willow youth
MENTAL HEALTH

New Patient Questionnaire

Please carefully fill in this form prior to your first appointment. We appreciate your cooperation and patience.

Patient's Name: _____ **Date of Birth:**_____ **Date:**_____

Patient's Birthplace:_____ **Sex:** ❒ M ❒ F

Race: ❒ African-American ❒ Caucasian ❒ Latino ❒ Asian ❒ Native American ❒ other_____

Person completing this form:_____ **Relation to child:**_____

Who referred you?_____

- Please describe the reasons for which you are seeking help at this time.

- Approximately when did the problem(s) begin?

- Any known stress cause or contribute to the problem(s)? ❒ **yes** ❒ **no**
  *If yes, please describe:*_____

_____

Has the patient ever received outpatient mental health treatment? ❒ **yes** ❒ **no**
If yes, please list in order, including Psyhological or IQ/School testing:

Clinician/Doctor	Date(s) of Evaulation or Treatment	Type of Evaluation or Treatment	Frequency of visits

- Has the patient ever received inpatient mental health treatment? ❒ **Yes** ❒ **No**
  If yes, please in order

Hospital Name	Dates of Treatment	Reason for hospitalization

Has your child ever threatened or attempted suicide? ❒ **Yes** ❒ **No**
*If yes, please describe:*_____

_____

- Has your child ever had any brain imaging or functional studies? (MRI, CAT scan, EEG, etc.)
  ❒ **Yes** ❒ **No**

- If your child has ever taken psychiatric medications, please list them below: ❒ **Not applicable**

Rx Name	Reason Given	Highest Dose	% Improvement	Side Effects	Dates Taken

Family Psychiatric History: *(Please note ADHD, Learing Disorders, Depression, Bipolar Disorder, Anxiety Disorders, Obsessive-Compulsive Disorder, Tic/Tourette's, Schizophrenia, Drug or Alcohol Abuse, suicide attempts, or other Psychiatric problems.*

- Is there a history of ADHD, mental illness, mental retardation, learning problems, alcohol or drug abuse in the patient's grandparents, parents, siblings, or 1st cousins? ❒ **Yes** ❒ **No**

  If yes, please fill in the following chart:

Affected Family Member	Mental Illness or substance abuse	Treatment (if any)

Childhood Development:

- **Pregnancy** - please check any that apply to the mother's pregnancy with this child:

  ❒ Received prenantal care _____
  ❒ Drank alcohol during pregnancy _____
  ❒ Smoked during pregnancy _____
  ❒ **u**sed drugs during pregnancy _____
  ❒ Took medications _____
  ❒ Infection(s) _____
  ❒ Nausea or vomiting _____
  ❒ Severe emotional distress _____
  ❒ Elevated blood pressure _____
  ❒ Diabetes of pregnancy _____
  ❒ Pre-eclampsia _____
  ❒ Premature labor _____
  ❒ Threatened miscarriage _____

- **Birth History:**
  Mother's age at time of birth: _____ years old Father's age at time of birth: _____ years old

  Delivery was ❒ spontaneous vaginal ❒ induced ❒ Casearian section

  Any complications with labor or delivery ❒ **Yes** ❒ **No** _____

  Was the baby premature? ❒ **Yes** ❒ **No** _____

  Baby's birthweight: _____lbs _____oz

  Did the baby have any of the following:
  ❒ Breathing problem
  ❒ Cord around the neck
  ❒ Abnormal color
  ❒ Abnormal tone
  ❒ Meconium
  ❒ Failure to thrive
  ❒ Jaundice
  ❒ infection

- **Developmental Milestones** *(answer as best you can recall)*
  Motor Development (sitting, crawling, walking) ❒ Normal ❒ Fast ❒ Slow

  Speech and Language ❒ Normal ❒ Fast ❒ Slow

  Self-help skills (dressing, brushing, toileting, hygiene) ❒ Normal ❒ Fast ❒ Slow

- Temperament as Infant: ❒ Easy baby ❒ Slow to warm up ❒ Difficult/"colicky"

Medical History:

- Who is your child's Pediatrician or Family Doctor? _____
- When was your child's last physical examination? _____
- Current Medications (include over the counter medications, vitamins, herbs, or supplements)
  ❒ None or Please list:

Rx Name	Dosage	Frequency	Prescribing MD

- Does your child have any drug allergies?
- Does your child have any current medical problems?
- Please check and briefly describe if your child has experienced any of the following conditions:

❒ Surgeries _____
❒ Chest pain _____
❒ Abnormal heart rate or rhythm _____
❒ High Blood Pressure _____
❒ Seizures/Convulsions _____
❒ Staring spells

_____

❒ Head injury

_____

❒ Frequent Strep Throat infections

_____

❒ Frequent Headaches

_____

❒ Frequent Stomach Aches

_____

❒ Vision problems

_____

❒ Hearing problems

_____

❒ Significant accidents or injuries _____

❒ Bedwetting

_____

❒ Fecal soiling of clothes

_____

❒ Exposure to Lead or Mercury_____

Social History:

- Now living with: ❒ Both biological parents ❒ Bio Father ❒ Bio Mother ❒ Other:_____
- Other children in family:
  Names and ages: _____ _____

  _____ _____
- Is the child adopted? **❒ Yes** **❒ No**
  If yes, please describe the circumstances of the adoption:_____

  _____
- Has the patient ever experienced or witnessed any physical abuse, sexual abuse, or neglect?
  ❒ Yes **❒ No**
  *If yes, please briefly describe:*_____

  _____
- Hobbies/Interests:_____
- Any concerns about peer relationships/social skills?_____

School History:

- Name of School:_____ Grade:_____

Current Academic Performance…..	**❒ Good**	**❒ Fair**	**❒ Poor**
Past Academic Performance	**❒ Good**	**❒ Fair**	**❒ Poor**
Current Behavioral Performance	**❒ Good**	**❒ Fair**	**❒ Poor**
Past Behavioral Performance:	**❒ Good**	**❒ Fair**	**❒ Poor**

- Grades repeated:_____

- Is the child in any special education programs? ❒ **Yes** ❒ **No**

  *If yes, please explain:*_____

- Any known learning disabilities? ❒ **Yes** ❒ **No**

  *If yes, please explain:*_____

Legal Problems:

- Has your child ever been arrested or had legal charges? ❒ **Yes** ❒ **No**

*If yes, please explain:*_____

Substance Use:

- Do you suspect that your child has ever used tobacco, alcohol or drugs? ❒ **Yes** ❒ **No**

*If yes, please explain:*_____

Religious Beliefs:

❒None ❒Jewish ❒Muslim ❒Hindu ❒Christian
❒Other_____

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Consent for Text and Email

I, _____, hereby consent and state my preference to have staff at Willow Youth Mental Health communicate with me by email or standard SMS messaging regarding various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing.

I understand that email and standard SMS messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my medical care might be intercepted and read by a third party.

I prefer to receive SMS text messages and voice messages at the following number:_____

Signature Date

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MENTAL HEALTH

Name Date

Check if you have the following:

General:
- Fever/chills ❑ yes ❑ no
- Sweats ❑ yes ❑ no
- Fatigue/malaise ❑ yes ❑ no
- Weight loss ❑ yes ❑ no

Eyes:
- Vision changes ❑ yes ❑ no
- Eye irritation ❑ yes ❑ no
- Eye discharge ❑ yes ❑ no
- Vision Loss ❑ yes ❑ no
- Light sensitivity ❑ yes ❑ no
- Eye pain ❑ yes ❑ no

Cardiovascular:
- Chest pain ❑ yes ❑ no
- Bluish lips/nails ❑ yes ❑ no
- Difficulty breathing with exertion ❑ yes ❑ no
- Palpitations ❑ yes ❑ no
- Swelling ❑ yes ❑ no
- Fainting ❑ yes ❑ no

Respiratory:
- Cough ❑ yes ❑ no
- Cough w/exertion ❑ yes ❑ no
- Short of breath ❑ yes ❑ no
- Coughing up blood ❑ yes ❑ no
- Wheezing ❑ yes ❑ no

Gastrointestinal:
- Nausea/Vomiting ❑ yes ❑ no
- Diarrhea ❑ yes ❑ no
- Constipation ❑ yes ❑ no
- Abdominal pain ❑ yes ❑ no
- Dark, tarry stools ❑ yes ❑ no
- Bloody stools ❑ yes ❑ no
- Yellow skin color ❑ yes ❑ no
- Heartburn ❑ yes ❑ no
- Trouble swallowing ❑ yes ❑ no

Genitourinary:
- Vaginal discharge ❑ yes ❑ no
- Incontinence ❑ yes ❑ no
- Urination at night ❑ yes ❑ no
- Painful urination ❑ yes ❑ no
- Blood in urine ❑ yes ❑ no
- Painful periods ❑ yes ❑ no
- Pelvic pain ❑ yes ❑ no
- Genital sores ❑ yes ❑ no

Musculoskeletal:
- Back pain ❑ yes ❑ no
- Joint pain/swelling ❑ yes ❑ no
- Muscle cramps ❑ yes ❑ no
- Muscle weakness ❑ yes ❑ no
- Joint stiffness ❑ yes ❑ no
- Restless legs ❑ yes ❑ no

Neurological:
- Frequent falls ❑ yes ❑ no
- Frequent headaches ❑ yes ❑ no
- Numbness/tingling ❑ yes ❑ no
- Seizures ❑ yes ❑ no
- Tremor ❑ yes ❑ no
- Poor balance ❑ yes ❑ no

Psychiatric:
- Thoughts of self harm ❑ yes ❑ no
- Thoughts of hurting others ❑ yes ❑ no
- Depression ❑ yes ❑ no
- Anxiety ❑ yes ❑ no
- Hyperactivity ❑ yes ❑ no
- Poor impulse control ❑ yes ❑ no
- Inattention ❑ yes ❑ no
- Obsessive thoughts ❑ yes ❑ no
- Compulsive behavior ❑ yes ❑ no
- Visual hallucinations ❑ yes ❑ no
- Auditory hallucinations ❑ yes ❑ no

Endocrine:
- Cold intolerance ❑ yes ❑ no
- Heat intolerance ❑ yes ❑ no
- Excessive thirst ❑ yes ❑ no
- Excessive hunger ❑ yes ❑ no
- Excessive urination ❑ yes ❑ no
- Weight change ❑ yes ❑ no

Hematology:
- Abnormal bruising ❑ yes ❑ no
- Abnormal bleeding ❑ yes ❑ no
- Enlarged lymph nodes ❑ yes ❑ no

Allergy:
- Hives ❑ yes ❑ no
- Allergic rash ❑ yes ❑ no
- Hay fever ❑ yes ❑ no

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OFFICE POLICIES

Appointments

Patients will be seen by appointment only. Same day appointments may be made available in the event of emergency. To schedule an appointment, call 405-400-1152. We ask that all minors have a parent and/or legal guardian present at all appointments.

After-Hours, Emergency, and Holiday Coverage

Our regular office hours are Monday-Friday 8am-5pm. If you are calling after-hours about a matter that does not necessitate immediate attention please leave a voicemail and we will return your call as soon as possible. However, if you are suicidal, fear that you will do harm to yourself or others, suspect you are having a severe allergic reaction to a medication, or face a life-threatening emergency, please call "911" or go to the nearest emergency room. You should instruct the emergency room to notify your provider. For the sake of continuity of care, we ask that you bring any discharge instructions or medication adjustments to your next appointment.

Use and Disclosure of Health Information for Treatment and Payment:

We may use or disclose health information in order to provide and coordinate your health care, or obtain payment for health care services.

I, (Patient Signature or Legal Guardian if patient is a minor) _____, have reviewed, understand, and consent to the use and disclosure of health information for treatment and payment purposes. I also acknowledge that I have received a copy of the notice of privacy practices with the effective date of 01/2019.

Payment

Payment, including insurance copayments and deductibles, must be provided at the time of service. Please be aware that services provided may not be covered by your insurer, but you are ultimately responsible for payment of all services rendered. Any balance that remains outstanding for more than 90 days may be referred to a collections agency.

I, (Patient Signature or Legal guardian if patient is a minor) _____, have reviewed and understand the payment policy.

Appointment Cancellations:

In order to provide effective care, patients must adhere to the recommended treatment plan, attending and arriving on time for all scheduled appointments. If you need to cancel or reschedule an appointment, we ask that you provide advanced notice of at least 24 hours. If you do not attend your appointment and fail to give advance notice, you may be discharged from our practice.

I, (Patient Signature or Legal guardian if patient is a minor) _____, have reviewed and understand the appointment cancellations policy.

Prescriptions and Refills:

Please be advised that we review the Oklahoma Prescription Monitoring Program before prescribing. We will not issue any prescription without first seeing you for an in-person appointment to evaluate your clinical needs. If you are in need of a remaining refill, please contact your pharmacy. Your pharmacy will contact our office if authorization is required. Your refill requests will be processed within 2 business days after the receipt of your pharmacy's request. Prescriptions will not be refilled after hours or on weekends, so please plan accordingly. We reserve the right to decline issuing prescription refills if medications have been lost or stolen, or if you have missed an appointment.

Evaluations for purposes other than treatment

We are at mental health treatment facility and our providers enter into a relationship with patients for the purpose of offering treatment. As such, we do not do evaluations for the purposes of determining eligibility for social security disability, fitness for duty, nor do we comment of matters concerning child custody.

Non-evidenced based treatments

We do not endorse or prescribe the use of medical marijuana or emotional support animals.

I have reviewed, understand, and agree to all office policies set forth above.

Signature of Patient/Legal Guardian Date of Signature

Printed Name Relationship to Patient if applicable

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24 Hour Cancellation & “No Show” Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, we reserve the right to charge a fee of $125.00 for all missed appointments (“no shows”) and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice.

“No Show” fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Three “no shows” in any 12 month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

Signature Date

Printed Name

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MENTAL HEALTH

NOTICE OF PRIVACY PRACTICES

Effective: 01/2019

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 of Privacy Practices, please contact our office at 405-400-1152.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

OKLAHOMA STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

Patient Name:_____ Medical Record #:_____

Date of Birth:_____ Social Security #:_____

I hereby authorize _____
Name of Person/Organization Disclosing PHI

to release the following information to _____
Name and Address of Person/Organization Receiving PHI

Information to be shared:

☐ Psychotherapy Notes (if checking this box, no other boxes may be checked) ☐ Entire Medical Record

☐ Billing Information for_____ ☐Mental Health Records

☐ Substance Abuse Records ☐ Medical information compiled between_____ and _____

☐ Other:_____

The information may be disclosed for the following purpose(s) only:

☐ Insurance ☐ Continued Treatment ☐ Legal ☐ At my or my representative's request

☐ Other:_____

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event:_____

_____

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Description of Legal Representative's Authority Expiration date (if longer than one year from date of signature or no event is indicated)

Instructions for Oklahoma Standard Authorization to Use or Share Protected Health Information (PHI)

1. Indicate patient name and date of birth.
2. OPTIONAL: Indicate Medical Record # and/or Social Security #.
3. Indicate the name of person/organization disclosing PHI.
4. Indicate the name and address of person/organization receiving PHI.

Information to be shared:

1. Check the appropriate box.
2. If the information to be shared is not listed, check the "other" box and indicate what information is to be shared in the space provided.
    a. If billing information is shared, indicate which billing information is requested. If all billing information is requested, just check the box.
    b. If psychotherapy notes are requested, no other information can be shared. A separate Authorization must be completed for additional information.

Purpose for disclosing information:

1. Check the appropriate box.
2. If the purpose is not listed, check the "other" box and indicate the purpose in the space provided.

Expiration Date:

1. Unless otherwise indicated at the bottom of the form, the expiration date is one year from the date of the patient's signature **or** upon the occurrence of an event chosen by the individual.
    a. If the patient chooses an event, list the event in the space provided.
    b. If the patient chooses to make the expiration date longer than one year, indicate in the space provided at the bottom of the form.

Signature:

1. Obtain the signature of the patient or Legal Representative
2. If a Legal Representative signs the form, indicate the description of the Legal Representative's authority.

Date:

1. The date is the date the form is signed.