DR# _____

CHART#_____

HOPE SPEAKS, PLLC
PATIENT INFORMATION

Please print and provide complete information.

LAST NAME: _____ FIRSTNAME: _____ 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 payers 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 therapists 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.

ACKNOWLEDGMENT 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 hat you will be treated by one of the other qualified providers for your follow up appointments.

PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

HOPE SPEAKS, PLLC
NOTICE of PRIVACY PRACTICES

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.

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, and in, or facilitate the collection of data for purposes. Such information may be released to insurance companies, HMO's and PPO's managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions. Medical records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for your medical care of the payment thereof.

We may use or disclose your protected health information to send your treatment or healthcare operations communications concerning treatment alternatives or other health related products or services. We may provide such communications to you in instances where we receive financial remuneration from a third party in connection with such communications. You have the right to opt out of receiving any such compensated communications, and should inform us if you do not wish to receive them. Additionally, if we send such communications, the communications themselves note that we have received compensation for the communication, and will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future. We may use and disclose limited amounts of your protected health information to send you fund raising materials. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

Other that expressly provided herein, any other disclosures of your protected health information will require your specific authorization. Most disclosures of protected health information for which we would receive compensation would require your authorization. Additionally, we would need your specific authorization for most disclosures of your protected health information to the extent it constitutes "psychotherapy notes" or is for marketing purposes.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy, and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office. As stated above, in most instances we do not have to abide by your request for restrictions of disclosures, we will be obligated to abide them. Specifically, if you pay for an item or service in full, out of pocket, and request that we do not disclose the information relating to that service to a health plan, we will be obligated to abide by that restriction. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information {such as a pharmacy filling a prescription}. It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket {and which would not be subject to the restriction}.

To the extent that this office maintains your Protected Health Information {PHI} in an electronic health record, we agree to account for all disclosures of such PHI upon your request for a period of at least three {3} years prior to such request, as required by HIPAA and HITECH regulations.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information. In certain instances, we may be obligated to notify you {and potentially other parties} if we become aware that your protected health information has been improperly disclosed or otherwise subject to a "breach" as defined by HIPAA.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. No retaliation will be made against you by this office because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

You may speak with the Office Manager to obtain additional information regarding any questions you may have concerning this notice or to receive a printed copy of the notice. This Notice of Privacy Practices is effective as of August 1, 2015

Patient/Guardian Signature: _____ **Date:** _____

Patient's Printed Name: _____

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 $35.00 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**

HOPE SPEAKS, PLLC 1200 EAST COLLINS BLVD. STE 300 RICHARDSON, TX 75081 PHONE 972-669-1733 SECURE FAX 972-644-7056

Chart # _____

MEDICATION CHECKLIST

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, side effects, made dizzy, gained weight, headaches, etc.

Anti-Depressants

Anafranil_clomiprimine
Brintellix_vortioxetine
Celexa_citalopram
Cymbalta_duloxetine
Deplin_Lmethylfolate
Desyrel_trazodone
Effexor_venlafaxine
Elavil_amitriptyline
Fetzma_levomilnacipra
Lexapro_escitalopram
Ludiomil_maprotiline
Luvox_maprotiline
Nardil_phenelzine
Nuvigil_armodafinil
Pamelor_nortriptyline
Parnate_tranylcyromine
Paxil_paroxetine
Pristiq_desvenlafaxine
Provigil_modafinil
Prozac_fluoxetine
Remeron_mirtazapine
Serzone_nefazodone
Sinequan_doxepin
Stavzor_valproic acid
Symbyax_olanzapine+fluoxetine
Tofranil_imipramine
Viibryd_vilazodone
Vivactil_protriptyline
Wellbutrin_bupropion
Zoloft_sertraline

Anti-Anxiety

Atavan_lorazepam
Buspar_buspirone
Klonopin_clonazepam
Librium_chloradiazipoxide
Niravam_alprazolam
Restoril_temazepam
Serax_oxazepam
Tranxene_clorazepate
Valium_diazepam
Vistaril_hydroxyzine Pamoate
Xanax_alprazolam

Insomnia/Sleep

Ambien_zolpidem
Dalmane_flurazepam
Doxepin_
Edular_zolpidem
Lunesta_eszoplidone
Restoril_temazepam
Rozerem_ramelteon
Silenor_doxepin hcl
Sonata_zaleplon
Trazedone_

Mood Stabilizers

Carbatrol_carbamazepine
Celontin_mesuximide
Depakote_divalproic acid
Dilantin_phentoin Na
Equatro_carbamazepine
Gabitril_tiagabine
Keppra_levetiracetam
Lamictal_lamotrigine
Lithium_
Mysoline_primidone
Nerontin_gabapentin
Phenobarbital_
Saphris_asenapine
Stavzor_valproic acid
Tegretol_carbamazepine
Topomax_topirimate
Trileptal_oxycrabamazepine
Zarontin_ethosuximide
Zonegran_zonisimide

Anti-Psychotics

Abilify_ariprazole
Clozaril_clozapine
Cogentin_benzatropine
FanApt_iloperidone
Geodon_ziprasidone
Haldol_haloperidol
Latuda_luvasidone
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 +

Adderall_amphetamine salts
Adderall_XR
Concerta_methylphenidate
Cylert_
Daytrana_methylphenidate
Dexadrine_dextroamphetamine
Focalin_dexmethylphenidate
Focalin_XR_dexmethylphenidate
Metadate_methylphenidate
Methylin_methylphenidate
Methylphenidate_
Quillivant_
Ritalin_methylphenidate
Vyvanse_lisdexamfetamine dimelylate

Attention Deficit Non-stimulants

Clonidine (ER)
Guanfacine
Intuniv_guanfacine
Kapvay_clonidine
Strattera_atomoxetine
Vayarin_

Early Cognitive Delay - AlzheimersDementia

Aricept_donepezil
Cerefolin NAC_
Cognex_tacrine
Exelon_rivastigmine
Lycoremine_galantamine
Metanx_(B6-B9-B12)
Namenda_memantine
Razadyne_galantamine
Reminyl_galantamine
Vayacog_

Migraine Relief/Prevention

Amerge_natatriptan
Axert_
Frova_frovatripan
Imitrex_sumatriptan
Keppra_levetiracetamir
Lamictal_tamotrigine
Prinivil_lisinopril
Midrin_
Neurontin_gabapentin
Relpax_eletriptan
Topamax_topiramate
Treximate_sumatriptan/naprxen na
Zomig_zolmitriptan

Pain

Amrix_
Anaprox_
Butalbital_
Butrans Patch_
Codeine_
Darvocet_
Esgic_
Fentanyl Patch_
Fiorcet_
Flexeril_
Hydrocodone_
Ketamine_
Lorcet_
Lortab_
Lorzone_
Lyrica_
Morphine_
Naprosyn_
Norco_
Opana_
Oxycodone_
Oxycontin_
Percocet_
Phrenilin_
Soma_
Stadol_
Suboxone_
Subutex_
Ultracet_
Ultram_
Vicodin_
Zanaflex_
Zydone_

HOPE SPEAKS, PLLC **1200 EAST COLLINS BLVD. STE 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#:** _____

Address: _____ **Phone #:** _____

Current 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 ☐Y ☐N; Weight Gain ☐Y ☐N; Weight Loss ☐Y ☐N; Night Sweats ☐Y ☐N; Insomnia ☐Y ☐N; Other ☐Y ☐N _____	**Renal/Urological Gynecologic**	Difficulty Urinating ☐Y ☐N; History of urinary tract infection ☐Y ☐N; Sexual Dysfunction ☐Y ☐N; Other ☐Y ☐N _____
Head and Neck	Visual Changes ☐Y ☐N; Eye Pain ☐Y ☐N; Nasal Bleeds ☐Y ☐N; Sore Throat ☐Y ☐N; Hoarseness ☐Y ☐N; Pain in Gums ☐Y ☐N; Ear Pain ☐Y ☐N; Hearing Loss ☐Y ☐N; Other ☐Y ☐N _____	**Musculoskeletal**	Joint Pain ☐Y ☐N; Back Pain ☐Y ☐N; Joint Swelling ☐Y ☐N; Other ☐Y ☐N _____
Connective Tissue Disease	Lupus ☐Y ☐N; Scleroderma ☐Y ☐N; Rheumatoid/Osteo Arthritis ☐Y ☐N; Sjogren's ☐Y ☐N; Other ☐Y ☐N _____	**Neurological**	Headaches ☐Y ☐N; Seizure ☐Y ☐N; Weakness ☐Y ☐N; Difficulty Speaking ☐Y ☐N; Other ☐Y ☐N _____
Respiratory	Difficulty breathing ☐Y ☐N; Hemoptysis ☐Y ☐N; Cough ☐Y ☐N; Wheezing ☐Y ☐N; Other ☐Y ☐N _____	**Endocrine**	Frequent Urination ☐Y ☐N; Fatigue ☐Y ☐N; Excessive Thirst ☐Y ☐N; Other ☐Y ☐N _____
Cardiovascular	Chest Pain ☐Y ☐N; Palpitations ☐Y ☐N; Feet/legs Swelling ☐Y ☐N; Other ☐Y ☐N _____	**Hematological**	Anemia ☐Y ☐N; Easy Bruising ☐Y ☐N; Other ☐Y ☐N _____
Gastrointestinal	Difficulty Swallowing ☐Y☐N; Vomiting ☐Y☐N; Diarrhea ☐Y☐N; Constipation ☐Y☐N; Abdominal Pain; Indigestion/ Heart Burn ☐Y☐N; Other ☐Y ☐N	**Immunological**	Hives ☐Y ☐N; Allergy to foods ☐Y ☐N; Other ☐Y ☐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 of skipped beats? ☐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 any 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 eye-wear ☐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 questions above 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
☐	☐	☐	Increased Crying
☐	☐	☐	Sad Mood
☐	☐	☐	Lack of Motivation
☐	☐	☐	Sleep Pattern (More) or (Less)
☐	☐	☐	Appetite Changes ↑ or ↓
☐	☐	☐	Weight Changes ↑ or ↓
☐	☐	☐	Lack of Interest
☐	☐	☐	Decreased Self Esteem
☐	☐	☐	Sad Affect
☐	☐	☐	Hopeless / Helpless Feeling
☐	☐	☐	Enery Level ↑ or ↓
☐	☐	☐	Chest Discomfort
☐	☐	☐	Abdominal (Stomach) Distress
☐	☐	☐	Feeling Dizzy
☐	☐	☐	Fear of Going Crazy
☐	☐	☐	Startled Response
☐	☐	☐	Chills o Hot Flashes
☐	☐	☐	Outburst of Anger
☐	☐	☐	Anxiety in General
☐	☐	☐	Restlessness, Keyed Up, Fatigued, Decreased Concentration, Irritability, Muscle Tension, Decreased Sleep
☐	☐	☐	Hyperviligance - excessive attention & focus on all internal and external stimuli
☐	☐	☐	Obsessions / Compulsions-constant checking, washing, or counting type behaviors; unrelenting worries
☐	☐	☐	Avoidance of stimuli associated with trauma
☐	☐	☐	Agoraphobia - anxiety of places or inescapable situations
☐	☐	☐	Specific Phobia - marked & persistent fear of social or performance situations where embarrassment may occur
☐	☐	☐	Post Traumatic Stress Experience
	YES	NO	
	☐	☐	SUICIDE IS A DEFINITE POSSIBILITY NOW

Occ'l	Weekly	Daily	Depression & Anxiety (cont'd)
☐	☐	☐	Intense Fear
☐	☐	☐	Rapid Heart Beat
☐	☐	☐	Increased Sweating
☐	☐	☐	Trembling
☐	☐	☐	Shortness of Breath
☐	☐	☐	Withdrawn
☐	☐	☐	Nightmares
☐	☐	☐	Other: _____
			OTHER SYMPTOMS
☐	☐	☐	Inattention
☐	☐	☐	Hyperactivity
☐	☐	☐	Delusions/Paranoia
☐	☐	☐	Hallucinations (hearing voices-music that no one else hears, seeing things no one else sees)
☐	☐	☐	High with Racing Thoughts, Increased Speech, Decreased Sleep, and Increased Activity
☐	☐	☐	Isolating self from all contact with others
☐	☐	☐	Amnesia
☐	☐	☐	Running Away
☐	☐	☐	Truancy
☐	☐	☐	Memory impaired with trouble organizing & sequencing
☐	☐	☐	Somatization - undue health worries with adequate medical explanation
☐	☐	☐	Agitated - Irritable (easily annoyed provoked to anger)
☐	☐	☐	Substance Abuse (including but not limited to drugs or alcohol)
☐	☐	☐	Drugs you've used: _____
☐	☐	☐	Behavioral Problems: _____
☐	☐	☐	Developmental Problems: _____
☐	☐	☐	Self-Mutilation: _____
☐	☐	☐	Legal Issue(s): _____
☐	☐	☐	Sexual Issue(s): _____
☐	☐	☐	Eating Issue(s): _____
☐	☐	☐	Impulsive
☐	☐	☐	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 you 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 your siblings? _____
6. School History - what type of grades? _____ How many years? _____ College? (where/degrees:) _____
7. Marriages - How many? _____ What types of stress in marriage? _____
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. Past Psychiatric Medication(s):

Medicine & Dose	Year Given	How long taken	Side Effects	Results

L. Any past medical problems/Surgeries:
M. Job History & Current Job:
N. Religious History:
O. 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 I 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

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. Secondly, 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 _____. Thirdly, 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): _____. Fourthly, 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 issues ☐Self Image issue(s) ☐Other Issue(s): _____. Fifthly, **[5] GENETIC FACTORS** {☐do not} {☐do} seem to contribute in that a relative of mine (name): _____ had _____. Last, in spite of all of the above, my **[6] SPIRITUAL LIFE** {☐has} {☐has not} been a factor in seems in the sense of _____. 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.

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HOPE SPEAKS, PLLC

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Name _____ Age: _____ Date: _____

Completed by: ☐ patient ☐ parent: _____ ☐ other: _____

ADHD QUESTIONAIRE

(Check all with either yes or no.)

☐ Yes ☐ No I have significant inattention.

☐ Yes ☐ No My inattention is to the defree that I have trouble functioning at work, school, and home.

☐ Yes ☐ No Although I have compensated, my inattention symptoms have been present before age 7.

☐ 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

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Name:_____ Date:_____

Self Rating Report of Symptoms

0----------1----------5----------10

Not significant most of the time. | Present a small amount of the time | Present most of the time, to a significant degree | As severe as 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

Overall, Since Your Last Visit, Do You Feel? (Check One) _____Improved _____Same _____Worse

List ALL medications you are taking including over the counter and vitamins or supplements:

1. _____ 7._____
2. _____ 8._____
3. _____ 9._____
4. _____ 10._____
5. _____ 11._____
6. _____ 12._____