LIFE healing center

mental healthcare individualized to fit your needs…

Phone: 678-344-8268
Fax: 888-627-6444

NEW PATIENT INTAKE 2019

PATIENT INFORMATION

Patient Full Name: _____ Maiden Name: _____

Date of Birth: _____ Age: _____ Social Security #: _____

Gender: □ Male □ Female Height: _____ Weight: _____

Sexuality: □ Heterosexual □ Homosexual □ Bisexual □ Other

Ethnicity: □ American Indian □ Hispanic/Latino □ Asian □ African American □ Pacific Islander □ White/Caucasian

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Appointment Reminders: □ Text Message □ Email (the system will automatically default to all unless otherwise specified)

EMERGENCY CARE INFORMATION

Name: _____ Relationship: _____ Phone: _____

SOCIAL HISTORY

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed □ Domestic Partnership

# of marriages: _____ Do you have children: □ No □ Yes: _____# of Sons _____# of Daughters Any Deceased: _____

Highest Level of Education: □ High School □ GED □ College □ Other: _____

Employment Status: □ Employed with _____ □ Unemployed □ Retired □ Disabled

Military Service: □ No □ Yes: Branch: _____ Years in Service: _____

Do you have any past/current legal issues: □ No □ Yes: _____

Have you experienced any Abuse, Neglect or Trauma: □ No □ Yes _____

Spiritual Beliefs: _____

PHARMACY

Pharmacy Name: _____ Phone: _____

Address: _____ City: _____

CURRENT BEHAVIORAL HEALTH STATUS

Please give a brief description of the major concerns that led you to seek treatment/therapy at this time.

_____

_____

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BEHAVIOR HEALTH STATUS CONTINUED

Are you currently experiencing any of the following (please check all that apply):

□ Depression □ Anxiety □ Memory Problems □ Anger Outbursts

□ Paranoia □ Hallucinations □ Mood Swings □ Panic Attacks

□ Sleeping Problems □ Manic Behaviors □ PTSD □ Suicidal / Homicidal Thoughts

□ Difficulty Focusing / Concentrating

PSYCHIATRIC HISTORY

Have you sought therapy/treatment in the past? □ No □ Yes

If yes, how was your experience with your previous therapy/treatment? □ Positive □ Neutral □ Limited □ Negative

Psychiatric Hospitalizations:_____

Substance Abuse Treatment: _____

FAMILY HISTORY

Are your parents still living: □ Mother Only □ Father Only □ Both Living □ Both Deceased

Do you have siblings: □ Yes □ No _____# of Brothers _____# of Sisters Any Deceased: _____

Please list any immediate family member(s) that have / had the following conditions:

□ Depression: _____ □ Anxiety: _____

□ Bipolar / Manic Depression: _____ □ Schizophrenia: _____

□ Suicide / Attempt: _____ □ Substance Abuse: _____

□ Dementia: _____ □ Other: _____

MEDICAL HISTORY

Primary Care Physician: _____ Phone: _____

Do you have/had any of the current conditions listed below? (Please check all that apply)

□ High Blood Pressure □ Cancer □ Asthma □ Heart Disease □ Stroke

□ Diabetes □ High Cholesterol □ Migraines □ Fibromyalgia □ Seizures

□ Thyroid Problems □ COPD □ Anemia □ Acid Reflux □ Sleep Apnea

Major Surgeries/Illnesses/Accidents/Hospitalizations: _____

_____

May we contact your personal physician to discuss medical or medication issues and/or coordinate your care?

No _____ Yes _____ If yes, please complete/sign a medical records release form.

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MEDICATIONS

Please list ALL CURRENT MEDICATIONS with STRENGTHS and INSTRUCTIONS, including over the counter medications:

Name of medication:	Dose	Directions
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES

Allergy to:	Onset (Child, Adult)	Severity	Reaction
_____	_____	_____	_____
_____	_____	_____	_____

Last Flu Vaccine: _____□ Never Last Pneumonia Vaccine: _____□ Never

PHYSICAL HEALTH STATUS

Tobacco Use:	□ Current	□ Former	□ Never	**Illicit Drugs**:	□ Current	□ Former	□ Never
Alcohol Use:	□ Daily	□ Socially	□ Never	**Rehab**:	□ Yes	□ No	
Exercise:	□ Regularly	□ Occasionally		□ Rarely		□ Never	
General Diet:	□ Healthy	□ Questionably Healthy		□ Not Very Healthy		□ Varies/Changes	
General Health:	□ Excellent	□ Good		□ Fair		□ Poor	

TREATMENT CONSENT & RELEASE FOR BILLING ACKNOWLEDGEMENT

RELEASE FOR BILLING: By signing below you are giving consent to Life Healing Center, PC to release any medical psychiatric or psychological information deemed necessary to the appropriate insurance companies in order to bill for services rendered. You are also agreeing to accept full responsibility of any balances, copays, and/or charges that are not covered by your insurance companies.

CONSENT FOR TREATMENT: By signing below, you are giving consent to all treatment by Life Healing Center PC, its agents, employees and contractors as deemed necessary by your providers or his/her consultants, associates or designees. You are giving informed consent to mental health treatment based on full, fair and truthful disclosure of known and reasonably foreseeable benefits, risks and hazards of the proposed treatment and of alternative treatments. Please note; for continuity of care, your treatment plan, progress and case notes may be discussed with any member of the treatment team to provide an integrative approach to your care.

ACKNOWLEDGEMENT OF POLICIES: Your signature below indicates that you were offered, have read and agreed to the LHC office policies, HIPAA Notice of Privacy Policies, Crisis Information, and LHC treatment consent form. These policies contain information on behavioral/mental health services, sessions, cancellation and no-show policies, billing and payments, insurance reimbursement, contacting us, professional records, confidentiality, and practice status; and you agree to abide by its terms during our professional relationship.

Patient / Guardian Signature: _____ Date: _____

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PSYCHIATRIC & CONTROLLED MEDICATIONS POLICY

As of January 1, 2012, the State of Georgia has issued new laws regarding the prescribing of psychiatric and controlled medications. In order to meet the requirements as they pertain to the Life Healing Center, PC, we have put into place the following guidelines:

- Patients must maintain regular appointments as determined by the physician in order to receive these medications. If you missed your scheduled appointment, we are unable to refill any medications until you see the doctor again.
- Early refills are not allowed on any controlled medications. No exceptions.
- Temporary supplies will not be given on any controlled medications.
- Life Healing Center, PC does not allow a 90- day supply on controlled medications.
- If a psychiatric medication or prescription is lost or stolen, the patient must contact the police and file a police report. This report will have to be sent to Life Healing Center, PC and placed in your chart. Please note that replacement prescriptions may not be possible depending on the medication, the availability of the physician and the circumstances in which the prescription was lost or stolen. Replacement prescriptions are never provided for controlled medications.
- If we suspect a patient of abusing prescription medications or any other substances, at any time, the patient will be discharged from the Life Healing Center, PC.
- If you receive duplicate medications from another physician, you will be discharged from Life Healing Center, PC as it is a violation of our policies and against the law.
- Any changes in medications or requests for additional medications will require an appointment with the doctor.
- Please be sure to call in your refill requests to our prescription line and allow up to 2 business days for processing. All medications will be e-prescribed to your pharmacy.

All pharmacies are required to report all controlled prescription medications to the Georgia Prescription Drug Monitoring Program as they are filled. Pharmacists and prescribers have access to this system to prevent fraud and abuse of controlled prescription medications. Therefore, we regularly check this database to ensure patient compliance to medications and do our part in helping to prevent fraud and abuse.

By signing below, you are agreeing to the above policy as it has been stated and are authorizing Life Healing Center, PC to send prescriptions electronically to your pharmacy. You are also authorizing Life Healing Center, PC to access your pharmacy/prescription history as well as controlled prescription history through the Georgia Prescription Drug Monitoring Program. **This form must be signed to receive any prescriptions from our office.**

Patient Name (PLEASE PRINT): _____

Patient / Guardian Signature: _____ Date: _____