

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: _____

Sex: _____ Identified Gender: _____ 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 _____

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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)

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____
Phone Number: _____ **Email:** _____

I consent to and authorize to disclose my protected health information relating to my identity, diagnoses, prognosis, and/or treatment. These records may include information related to medical conditions, tests, mental or behavioral health, 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: PCP Family Member Other Medical Provider Other _____

Name: _____
Address: _____
Phone Number: _____
Fax Number: _____

The purpose for this disclosure is: Coordination of Care Disability Application 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 Scheduling appointments/Medication refills Insurance claims and payments only
 Other _____

****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 upon my written request 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 my 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)

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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)

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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)

Office Use Only

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

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)

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

Other: _____

Current stressors (Please circle)

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

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)*

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
Increased Appetite	Y	N
Difficulty falling or staying asleep	Y	N
Fatigue	Y	N
Negative Thoughts	Y	N
Low Self Esteem	Y	N
Social isolation	Y	N
Feeling Worthless	Y	N
Feeling Hopeless/Helpless	Y	N
Homicidal Thoughts	Y	N

Weight loss	Y	N	How much _____
Weight gain	Y	N	How much _____
Total Hours of Sleep per day _____ hrs.			
Self-Injury	Y	N	
Suicidal Thoughts	Y	N	
Thoughts of Death/Dying	Y	N	
Access to firearms	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 _____

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

Panic Attacks: Y N How often? _____
 Duration? _____ Where? _____
 Triggers? _____

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

<u>Obsessions</u> Y N	Describe: _____
<u>Repetitive Behaviors</u> Y N	Describe: _____
<u>Fears</u> Y N	Describe: _____
<u>Flashbacks</u> Y N	Describe: _____
<u>Nightmares</u> Y N	Describe: _____
<u>Delusions</u> Y N	Describe: _____
<u>Paranoia</u> Y N	Describe: _____
<u>Hallucinations</u> 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

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

Concussion/head injury intake- 2018

Physical Symptoms 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
Ringings 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 _____

Concussion/head injury intake- 2018

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)

<u>Name</u>	<u>Dose</u>	<u>How Long</u>	<u>For What</u>	<u>Who Prescribed</u>
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? - _____

Concussion/head injury intake- 2018

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 you to do your work, take care of things at home, or get along with other people?

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

Today's Score _____

Past scores _____

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

BAI

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: _____