NeuroPsychiatry Center - Ravi Kant, MD, P.C.
300 Old Pond Road, Suite 201, Bridgeville, PA 15017
Tel. # 412-220-7323 Fax # 412-220-7325

REGISTRATION

Patient ____
Last Name **First Name** **Middle Initial**

Street Address ____

City ______________________ **State** ________ **Zip** ________-______

Phone Numbers: Home- ________________**Work:** ________________**Cell:** ______________

Gender: □ **M** □ **F** **Age:** ______**Birth Date** ______________**E-mail:** ______________________

Race: □ **White** □ **Black** □ **Asian** □ **Other** _______ **Ethnicity** __________ **Preferred Language** _________

Emergency contact ____________________ **Phone #** ________________ **Relationship** ________

If patient is a minor or has a legal representative or guardian, please fill out the information below.
(Guardian/Legal Representative is required to attach supporting legal documentation)

Responsible Party ____

Street Address (if different from patient) ______________________________

City ______________________ **State** ________ **Zip** ________-______

Date of Birth ______________ **Phone Number** ____________ **E-mail** ______________________

Insurance Information

1. Primary Insurance ____

Policyholder Name ________________________ **Relationship to Patient** ________________

Date of Birth ______________ **Policy #** __________________________ **Group #** __________

2. Secondary Insurance ____

Policyholder Name ________________________ **Relationship to Patient** ________________

Date of Birth ______________ **Policy #** __________________________ **Group #** __________

√ **Can we leave a text or message at the phone number provided with family member/s or on the voicemail for appointment reminders or other information? – Yes** □ **No** □

Name:____________________ **Signature** ____________________ **Date:**______________

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ASSIGNMENT/RELEASE/CONSENT TO TREATMENT

Patient Name ____ **Date of Birth** _____/_____/_______

(All patients/guardians sign below)

I authorize and request treatment/s from **RAVI KANT, M.D**. and/or his associates to perform routine diagnostic procedures and to provide medical treatment as is medically necessary in his/their professional judgment.

I hereby authorize release of protected health information, including mental health and/or substance abuse (drug and alcohol), necessary to file a claim with my insurance carrier and assign benefits otherwise payable to me to **RAVI KANT, M.D. PC** as indicated on the insurance claim form. I understand that this facility and its providers are mandated reporters of any and all suspected or witnessed child abuse and/or neglect. (Section 6383 (b) of Title 23 of the Pennsylvania Consolidated Statutes/Act of July 1, 2015, P.L. 94, No. 15). I also understand that I am financially responsible for any balance not covered by my insurance carrier(s) (including but not limited to deductibles and/or co-payments) and agree to pay the full charges if payment is/are denied by my insurance carrier(s) for any reason or if no insurance coverage exists at the time of services. It is my responsibility to update any changes in insurance. I understand it is mandatory to notify the health care provider of any other party who may be responsible for payments (section 1128 B, Social Security Act and 31 U.S.C. 3801- 3812 provides penalties for withholding this information). Medicare regulations apply. I have received, read and agree with the billing and other office policies.

With my consent, Ravi Kant, M.D., his associates, and office staff can call my home and leave messages on an answering machine or with a person, text, or e-mail me regarding appointments and contact the designated emergency contact person if needed. I may revoke my consent in writing except to the extent that the practice has already acted upon in reliance upon my prior consent. If I do not sign this consent, Ravi Kant, M.D. and his associates may decline to provide services to me. I agree with the above.

All the information provided in this Registration-Assignment/Release/Consent to Treatment is true and current.

Notice of Health Information Practices - Ravi Kant, MD, P.C.

(Copy is available and posted in office for your review or available for download at www.drkant.com)
I have read and understood the above Notice of Health Information Practices. I recognize that this is a federal mandate that this facility must comply with. Patient Initials _____

Notice of Patient Rights and Responsibilities - Ravi Kant, MD, P.C.

(Copy is available and posted in office for your review or available for download at www.drkant.com)
I have read and understood the Patient Rights and Responsibilities provided at the office. Patient Initials _____

Notice of Grievance Procedure – Ravi Kant, MD, P.C.

(Copy is available and posted in office for your review or available for download at www.drkant.com)
I have read and understood the Grievance Procedure provided at the office. Patient Initials _____

Patient Signature ____ Date ____________
(If patient is a minor (ages 14-18) he/she must sign this Registration-Assignment/Release/Consent to Treatment)

Print Name ____

Responsible Party Signature ______________________________________ Date ____________
(Parent/Guardian/Legal Representative)

Print Name ____

Relationship to Patient ____
(Guardian/Legal Representative is required to attach supporting legal documentation)

Office use only
Witness __________________________Name ____________________________ Date ________________

Concussion/head injury intake- 2018

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OFFICE POLICIES

Patient Name ____ **Date of Birth** _____/_____/_______

Insurance Coverage:
Due to frequent changes in insurance coverage (benefits, exclusions, deductibles and/or prescription coverage, etc.), we cannot inform or advise you about your benefits. In some insurance policies, certain diagnoses may be excluded, such as ADHD, Autism, Mental Retardation and related conditions. We do not routinely do the paperwork for non-formulary medicines not covered by your insurance company. You are responsible for keeping track of number of visits allowed in your plan and how many visits you have used with your therapist and prescriber. You will be charged for additional visits. If you do not have insurance coverage, you are responsible for the full charges. Please inquire in advance about our charges if you do not have insurance.

Payments:
It is our policy to collect all **co-payments and/or deductibles** at the time of service unless arrangements are made ahead of time. **We accept checks, cash, and debit or credit cards (Visa, MasterCard American Express or Discover).**

A service charge of **$10.00** plus interest (1.5%/month) will be added to any outstanding balance over 30 days past due. Also, all delinquent accounts (over 90 days past due) may be turned over to a collection agency. An additional **$40.00** as a handling fee and the costs of collection (including attorneys' fees and costs) will be added to the total amount due.

Attendance Policy:
We understand that it is not always possible to keep a scheduled appointment or give 24 hours notice of cancellation. If a pattern of same day cancellation or "No Shows" develop, we reserve the right to bill you **$50.00** fee for the missed appointment time. Your insurance company is not responsible for this charge. Prescriptions may not be called in for No Show or Canceled appointments. Additionally, if there are frequent No Show for appointments or non-compliance with treatments, you may be discharged from the practice.

Lost Prescription Fee:
A service fee of **$20.00** will be charged to replace lost scripts. Scripts will need to be picked up from the office after payment of the fee.

Returned checks – Fee of **$40.00** will be charged for checks returned for any reason.

****Fees may be changed without notice.**

I have read and agree to be legally bound by the terms of these office policies including the financial responsibility provisions hereof. I understand that I am financially responsible for any amounts not covered or paid by my insurance carrier and that I am responsible for providing current insurance information and inform the office of any address and/or insurance changes.

Patient Signature ____ Date _______________
(If patient is a minor (ages 14-18), he/she must sign this Office Policy Form)

Print Name ____

Responsible Party Signature ______________________________________Date _______________
(Parent/Guardian/Legal Representative)

Print Name ____

Relationship to Patient ____
(Guardian/Legal Representative is required to attach supporting legal documentation)

Office Use Only
Witness ________________________ Name ________________________Date _______________

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, ________________________________ date of birth ___________, do hereby consent to and authorize to
Patient's Name (Print)
disclose health information about me and that can be identified with me from my records relating to my identity, diagnoses, prognosis, and/or treatment, which records may include information related to medical conditions, tests, mental or behavioral health, and substance abuse (drug and alcohol), and HIV-related. These records are called protected health information and are protected by federal and/or state law.

From ______________ **Ravi Kant, MD, P.C.** ______________
(Name and address of provider or facility releasing records)

To ____
(Name and address of provider, facility, or family member where records are being released to)

I authorize the entities named above to share the health related information related to my care. Initial ________

The purpose or need for this disclosure is ☐ Coordination of Care ☐ Disability Application or
☐ Other ________________________________

I understand that the specific types of records to be released (identify all records or all that apply) are:

☐ All records including Psychiatric/psychological evaluation ☐ Laboratory reports & tests
☐ Physician notes only ☐ Acupuncture ☐ Other (specify) _________________
☐ Insurance claims and payments only (including Medicare and Medicaid)

****Mental or behavioral health, substance abuse, and HIV-related information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated.****

DO NOT RELEASE: ☐ Mental/Behavioral Health (Psychiatric) ☐ HIV-Related ☐ Substance Abuse (Drug and Alcohol)

I understand that this authorization is revocable except to the extent that action has been taken in reliance thereon and that this consent will remain in force unless revocation from the patient or legal guardian is received. I also understand that any revocation of this authorization must be in writing and sent or delivered to health care provider's office. I also understand that my decision to revoke this authorization may result in my insurance company not being able to pay for my medical care and I will be liable for payment for the services rendered.

Patient Signature ________________________________ **Date** ______________
(If patient is a minor (ages 14-18) he/she must sign this Authorization for Release of Protected Health Information Form)

Print Name ________________________________

Responsible Party Signature ________________________ **Date** ______________
(Parent/Guardian/Legal Representative)

Print Name ________________________________

Relationship to Patient ________________________________
(Guardian/Legal Representative may be required to attach supporting legal documentation)

Office Use Only
Witness ____________________ Name ______________ Date ______________

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CONSENT TO DISCUSS PROTECTED HEALTH INFORMATION VIA ELECTRONIC COMMUNICATION

Patient Name: ____ Date of Birth: ______/_____/_______

Parent/Legal Guardian Name: _____________________________________ Relationship__________________

By signing below, I permit NeuroPsychiatry Center to communicate protected health information for the above patient via e-mail at_____________________________________@___________________.__________

E-MAIL RISKS AND YOUR RESPONSIBILITY:

You and your provider/s at NeuroPsychiatry Center (NPC) and its employees and staff have agreed to correspond using e-mail. These e-mails may contain personal protected health information including, mental health issues. You need to be aware of the risks and your responsibilities.

A.) As the internet is not secure or private, unauthorized people may be able to intercept, read, and possibly modify e-mail/s you send or receive from NPC. You must protect your e-mail account and password against unauthorized use. Hackers can get access to your account.
B.) Viruses can be spread via e-mail and some may cause e-mail messages to be sent to unintended people.
C.) E-mails can be copied, printed, and forwarded by recipients; be careful with whom you send or share e-mails.

1. CONDITIONS FOR THE USE OF E-MAIL:

By consenting to the use of e-mail with NPC you agree that:

A.) NPC may forward e-mails, as appropriate, for diagnosis, treatment, billing, and other related reasons. Employees and medical staff other than the intended recipient may have access to your e-mails.
B.) Although NPC will try to read and respond to your e-mail, we may not read your e-mail immediately. If you do not receive a response within a reasonable time, it is your responsibility to contact us to follow up.
C.) You should carefully consider the use of e-mail for the communicating sensitive medical and personal information.
D.) E-mail messages should be **short, clear, and concise**.
E.) NPC reserves the right to save your e-mail including the information contained there in the medical records.
F.) You agree not to abuse the right to communicate with your physician's office and your communications will be professional in content.
G.) E-mail access to staff is being provided as a convenience to our patients and NPC has the right to restrict your ability to communicate with us via e-mail at any time for any reason, including cases where NPC reasonably believes that it is not in your best interest to continue to seek advice via e-mail and an in person appointment is needed or that e-mail is being used excessively in lieu of in person care.

2. INSTRUCTIONS:

A.) You should immediately inform the staff at NPC of any changes in your e-mail address.
B.) **E-mail should be used only for non-sensitive and non-urgent issues such as prescriptions, scheduling, general questions or advice. E-mail is not a substitute for psychotherapy or medication management appointments.**
C.) Please put the patients name and date of birth in the body of the e-mail for proper identification.
D.) If you wish to withdraw your consent to communicate via e-mail, you must inform NPC in writing.

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CONSENT TO DISCUSS PROTECTED HEALTH INFORMATION VIA ELECTRONIC COMMUNICATION

ACKNOWLEDGEMENT AND AGREEMENT

NeuroPsychiatry Center will use reasonable means to protect the privacy of the patient's health information. However because of the risks outlined above, NPC cannot guarantee e-mails will be confidential. Also NPC will not be liable in an event that you or anyone else inappropriately uses or accesses your e-mail. NPC will not be liable for improper disclosure of your health information that is not caused by our intentional misconduct.

NPC is not responsible for e-mail messages that are lost due to technical failure during composition, transmission and/or storage. NPC may impose restrictions to communicate with me by e-mail. I have read and understand the information above, and had any questions answered to my satisfaction. I have received the copy of this consent form. I agree to the guidelines for e-mail communication. I understand that this consent is valid until such time as I revoke the consent outlined above, except to the extent that a staff has already acted in reliance upon this authorization.

Patient Signature ____ **Date** ______________________
(If patient is a minor (ages 14-18) he/she must sign this Release of Protected Health Information via Electronic Communication Form)

Print Name ____

Responsible Party Signature ______________________________________ **Date** ______________________
(Parent/Guardian/Legal Representative)

Print Name ____

Relationship to Patient ____
(Guardian/Legal Representative may be required to attach supporting legal documentation)

DO NOT SEND E-MAIL FOR EMERGENCIES

GO TO THE NEAREST HOSPITAL, CALL 911, OR CONTACT YOUR COUNTY'S EMERGENCY CRISIS NUMBER

We will not read e-mails on weekends, holidays, or when on vacation.

Office Use Only

Witness ____________________________ Name ______________________ Date ______________________

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PRESCRIPTION REFILL POLICIES AND PROCEDURES

Patient Name: ____ **Date of Birth:** _________________

Parent/Legal Guardian Name: ________________________________ **Relationship**___________________

In order to make the prescribing medication and requesting temporary refills process efficient, we will follow the procedures listed below. Patients or a parent/legal guardian should initial and sign below.

● Check which medications need refilled before coming to your appointment. It is **YOUR** responsibility to get your medications refilled during your visit. Schedule your next visit at least **1 week prior** to running out of your current refill(s).

● If you require a medication refill in-between scheduled appointments, it is **YOUR** responsibility to request it from our website - www.drkant.com and fill in the "Medication Refill Request" online. Refill requests are **NOT** accepted via phone. We need at least **72** hours notice (excluding weekends or holidays) to respond to your request. Please note that we do **NOT** accept medication refill requests from pharmacies.

I understand the above: X________________

● Regular office visits are required for monitoring and prescribing medications as determined by your provider. Medications will not be called in without required office visits.

I understand the above: X________________

● Blood work is needed for some medications to assess the safety and effectiveness. For patients who do not get the blood work done in a timely fashion, we will refuse to fill their prescriptions.

I understand the above: X________________

● If prescribed a controlled substance as identified by the DEA, per office policy, patients must be seen at least every 4-8 weeks, at the discretion of the provider. Refills for controlled substances will only be provided during appointments. Random urine screens may be requested to assess the use of narcotics or abuse of illicit drugs.

I understand the above: X________________

I have read the **Prescription Refills Policies and Procedures** and by initialing above and signing below, I agree to abide by them in full and have been given a copy if requested.

Patient Signature ____ **Date** ______________________
(If patient is a minor (ages 14-18) he/she must sign this Prescription Refill Policies and Procedures Form)

Print Name ____

Responsible Party Signature _______________________________________ **Date** ______________________
(Parent/Guardian/Legal Representative)

Print Name ____

Relationship to Patient ____
(Guardian/Legal Representative may be required to attach supporting legal documentation)

Office Use Only

Witness ____________________________ Name ______________________ Date _______________________

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E-PRESCRIBING MEDICATION HISTORY CONSENT

Patient Name ____ **Date of Birth** _____/_____/_______

I understand that NeuroPsychiatry Center utilizes e-prescribing. I understand that e-prescribing allows the practice to send prescriptions electronically to pharmacies, eliminating the need for prescribing via paper, phone, or fax.
E-Prescribing is fast, convenient, legible, secure, cost-effective and safe. In some cases, it also allows the health care provider to access critically important information about patient's current and past medications from pharmacy benefit managers and community pharmacies. This helps to alert the provider to other potential medication interactions or if patient is getting same or similar medications from multiple providers.

I have been given an opportunity to ask questions about the e-prescribing process and have had those questions answered to my satisfaction. I hereby consent to the practice requesting and using my medication history from other health care providers, pharmacies, or third party pharmacy benefit payers for treatment purposes.

Patient Signature ____ **Date** _______________________
(If patient is a minor (ages 14-18) he/she must sign this Authorization for E-Prescribing Medication History Consent Form)

Print Name ____

Responsible Party Signature ____ **Date** _______________________
(Parent/Guardian/Legal Representative)

Print Name ____

Relationship to Patient ____
(Guardian/Legal Representative may be required to attach supporting legal documentation)

<u>Office Use Only</u>

Witness _____________________________ Name _______________________ Date ________________________

FOR MOTOR VEHICLE ACCIDENT

OR

WORKER'S COMPENSATION CASE ONLY:

Check one □ **Motor Vehicle Accident** □ **Worker's Compensation**

Insurance Carrier ____

Claims Rep Name __________________________ **Tel #** _______________

Address ____

Date of Accident ______________________ **Claim #** __________________

Employer __________________________ **Phone #** __________________
(If work related)

Have you filed a workers' compensation claim with your employer? YES NO

Is your motor vehicle insurance medical claim still open and payable? YES NO

Did you get authorization from your claim rep for this visit YES NO

Do you have an attorney? If yes, Name ____

______________________________________ ___________________

Signature **Date**

____

Print Name

Ravi Kant, MD, P.C. NeuroPsychiatry Center
300 Old Pond Rd., Suite 201, Bridgeville, PA 15017 Tel. 412-220-7323

Name ____ DOB ______/______/______ Date_________

PERSONAL CRISIS PLAN

My Triggers: ____
____

Thoughts/Inside Warnings: ____
____

Outside Warning Signs: ____
____

When Notice My Triggers I will: ____
____

When Others Notice I'm Upset I'd like them to: ____
____

Things That Help Me Stay Better Now: ____
____

Things That Help Me Stay Well on a Regular Basis: ____
____

Things That Make Me Feel Worse: ____
____

*If I'm feeling unsafe, I will go to the ER of local hospital, call Suicide Hotline 1-800-273-8255, or call my county's crisis number.

Patient Signature ______________________________________ Date ______________
(If patient is a minor (ages 14-18) he/she must sign this Registration-Assignment/Release/Consent to Treatment)

Print Name ______________________________________

Responsible Party Signature ______________________________________ Date ______________
(Parent/Guardian/Legal Representative)

Print Name ______________________________________

Relationship to Patient ______________________________________
(Guardian/Legal Representative is required to attach supporting legal documentation)

Office use only
Witness ____________________________Name ______________________________ Date _________________

Concussion/head injury intake- 2018

Ravi Kant, MD, P.C.
NeuroPsychiatry Center

300 Old Pond Rd., Suite 201 Bridgeville, PA 15017

Name ________________________________ DOB ____/____/____ Age________

You will be responsible for full payment if your insurance company denies payment for any reasons

Co-Payments are due at each visit. Bring all relevant medical records with you. (No X-Ray)

Current healthcare providers	Address	Phone	Fax
General Practitioner:			
Therapist/Psychologist:			
Attorney:			
Other Health Care Provider:			

Who can we thank for recommending our practice? ______________________________

Current Pharmacy: Name ____________ City ________ Zip ________ Phone ____________

Allergies: Y N If yes what?______________________________

Reaction(s) ______________________________

Height - ____________ **Weight -** ____________

Chief Complaints (Please circle)

Depression	Y	N	Psychosis	Y	N
Anxiety	Y	N	Attention/Concentration	Y	N
Panic Attacks	Y	N	Eating Disorder	Y	N
Hypomanic/Manic Episodes	Y	N	Drugs/Alcohol	Y	N
Anger	Y	N	Headaches	Y	N

Other: ______________________________

Current stressors (Please circle)

School	Y	N	Social	Y	N	Financial	Y	N
Marital Issues	Y	N	Family	Y	N	Medical	Y	N
Pain/Disability	Y	N	Work/Job	Y	N	Legal	Y	N

Other: ______________________________

Describe in your own words your current symptoms:

____

____

____

Concussion/head injury intake- 2018

History

When did your symptoms start? ____Years or ____ Months ago   Have you had similar symptoms in the past? Y   N

What, if any, triggered the symptoms? ____

____

What has been helpful to control the symptoms? ____

____

Mood Symptoms:

Circle the appropriate answer, then rate IF YES: ***(Rate symptoms on scale of 0 to 10; 0 good, 10 worse)***

Symptom			Rating
Depression	Y	N	0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
Mania/Hypomania	Y	N	0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
Anger/Irritability	Y	N	0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Depression:

Irritability	Y	N				
Tearfulness	Y	N				
Loss of Interests/ Motivation	Y	N				
Decreased Appetite	Y	N	Weight loss	Y	N	How much ______
Increased Appetite	Y	N	Weight gain	Y	N	How much ______
Difficulty falling or staying asleep	Y	N	Total Hours of Sleep per day ______hrs.			
Fatigue	Y	N				
Negative Thoughts	Y	N	Self-Injury	Y	N	
Low Self Esteem	Y	N	Suicidal Thoughts	Y	N	
Social isolation	Y	N	Thoughts of Death/Dying	Y	N	
Feeling Worthless	Y	N				
Feeling Hopeless/Helpless	Y	N	Access to firearms	Y	N	
Homicidal Thoughts	Y	N	If yes, is firearm in secure location?	Y	N	

Would you reach out to someone if you feel strongly suicidal? Y N Who? ______________________

(You can call ER of local hospital / Suicide Hotline 1-800-273-8255 / Resolve Crisis Hotline 1-888-796-8226)

Hypomania/Mania:

Has there ever been a period of time when you were not your usual self and:

You were much more talkative?	Y	N
You had much more energy?	Y	N
You were more social or outgoing than usual?	Y	N
You did things that were unusual or that other people might have thought were excessive, foolish or risky?	Y	N
You spent excessive amounts of money or got your family into trouble?	Y	N

Give details of above symptoms: ____

____

____

____

Concussion/head injury intake- 2018

Anxiety:

Excessive Worrying ______ Y ____ N How often? ______

If yes give examples ______

______

______

Do you find it difficult to control the worry?	Y	N	Bothered by Crowds	Y	N
Restlessness	Y	N	Avoid Going Places	Y	N
Fatigue	Y	N	Social Isolation	Y	N
Irritability	Y	N	Muscle Tension	Y	N
Difficulty falling or staying asleep	Y	N			

Panic Attacks: ______ Y ____ N How often? ______

Duration? ______ Where? ______

Triggers? ______

Palpitations	Y	N	Nausea	Y	N
Chest pressure	Y	N	Fear of Dying	Y	N
Sweating/Chills	Y	N	Dizziness	Y	N
Shakiness	Y	N	Numbness/Tingling	Y	N
Out of Breath	Y	N	Fear of Losing Control	Y	N
Feelings of Choking	Y	N	Fear of Being Trapped	Y	N

Obsessions	Y	N	Describe: ______
Repetitive Behaviors	Y	N	Describe: ______
Fears	Y	N	Describe: ______
Flashbacks	Y	N	Describe: ______
Nightmares	Y	N	Describe: ______
Delusions	Y	N	Describe: ______
Paranoia	Y	N	Describe: ______
Hallucinations	Y	N	Describe: ______

Cognitive Symptoms

Long Term Memory ______ Intact---------------Impaired a Little---------------Impaired a Lot

Short Term Memory ______ Intact---------------Impaired a Little---------------Impaired a Lot

Make Careless Mistakes	Y	N	Forgetful	Y	N
Difficulty Sustaining Attention	Y	N	Easily Confused	Y	N
Easily Distracted	Y	N	Word Finding Difficulties	Y	N
Fail to Finish Tasks	Y	N	Difficulties with Info. Processing	Y	N
Frequently Lose Things	Y	N	Restless/Fidgety	Y	N

Concussion/head injury intake- 2018

History of Injury:

Date of injury:_________________ Where? ____

____

What happened? ____

____

____

Lost Consciousness Y N How Long ____________________

Were Dazed/Confused Y N Had Seat belt On Y N

Were you Driver? Passenger? Front or Rear seat

Were you Intoxicated Y N Did you hit your head anywhere Y N

Last Memory **Before** Accident____

First Memory **After** Accident ____

Do you remember details of accident Y N

Memories ____

____

____

How much damage to the vehicle **$** ___________________

Treatments for Accident:

Treated and released from ER (where) ____

Hospitalized Y N How many days ________________________

Where ______________________________ Doctor ________________________________

Test results: (if known)

X-Rays ______________CT brain _____________MRI brain ____________EEG _________ Other ______________________

Results ____

Rehab treatments: Where: Type: How Long

Had ImPACT or Neuropsychological testing done Y N When and where

Ever suffered Concussion in the past Y N Details ______________________________

Ever had similar problems before this accident: Y N Details______________________________

Extended exposure to chemicals Y N Describe _____________________________

Family member observations- How is the injured person different after the injury, please describe:_______________________

____

____

____

Physical Symtpoms Related to Head Injury/Concussion – any problems in following systems?

Sense of Taste	Y	N			Sense of Smell	Y	N
Vision	Y	N			Hearing	Y	N
Ringing in Ears	Y	N	Left	Right	Testing Done	Y	N
Balance Problems	Y	N			Testing Done	Y	N

If yes to testing, where did testing occur? What type of testing? ______________________________

Physical Changes (If Yes, Describe Symptoms and Identify Treatment)

Neurological Changes	Y	N	______________________________
Changes in Thyroid	Y	N	______________________________
GI Symptoms	Y	N	______________________________
Gynecological	Y	N	______________________________
Sexual Dysfunction	Y	N	______________________________
Severe PMS	Y	N	______________________________
Neck Pain	Y	N	______________________________
Back Ache	Y	N	______________________________
Headache	Y	N	______________________________
Migraines	Y	N	______________________________

Give details of symptoms above: ______________________________

Past Psychiatric History:

Out Patient Treatments (where and for what reason): ______________________________

____

Inpatient Treatments (where and for what reason): ______________________________

____

Therapists/Psychiatrist(s) seen: ______________________________

____

Medications tried in the past: ______________________________

____

History of suicide attempt(s)? ______ Y N

If yes provide details: ______________________________

____

Concussion/head injury intake- 2018

Family History:

Medical problems______ Y N If yes, who? ____________________

____

Diagnosis: ____________________

Emotional problems______ Y N If yes, who? ____________________

____

Diagnosis: ____________________

Alcohol/Drug Abuse______ Y N If yes, who? ____________________

____

Describe: ____________________

Patient's Medical History

Diabetes	Y	N	Asthma	Y	N	High Blood Pressure	Y	N
Heart Disease	Y	N	Multiple Sclerosis	Y	N	Fibromyalgia	Y	N
Seizures	Y	N	High Cholesterol	Y	N	Hypothyroidism	Y	N

Other ____________________

Surgeries Y N Please describe: ____________________

Hospitalizations Y N Please describe: ____________________

Have you ever suffered a stroke, head bleed, concussion or other type of head injury? Y N

If yes, please explain: ____________________

____

Test results (if any)

X-Rays	Y	N	Results: ____________________
CT / MRI	Y	N	Results: ____________________
Psychological Tests	Y	N	Results: ____________________
Blood Work	Y	N	Results: ____________________

Social History

Marital Status **(circle one)** Single / Married / Divorced / Separated / Other

Who are you currently living with? ____________________

Do you have any children? Y N Ages: ____________________

Are you currently working? Y N

Current Job ____________________ For how long? ____________________

Highest level of education: < HS____ HS ___ GED___ College___ Tech./Vocational___

Type of degree/certification you hold: ____________________

Currently in school? Y N If yes, where? ____________________

Average Grades______ Y N Anticipated Graduation Date: ____________________

Hobbies ____________________ Last enjoyed ____________________

Social History Continued

Are you involved in community and social activities? Y N
Please Circle: Church/Temple Clubs Sports AA/NA Volunteer work Other:______________

Do you have a history of past physical/psychological/sexual abuse, neglect, trauma, domestic violence, or have you witnessed domestic violence? Y N
If yes, please describe:
If yes, have you had treatment for the trauma? Y N
If you have not received treatment, would you like to address the trauma during treatment? Y N

Caffeinated Drinks Y N _______cups per day
Current Tobacco Use Y N If yes, do you want to quit? Y N
Type of Usage:
Amount Per Day: How Often? How Long?
Have you ever received treatment? Y N Do you want treatment? Y N
Former Tobacco Use Y N
When Did You Start? When Did You Quit?

Drink Alcohol Y N _______drinks per day/week for__________years
Have you ever received treatment? Y N Do you want treatment? Y N
Impact social/family life Y N
Have you ever felt that you should cut down on your drinking? Y N
Have people annoyed you by criticizing your drinking? Y N
Have you ever felt bad or guilty about your drinking? Y N
Have you ever had a drink first thing in the AM to steady your nerves? Y N
Do your family/friends complain about your alcohol/drug use? Y N

Current Drug Use/Misuse Y N
IV drug use Y N
Type of Usage:
Amount Per Day: How Often? How Long?
Have you ever received treatment? Y N Do you want treatment? Y N
Former Drug Use/Misuse Y N
Type of Usage:
Amount Per Day: How Often? How Long?

Legal History:
Do you have any past or current legal problems (e.g. DUI's, arrests, etc.)? Y N
If yes, please describe:

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Have you ever been on Disability or Workers' Comp Y N

If yes, please describe:____

____

Current Disability Status- None_____ Short term_____ Long term_____ Work. Comp_____ SSDI_____

Current litigation status, if any ____

____

Military Service - Service ______________________________ How long? ______________________

Any combat exposure? Y N Describe: ____

Any service related medical conditions? Y N Describe: ______________________________

Discharge- Honorable Y N

Any other relevant information ____

____

____

Current Medications **(bring the bottles with you)**

Name	Dose	How Long	For What	Who Prescribed
1.				
2.				
3.				
4.				
5.				
6.				

Do you take any over the counter and/or herbal/natural products? Y N

If yes, please list: ____

____

Do you take any medications that belong to a friend/family member? Y N

If yes, please list: ____

____

What do you identify as your strengths? - ____

____

____

What do you identify as your weaknesses? - ____

____

____

What are your perceived barriers to treatment, if any? - ____

____

____

I certify that I have reviewed the above information provided by me, and to the best of my knowledge it is true and complete. I am aware that this information may be released to other parties such as insurance co., attorneys and other medical professionals/ hospitals as per my consent/authorizations, or via court orders as allowed by prevailing federal, state and/or local laws. This information may be shared with treating professionals/law enforcement authorities without your consent in case of an emergency, when relied upon in good faith. I will hold Dr. Kant and/or his designees harmless for any loss, injuries, damage that may arise from the actions taken.

I/We will be responsible for payment of charges billed if payments are denied by the insurance company(ies) for any reason. It is my responsibility to update my insurance information for billing whenever there are any changes.

Signature ________________________ Name ________________________ Date ____________

Office use only:

This information was reviewed with patient and/or guardian by

1.________________________ Signature ________________________ Date ____________

2.________________________ Signature ________________________ Date ____________

Patient Health Questionnaire (PHQ-9)

Over the last two (2) weeks, how often have you been bothered by any of the following problems?

Name ____ Date____________________

		Not at all **0**	**Several days** **1**	**More than half the days** **2**	**Nearly every day** **3**
1	Little interest or pleasure in doing things				
2	Feeling down, depressed or hopeless				
3	Trouble falling asleep, staying asleep or sleeping too much				
4	Feeling tired or having little energy				
5	Poor appetite or overeating				
6	Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
7	Trouble concentrating on things such as reading the newspaper or watching TV				
8	Moving or speaking so slowly that others could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual				
9	Thinking that you will be better off dead or that you want to hurt yourself in some way				

If you have checked off any problems, how difficult have these problems made it for your to do your work, take care of things at home, or get along with other people?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult

Today's Score _______ Past scores_______________________________________

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The Rivermead Post-Concussion Symptoms Questionnaire

NAME:___________________________________ DATE ___________________

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer from any of the symptoms given below. As many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each one, please circle the number closest to your answer.

1 = Not experienced at all
2 = No more of a problem
3 = A mild problem
4 = A moderate problem
5 = A severe problem

Compared with before the accident, do you now (i.e., over the last 24 hours) suffer from:

Headaches	0	1	2	3	4
Feelings of Dizziness	0	1	2	3	4
Nausea and/or Vomiting	0	1	2	3	4
Noise sensitivity, easily upset by loud noise	0	1	2	3	4
Sleep Disturbance	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being Irritable, easily angered	0	1	2	3	4
Feeling Depressed or Tearful	0	1	2	3	4
Feeling Frustrated or Impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor Concentration	0	1	2	3	4
Taking Longer to Think	0	1	2	3	4
Blurred Vision	0	1	2	3	4
Light Sensitivity,	0	1	2	3	4
Easily upset by bright light	0	1	2	3	4
Double Vision	0	1	2	3	4
Restlessness	0	1	2	3	4

Are you experiencing any other difficulties?

1. ______________________________	0	1	2	3	4
2. ______________________________	0	1	2	3	4

*King, N., Crawford, S., Wenden, F., Moss, N., and Wade, D. (1995) J. Neurology 242: 587-592

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Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each symptom during the **PAST WEEK INCLUDING TODAY**, by placing an X in the corresponding space next to each symptom.

NAME________________________________ DATE____________________________

	Not at All-0	Mildly-1	Moderately-2	Severely-3
1. Numbness or tingling.				
2. Feeling hot.				
3. Wobbliness in legs.				
4. Unable to relax.				
5. Fear of the worst happening.				
6. Dizzy or lightheaded.				
7. Heart pounding or racing.				
8. Unsteady.				
9. Terrified.				
10. Nervous.				
11. Feelings of choking.				
12. Hands trembling.				
13. Shaky.				
14. Fear of losing control.				
15. Difficulty breathing.				
16. Fear of dying.				
17. Scared.				
18. Indigestion or discomfort in abdomen.				
19. Faint.				
20. Face flushed.				
21. Sweating (not due to heat).				

Total Score:_________