PATIENT INFORMATION AND MEDICAL HISTORY FORM

PATIENT DEMOGRAPHICS

Preferred Called Name:_____ Age:_____

Last Name:_____ First Name:_____

Date of Birth:_____ Social Security Number:_____

CONTACT

Home:_____ Work:_____ Cell:_____

May we leave a detailed message? □ Yes □ No IF YES, please circle the preferred number.

Email:_____

May we email you for appointment reminder, confidential results, promos, etc? □ Yes □ No

Preferred appointment reminder: Select

ADDRESS

Address:_____

City:_____ State:_____ Zip:_____

EMPLOYMENT

Employer:_____ Occupation:_____

EMERGENCY CONTACT

Last Name:_____ First Name:_____

Phone number:_____ Relationship to Patient:_____

FINANCIALLY RESPONSIBLE PARTY (Complete if NOT self/patient is a MINOR/NOT the main policy holder)

Last Name:_____ First Name:_____

Relationship to patient:_____ Date of Birth_____ SSN:_____

Address:_____ Phone:_____

PRIMARY PHYSICIAN

Physician Name:_____ Physician Phone:_____

Physician Address:_____

PREFERRED PHARMACY

Pharmacy Name:_____ Address:_____

Phone:_____ Fax:_____

TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™
F. Marie Hall Institute *for*
Rural *and* Community Health

Patient Name:
DOB:
Medical/TDCJ #:
Provider Name:
Telemedicine site:

Informed Consent to Telemedicine/Telepharmacy Consultation

I have been asked by my healthcare provider to take part in a telemedicine/telepharmacy consultation with Texas Tech University Health Sciences Center (TTUHSC) and its physicians, associates, technical assistants, pharmacists, affiliated hospitals and others deemed necessary to assist in my medical care through a telemedicine consultation.

I understand the following:

1. The purpose is to assess and treat my medical condition.
2. The telemedicine/telepharmacy consult is done through a two-way video link-up whereby the physician or other health provider at TTUHSC can see my image on the screen and hear my voice. However, unlike a traditional medical consult, the physician or other health provider does not have the use of the other senses such as touch or smell; and it may not be equal to a face-to-face visit.
3. Since the telemedicine consultants practice in a different location and do not have the opportunity to meet with me face-to-face, they must rely on information provided by me or my onsite healthcare providers. The TTUHSC and affiliated telemedicine/telepharmacy consultants can not be responsible for advice, recommendations and/or decisions based on incomplete or inaccurate information provided by me or others.
4. I can ask questions and seek clarification of the procedures and telemedicine technology.
5. I can ask that the telemedicine exam and/or videoconference be stopped at any time.
6. I know there are potential risks with the use of this new technology. These include but are not limited to:
    - Interruption of the audio/video link.
    - Disconnection of the audio/video link
    - A picture that is not clear enough to meet the needs of the consultation
    - Electronic tampering.

    If any of these risks occur, the procedure might need to be stopped.
7. The consultation may be viewed by medical and non-medical persons for evaluation, informational, research, educational, quality, or technical purposes.
8. I understand the examination may be videotaped for internal quality review or as might be required by my health coverage plan, however the video images will only be used for those purposes unless further authorized below.
9. I will not receive any royalties or other compensation for taking part in this telemedicine/telepharmacy consult or associated with any use by TTUHSC.
10. I understand I can make a complaint of my provider to the Texas Medical Board by going online at http://www.tmb.state.tx.us/page/place-a-complaint or calling the Complaint Hotline at 800-201-9353.

I, the undersigned patient, do hereby understand and state that I agree to the above consents that I have initialed as "agree" and I do not agree to any that I have initialed as "decline."

I certify that this form has been fully explained to me. I have read it or have had it read to me. I understand and agree to its contents. I volunteer to participate in the telemedicine examination. I authorize TTUHSC and the doctors, nurses, and other providers involved to perform procedures that may be necessary for my current medical condition.

Date: _____ **Time:**_____ Select

Signature:_____ **Printed Name:**_____

Witness: _____ **Interpreter (if applicable):**_____

Texas Tech University Health Sciences Center Ambulatory Clinics Consent to Treatment/Health Care Agreement	Patient Label (Name, DOB, MRN)

CONSENT TO TREATMENT: I voluntarily consent to receive medical and health care services provided by Texas Tech University Health Sciences Center physicians, employees and such associates, assistants, and other health care providers (otherwise referred to as "TTUHSC"), as my physicians deem necessary. I understand that such services may include diagnostic procedures, examinations, and treatment. I understand photographs, videotapes, digital and/or other images may be made/recorded for treatment, identification and payment purposes only. I understand that TTUHSC is a teaching institution. I acknowledge that no warranty or guarantee has been made to me as to result or cure.

I understand that this Consent to Treatment/Health Care Agreement will be valid and remain in effect as long as I attend or receive services from the TTUHSC Ambulatory Clinics, unless revoked by me in writing with such written notice provided to each clinic I attend or from which I receive services.

RELEASE OF MEDICAL INFORMATION: I understand that my prescriptions and prescription history will be sent, received and shared electronically with other healthcare providers and pharmacies. In addition, my medical records are available to other healthcare providers for treatment purposes through Health Information Exchanges (HIE). An HIE is an electronic system that stores your health information from multiple sources, not just TTUHSC, and may contain mental health and substance abuse information. Providers will attempt to exclude certain mental health and substance abuse records, but some portions of this information may be included. I may opt out of the HIE by completing an Opt-Out form. If I later change my mind, I may opt back in the same way.

I acknowledge that the "Notice of Privacy Practices" provides more information about how TTUHSC and its workforce may use and/or disclose protected health information (PHI). I understand that my PHI includes some but not all of the following like diagnosis, test results, prescriptions, medical history, treatment, my progress or any other such related information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs, or communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"). I understand my PHI will only be used or released for treatment, payment or healthcare operations, and as otherwise allowed by law. I understand TTUHSC cannot be responsible for use or re-disclosure of information by third parties.

NOTICE OF PRIVACY PRACTICES:
I have received or reviewed a copy of TTUHSC's Notice of Privacy Practices. _____ (Patient's Initials)

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: In consideration for receiving medical or health care services, I hereby assign to TTUHSC physicians and providers and/or the TTUHSC Medical Practice Income Plan my right, title, and interest in all insurance, Medicare/Medicaid, or other third-party payer benefits for medical or health care services otherwise payable to me. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third-party payer, up to the total amount of my medical and health care charges, to TTUHSC physicians and/or Medical Practice Income Plan. I certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare/Medicaid, is correct. **I agree to pay all charges for medical and health care services not covered by, or which exceed, the amount estimated to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third-party payer, and agree to make payment as requested by TTUHSC.**

USE OF CELL PHONE OR EMAIL: TTUHSC, its affiliates and agents may use an automated telephone dialing system, texting, and email to contact the cellular telephone number(s) or email addresses that I provide to TTUHSC for appointment and payment purposes.

ADVANCE DIRECTIVE:

Do you have a current, signed Advance Directive?	☐ YES	☐ NO
Has a signed copy been provided to TTUHSC?	☐ YES	☐ NO

By signing below, I agree I have read this form or it has been read to me and I understand what it is saying and agree to the terms.

Date	**Print Name**	**Signature Patient/ legally authorized person**

Witness/Translator	**Relationship to Patient**

Texas Tech University Health Sciences Center

Confidential Communication Request

Patient Name: _____

MRN: _____

DOB: _____

TTUHSC values the privacy of its patients and is committed to operating our practice in a manner that promotes patient confidentiality while providing high quality patient care. TTUHSC will accommodate reasonable requests.

If you need copies of medical records, you will need to complete a different authorization form. Please ask a staff member for the required form.

☐ Permission to give verbal protected health information (including appointment information) and leave messages with the following person(s): Example: family members, friends, personal caregivers, etc. You do not need to list any medical providers who are involved in your care. The patient and individuals listed below must provide at least one of the following: patient's address, patient's date of birth, last four digits of the patient's Social Security number.

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Please note that TTUHSC cannot leave specific test results or details of treatment plan on answering machines or voice mail due to our concern for your privacy.

Please complete the following questions for additional level of security which staff may ask if they have concerns on releasing your information. **Please provide at least one answer.**

1. What was your mother's maiden name? _____
2. What town were you born in? _____
3. What is your grandmother's name? _____
4. What is the name of your first pet? _____

Date

Print Your Name and Relationship to Patient (Person signing consent form)

Signature (Patient or Other Legally Authorized Person)

Relationship to Patient

Psychiatric Intake Form

(All information on this form is strictly confidential)

Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will it will go quickly. You may need to ask family members about the family history. **Also, please print out and complete the following:** MDQ and Depression questionnaire. Thank you!

Today's date: _____
Name: _____ Date of Birth: _____
Home Phone: _____ May I leave messages on this phone? ☐ Y ☐ N
Work Phone: _____ May I leave a message on this phone? ☐ Y ☐ N
Cell Phone: _____ E-mail: _____
Street address: _____
City: _____ Zip code: _____
Emergency Contact: _____
Phone: _____ Relationship to you: _____
Marital status: S ☐ M ☐ D ☐ W ☐ Non-married committed relationship? ☐
Name all the people with whom you live and their relationship to you:
_____
_____
Occupation: _____
Employer: _____
Highest level of education: _____ Age: _____ Sex: M ☐ F ☐

Do you wish me to contact your referral person regarding today's visit? ☐ Y ☐ N
If yes, person's name, address and phone number: _____
_____
_____
List the problems for which you wish to be seen today:

1. _____
2. _____
3. _____

What are your three biggest stressors right now?

1. _____
2. _____
3. _____

What are your goals for treatment?
_____
_____

Psychiatric History

Do you have a history of mental health problems or hospitalizations? ☐ Y ☐ N

If so, please complete the following:

Diagnosis Dates treated By whom

_____
_____
_____
_____

Are you currently receiving professional counseling or any kind of psychotherapy?

☐ Y ☐ N If yes, by whom: _____ Phone: _____

If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can remember all the details, just write in what you do remember.)

Dates Dosage Helpful?

Prozac (fluoxetine) _____
Zoloft (sertraline) _____
Luvox (fluvoxamine) _____
Paxil (paroxetine) _____
Celexa (citalopram) _____
Lexapro (escitalopram) _____
Effexor (venlafaxine) _____
Cymbalta (duloxetine) _____
Wellbutrin (bupropion) _____
Desyrel (trazodone) _____
Remeron (mirtazapine) _____
Serzone (nefazodone) _____
Anafranil (clomipramine) _____
Pamelor (nortriptyline) _____
Tofranil (imipramine) _____
Elavil (amitriptyline) _____
Tegretol (carbamazepine) _____
Lithium _____
Depakote (valproate) _____
Lamictal (lamotrigine) _____
Seroquel (quetiapine) _____
Zyprexa (olanzapine) _____
Geodon (ziprasidone) _____
Abilify (aripiprazole) _____
Clozaril (clozapine) _____
Haldol (haloperidol) _____
Prolixin (fluphenazine) _____
Xanax (alprazolam) _____
Ativan (lorazepam) _____

Restoril (temazepam) _____
Klonopin (clonazepam) _____
Valium (diazepam) _____
Ambien (zolpidem) _____
Buspar (buspirone) _____
Adderall (amphetamine) _____
Concerta (methylphenidate) _____
Ritalin (methylphenidate) _____
Strattera (atomoxetine) _____

Suicide Risk Assessment

Have you ever had feelings so bad that you have thoughts that you didn't want to go on, or that you might want to kill, yourself? ☐ Y ☐ N
If YES, please answer the following... If no, please skip to family history.
Is this unhappy feeling so strong you wish you were dead? ☐ Y ☐ N
How often have you had these thoughts? _____
Has anything happened recently to make you feel this? _____
_____
On a scale of 1 to 10, how strong is your desire to kill yourself? _____
What would it take to move you one point down the scale? _____
_____
Have you ever thought about how you would kill yourself? _____
Is this method you would use readily available? _____
Have you planned a time for this? _____
Have you ever tried to kill or harm yourself before? _____
Did things change as a result of these attempts? _____
Is there anything that would stop you from killing yourself? _____
_____
If you could look into the future, what do you feel you could look forward to? _____
_____
Are you bothered by problems with sleep? ☐ Y ☐ N
Are you bothered by hearing or seeing things or by voices? ☐ Y ☐ N If yes, please complete the DES questionnaire.
Do you have difficulty with focusing or following through on task? ☐ Y ☐ N

Family Psychiatric History

Has anyone in your family been diagnosed with or treated for:

	Yes	No		Yes	No
Bipolar disorder	Select		Schizophrenia	Select	
Depression	Select		Post-traumatic stress	Select	
Anxiety	Select		Alcohol abuse	Select	
Anger	Select		Other substance abuse	Select	
Suicide	Select		Violence	Select	
ADHD	Select				

If yes, who had what problem?

_____

_____

Has any family member been treated with a psychiatric medication? ☐ Y ☐ N If yes, what medications and how effective were they? _____

_____

_____

Medical Information Allergies: _____

Current prescription medications and how often you take them: (if none, write none)

_____

_____

Current over-the-counter medications or supplements: _____

_____

Current medical problems: _____

_____

Past medical problems, hospitalizations or surgeries: _____

_____

Do you have any concerns about your health you would like to discuss with me? ☐ Y ☐ N

On a 1 to 10 scale, with 10 being the most pain, what number would you rate your current physical pain now? _____ What number is it normally? _____

Name of your primary health care provider: _____

Phone: _____ Address: _____

Date and place of last physical exam: _____

Have you ever had an EKG? ☐ Y ☐ N Date: _____

For women only: Date of last menstrual period _____ Are you currently pregnant or do you think you might be pregnant? ☐ Y ☐ N

Are you planning to get pregnant in the near future? ☐ Y ☐ N

Birth control method _____

How many times have you been pregnant? _____ How many live births? _____

Do you have history of:

	Yes	No		Yes	No
Thyroid Disease			Depression		
Anemia			Bipolar Disorder		
Liver Disease			Psychosis		
Fibromyalgia			Anxiety		
Chronic Fatigue			Panic Attacks		
Heart Disease			Epilepsy/seizures		
Kidney Disease			Chronic Pain		

Diabetes _____ High Cholesterol _____

Asthma/respiratory problems _____ High blood pressure _____

Stomach or intestinal problems _____ Head trauma_____

Cancer _____

Is there a family history of anything **NOT** listed here? (Please explain):

_____

_____

When your mother was pregnant with you, were there any complications around the pregnancy or birth? _____

How many days a week do you exercise? _____ How many minutes w week do you exercise? _____ What kind of exercise do you get? _____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ☐ Y ☐ N

If yes, for which substances? _____

If yes, where and when were you treated? _____

_____

How many alcoholic drinks do you consume each week? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

Have you used any street drugs in the past 3 months? ☐ Y ☐ N

If yes, which ones? _____

Have you ever felt you ought to cut down on your drinking or drug use? ☐ Y ☐

Have people annoyed you by criticizing your drinking or drug use? ☐ Y ☐ N

Have you ever felt bad or guilty about your drinking or drug use? ☐ Y ☐ N

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ☐ Y ☐ N

Do you think you may have a problem with alcohol or drug use? ☐ Y ☐ N

Check if you have ever tried the following:

	Yes	No	If yes, when did you last use it?
Methamphetamine	Select		_____
Cocaine	Select		_____
Stimulants (pills)	Select		_____
Heroin	Select		_____
LSD or Hallucinogens	Select		_____
Marijuana	Select		_____
Pain killers (not prescribed)	Select		_____
Methadone	Select		_____
Tranquilizers/sleeping pills	Select		_____

Ecstasy Select _____
Alcohol Select _____
Other_____
How many caffeinated beverages do you drink a day? _____

Tobacco History
Cigarettes: Now? ☐ Y ☐ N In the past? ☐ Y ☐ N When did you quit? _____
How many per day on average? _____ For how many years? _____
Pipe, cigars, or chewing tobacco: Now? ☐ Y ☐ N In the past? ☐ Y ☐ N
What kind? _____ How often per day average? _____ For how many years? _____

Social History
Family Background and Childhood History
Were you adopted? ☐ Y ☐ N Where were you raised? _____
Please list your brothers and sisters and their ages: _____
_____
What is your father's occupation? _____
What is your mother's occupation? _____
Did your parents' divorce? ☐ Y ☐ N If so, how old were you when they divorced? _____
If your parents divorced, who raised you? _____
Describe your father and your relationship with him:
_____
Describe your mother and your relationship with her:
_____
_____
How old were you when you left home? _____
Where you ever physically or sexually abused? _____
Is so, at what age(s)? _____
Has anyone in your immediate family died? _____
Who and when? _____

Educational History
Did you attend college? _____ Where? _____
What was your major? _____
What is your highest educational level or degree attained? _____

Occupational History
Are you currently: ☐ Working ☐ Not working
How long in present position? _____

What is you occupation? _____

Where do you work? _____

Have you ever served in the military? _____ If so, what branch and when? _____

_____

Have you ever been arrested? _____ Do you have pending legal problems? _____

Marital History and Current Family

Are you currently dating, sexually active, or in a relationship(s)? ☐ Y ☐ N

How would you identify your sexual orientation?

☐ straight/heterosexual ☐ lesbian/gay/homosexual ☐ bisexual ☐ transsexual

☐ unsure/questioning ☐ asexual ☐ other ☐ prefer not to answer

Do you have concerns related to your sexual orientation? ☐ Y ☐ N

Are you currently: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Non-married committed

For how long? _____

What is your significant other's occupation? _____

Describe your relationship with your spouse or significant other:

_____

Have you had any prior marriages? ☐ Y ☐ N If so, how many? _____

For how long? _____

Do you have children? ☐ Y ☐ N Ages: _____

Describe your relationship with your children: _____

List everyone who currently lives at home: _____

_____

Trauma History

Do you have history of trauma from childhood abuse, military, combat, workplace trauma, domestic violence, rape, or medical trauma? _____

If you have a history of trauma, please complete the PSTD questionnaire.

Spiritual Assessment:

Do you belong to a particular religion or spiritual group? ☐ Y ☐ N

If yes, what is the level of your involvement? _____

Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ☐ more helpful ☐ stressful

If you do not belong to a particular group, do you have any particular religious, spiritual beliefs or a philosophy of life that are particularly important to you?

☐ Y ☐ N

Do your beliefs or philosophy of life affect how you think or feel about your illness?

☐ Y ☐ N If so, how? _____

Are there parts of your belief which you are calling into question because of your illness and current situation? ☐ Y ☐ N

As you face this illness, what activities do you use to help cope, feel better, and heal?

_____

What would you like your health care team and me, as your provider, to know about your spiritual needs as we care for you during this illness? _____

_____

What can I, as your provider, do to support you in your spiritual coping with this illness?

_____

Treatment Goals Checklist

This information is being collected under the authority of the Health and Social Service Authority in order to provide services. It is protected by the privacy provisions of the Access to information and Protection of Privacy (ATIPP). If you have questions about the collection or use of the information, please contact the manager/supervisor at the program providing the service. (The receptionist can direct you to the manager or supervisor)

Client Name: _____ Date: _____

The following is a list of goals that people coming to treatment sometimes have. Please indicate which your present goals are by circling Yes and which are not your present goals by circling No.

1. To deal with my problem of alcohol and/or drug use and/or gambling.	Yes	No
2. To learn to manage stress appropriately.	Yes	No
3. To learn to stand up for myself better.	Yes	No
4. To be able to deal with my feelings and express them directly.	Yes	No
5. To improve my relationship with members of my family (spouse, children, parents, etc.).	Yes	No
6. To be able to get along better socially.	Yes	No
7. To improve my ability to find and keep a job.	Yes	No
8. To learn to use my leisure time better.	Yes	No
9. To improve my living arrangements.	Yes	No
10. To deal effectively with my financial problems.	Yes	No
11. To deal effectively with my legal problems.	Yes	No
12. To deal effectively with my medical problems.	Yes	No
13. To manage my emotional/mental health issues appropriately.	Yes	No
14. Other-Please specify _____	Yes	No

Summary

How many goals have you indicated? _____

Of the goals you indicated, which are the most important for you to solve at the moment?

My first most important goal is # _____

My second most important goal is # _____

My third most important goal is # _____