew up in the country a small town a large city. Both parents { were} { were not} in the home. I was one of _____ children and was # _____ in the birth order. My childhood was good difficult very difficult in the sense of _____. My teen years were good difficult very difficult in the sense of _____. In high school my life revolved around sports, work, church, social, academics other: _____. After high school I { did} did not attend college. After high school life has been good difficult very difficult in the sense of _____.

I am currently single married for _____ years. I have been married _____ time(s). I { do not have} { do have} _____ children. I presently live alone with spouse with parents other (name) _____. My current support system is good fair poor. I { do not have} { do have} health problems. (List any past or present problems: _____) Life now centers around family work friends other: _____. Recently life has been good difficult very difficult in the sense of _____.

IV. DYNAMIC FORMULATION: (putting it all together)

Several factors may be involved in why I am in my current state of mind. First, a [1] **Current Stressful Life Event** of relationship issue(s) Job/School issue(s) Health issue(s) Financial issue(s) Other: _____ (name) has been present. Second, under stress I tend to turn to the [2] **DEFENSE MECHANISM** of Interjection of my emotions Denial of my emotions Suppression / Repression of emotions Acting out Rationalization Projection of my emotions onto others Undue health worries Withdrawal into my own world Passive behavior Other Defenses of _____. Third, with my [3] **PERSONALITY** of being: Perfectionistic Emotional Suspicious Idealizing then devaluating others: Having few or no friends Living in my own world Low self-confidence self-centered Eccentric Withdrawn and depressed Alternating moods from high to low Other personality issue(s): _____. Fourth, my [4] **EARLY LIFE** is an important factor in that it was good difficult very difficult with Abuse issue(s) of some kind (verbal, physical, sexual) Abandonment issue(s) Self image issue(s) Other issue(s): _____. Fifth, [5] **GENETIC FACTORS** { do not } { do } seem to contribute in that a relative(s) of mine (name): _____ had _____. Last, in spite of all of the above, my [6] **SPIRITUAL LIFE** { has} { has not} been a factor in the sense that _____. By putting all of the above together, insight into my life may emerge.

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM. This information will be utilized to assist in your treatment.
HOPE SPEAKS, PLLC
 1200 East Collins Blvd. Ste. 300 Richardson, TX 75081
 Office phone # 972-669-1733 Secure Fax # 972-644-7056

Name _____ age: _____ Date _____

Completed by: patient parent: _____ other _____

ADHD QUESTIONNAIRE:

(Check all with either yes or no)

- Yes No I have significant inattention.
- Yes No My inattention is to the degree that I have trouble functioning at work, school, and home.
- Yes No Although I have compensated, my inattention symptoms have been present before age 12.
- Yes No I also have hyperactivity and/or impulsivity.

ABBREVIATED ADHD SYMPTOMS CHECKLIST

Directions: Indicate the degree to which each item below is a problem. Please respond to all items by circling a number

	Never	At least once MONTHLY (Sometimes)	At least once WEEKLY (Often)	At least once DAILY (Very Often)
1. Doesn't pay attention to details; makes careless mistakes.....	1	2	3	4
2. Difficulty paying attention.....	1	2	3	4
3. Does not seem to listen.....	1	2	3	4
4. Difficulty following instructions; Does not finish things.....	1	2	3	4
5. Difficulty getting organized.....	1	2	3	4
6. Avoids doing things that require a lot of mental effort.....	1	2	3	4
7. Loses things.....	1	2	3	4
8. Easily distracted.....	1	2	3	4
9. Forgetful.....	1	2	3	4
10. Fidgets with hands or feet; squirms in seat.....	1	2	3	4
11. Difficulty remaining seated.....	1	2	3	4
12. Runs about or climbs on things.....	1	2	3	4
13. Difficulty playing quietly.....	1	2	3	4
14. "On the Go", Act as if "Driven by a motor".....	1	2	3	4
15. Talks excessively.....	1	2	3	4
16. Blurts out answers to questions.....	1	2	3	4
17. Difficulty awaiting turn.....	1	2	3	4
18. Interrupts others or butts into their activities.....	1	2	3	4

Hope Speaks, PLLC

1200 E. Collins Blvd. Ste.300 Richardson TX 75081 P: 972-669-1733 F: 972-669-1403

Name: _____

Date: _____

Self Rating Report of Symptoms

0-----1-----5-----10
Not significant Present a small amount Present most of the As severe as
most of the time. of the time time, to a significant degree possible.

- | | | |
|-----------------------------|-------|---|
| 1. Upset | _____ | Flustered, Distressed, Feel Bothered |
| 2. Depression | _____ | Blue, Sad, Down Feeling |
| 3. Anxiety | _____ | Nervous, Tense, Apprehensive |
| 4. Insomnia | _____ | Difficulty Falling and Staying Asleep |
| 5. Low Energy | _____ | Tired, Fatigued |
| 6. Anger | _____ | Irritability, Anger, Frustrated |
| 7. Low Motivation | _____ | Low Interests |
| 8. Manic | _____ | Overly High, Energetic, Poor Judgement, Rapid Thinking |
| 9. Inattention | _____ | Trouble Paying Attention, Distractible, Forgetful |
| 10. Behavior Problems | _____ | (Specify) _____ |
| 11. Hyperactivity | _____ | Hyperactive, Fidget, Squirm |
| 12. OCD | _____ | Repetitive, Irrational Worry or Actions |
| 13. Trouble Functioning | _____ | At Work, Socially |
| 14. Dysthymia | _____ | Sad Mood Most Days For Last 2 Years |
| 15. Stressor Severity | _____ | Briefly List: _____
(Current Stressors, Changes, & Events) |
| 16. Worry | _____ | |
| 17. Pain | _____ | (Specify) _____ |
| 18. Mood Swings | _____ | Drastic Changes in Mood |
| 19. Decreased Cognition | _____ | Difficulty thinking, Decreased Ability to retain or learn information |
| 20. Auditory Hallucinations | _____ | Hearing things that are not there |
| 21. Visual Hallucinations | _____ | Seeing things that are not there |
| 22. Paranoia | _____ | Intense suspicion or exaggerated distrust of others |