



8 Broad Street
Plattsburgh, NY 12901
Phone: (518) 825-1555 Fax: (518) 825-1550

INTAKE FORM

The treatment and counseling work we do is unique to you, just as it is to each one of our patients. Before we get started we need to collect some general information from you.

GENERAL INFORMATION

First Name	Last Name	Gender
Date of Birth (mm/dd/yyyy)		Social Security Number
Address		
City	State	Zip Code
Main Phone	Other Phone	
Email		

EMERGENCY CONTACT

First Name	Last Name
Phone	Relationship

Do you authorize this person to discuss care or treatment with the office in the case of an emergency?

YES NO

INSURANCE INFORMATION

PRIMARY INSURANCE	Policy Holder	
Policy Holder D.O.B. (mm/dd/yyyy)	Relationship	
Policy Holder Address		
City	State	Zip Code
Policy Number	Group Number	



SECONDARY INSURANCE		Policy Holder
Policy Holder D.O.B. (mm/dd/yyyy)		Relationship
Policy Holder Address		
City	State	Zip Code
Policy Number	Group Number	

PARENT/GUARDIAN INFORMATION (If applicable)

First Name	Last Name
Phone	Relationship
First Name	Last Name
Phone	Relationship

MENTAL HEALTH HISTORY/STATUS

What problems are you seeking help for?

Past Mental Health Treatment

Have you ever been hospitalized for psychiatric reasons? YES NO


If yes, when and where?

Have you ever had outpatient treatment by a psychiatrist or psychiatric provider (e.g. NP or PA)? YES NO

If yes, when and by whom?

Have you ever received counseling or psychotherapy in the past? YES NO

If yes, when and by whom?

 <p style="text-align: center;">MEDICATION QUESTIONNAIRE</p>	<p>Name: _____</p> <p>Date: _____ Date of Birth: _____</p>
---	--

DIRECTIONS: Please place a check mark in the box that describes your experience with any of the medications listed below.

Generic Name	Trade Name	Helpful	Not Helpful	Current Use	History of Use	Adverse Reaction	Approximate Dates of Use
ANTIDEPRESSANTS							
Amitriptyline	Elavil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bupropion	Wellbutrin, Wellbutrin SR, Wellbutrin XL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Citalopram	Celexa	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Clomipramine	Anafranil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Desipramine	Norpramin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Desvenlafaxine	Pristiq	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Doxepin	Sinequan, Silenor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Duloxetine	Cymbalta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Escitalopram	Lexapro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fluoxetine	Prozac, Sarafem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fluvoxamine	Luvox, Luvox CR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Imipramine	Tofranil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Isocarboxazid	Marplan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Levomilnacipran	Fetzima	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Milnacipran	Savella	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mirtazapine	Remeron, Remeron SolTab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nefazodone	Serzone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nortriptyline	Pamelor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Paroxetine	Paxil, Paxil CR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Phenelzine	Nardil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Selegiline Transdermal	Emsam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sertraline	Zoloft	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tranylcypromine	Parnate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Trazodone	Desyrel, Oleptro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Venlafaxine	Effexor, Effexor XR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vilazodone	Viibryd	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vortioxetine	Trintellix, Brintellix	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ANTIPSYCHOTICS “major tranquilizers”							
Aripiprazole	Abilify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Asenapine	Saphris	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Brexpiprazole	Rexulti	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cariprazine	Vraylar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chlorpromazine	Thorazine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Clozapine	Clozaril, FazaClo, Versacloz	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fluphenazine	Prolixin, Prolixin Decanoate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Haloperidol	Haldol, Haldol Decanoate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Iloperidone	Fanapt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



MEDICATION QUESTIONNAIRE

Name:

Date:

Date of Birth:

Generic Name	Trade Name	Helpful	Not Helpful	Current Use	History of Use	Adverse Reaction	Approximate Dates of Use
Loxapine	Loxitane	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lurasidone	Latuda	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Molindone	Moban	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Olanzapine	Zyprexa, Zyprexa Zydis, Zyprexa Relprevv	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Paliperidone	Invega, Invega Sustenna, Invega Trinza	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Perphenazine	Trilafon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pimavanserin	Nuplazid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Quetiapine	Seroquel, Seroquel XR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Risperidone	Risperdal, Risperdal Consta, Risperdal M-Tab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thioridazine	Mellaril	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thiothixene	Navane	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Trifluoperazine	Stelazine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ziprasidone	Geodon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ANXIOLYTICS “anti-anxiety” “minor tranquilizers”							
Alprazolam	Xanax, Xanax XR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bupirone	BuSpar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chlordiazepoxide	Librium	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Clonazepam	Klonopin, Klonopin Wafers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Clorazepate	Tranxene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diazepam	Valium	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hydroxyzine	Vistaril, Atarax	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lorazepam	Ativan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Oxazepam	Serax	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ANTICHOLINESTERASE/ALZHEIMER’S AGENTS							
Donepezil	Aricept	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Galantamine	Razadyne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Memantine	Namenda, Namenda XR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rivastigmine	Exelon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Selegiline	Eldepryl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tacrine	Cognex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ALCOHOL/DRUG/SMOKING CESSATION AGENTS							
Acamprosate	Campral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Buprenorphine/ Naloxone	Suboxone, Bunavail, Zubsolv	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bupropion	Zyban	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Disulfiram	Antabuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Methadone	Dolophine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Naltrexone	ReVia, Vivitrol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



MEDICATION QUESTIONNAIRE

Name: _____

Date: _____

Date of Birth: _____

Generic Name	Trade Name	Helpful	Not Helpful	Current Use	History of Use	Adverse Reaction	Approximate Dates of Use
Varenicline	Chantix	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MOOD STABILIZING AGENTS/AED's							
Carbamazepine	Tegretol, Tegretol XR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fluoxetine/Olanzapine	Symbyax	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gabapentin	Neurontin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lamotrigine	Lamictal, Lamictal XR, Lamictal ODT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Levetiracetam	Keppra, Keppra XR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lithium	Eskalith, Eskalith CR, Lithobid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Oxcarbazepine	Trileptal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tiagabine	Gabitril	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Topiramate	Topamax	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Valproate	Depakene, Depakote, Depakote ER, Valproic Acid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PSYCHOSTIMULANTS							
Amphetamine Salts	Adderall, Adderall XR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Armodafinil, Pemoline	Nuvigil, Cylert	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Atomoxetine	Strattera	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dexmethylphenidate	Focalin, Focalin XR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dextroamphetamine	Dexedrine, Dextrostat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lisdexamfetamine	Vyvanse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Methylphenidate	Ritalin, Ritalin SR, Ritalin LA, Concerta, Metadate ER/CD, Methylin, QuilliChew ER, Quillivant XR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Methylphenidate Transdermal	Daytrana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Modafinil	Provigil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SEDATIVE/HYPNOTICS							
Chloral Hydrate	Noctec	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eszopiclone	Lunesta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Flurazepam	Dalmane	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ramelteon	Rozerem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Suvorexant	Belsomra	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Temazepam	Restoril	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Triazolam	Halcion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Zaleplon	Sonata	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Zolpidem	Ambien, Ambien CR, Intermezzo, Edluar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
OTHER							
Benzotropine	Cogentin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



GENERAL MEDICAL HISTORY

Primary Care Physician:

Please list any medical problems you may have below:

Please list any serious medical procedures you have had in the past:

Are you on any medications for any general medical problems you may have? YES NO

If yes, which ones?

Do you have any allergies to medications? YES NO

If yes, which ones?



Alcohol, Drug, and Tobacco Use

Describe your use of alcohol:

Describe your use of recreational drugs:

Describe your use of tobacco:

Family Medical History

List any history of illness (mental or other) and substance abuse among blood relatives:

Mother's side

Father's side

SOCIAL HISTORY

Birth place:

Where did you grow up?

Did your parents get divorced as a child? YES NO

If so, how old were you when they separated?

Father's occupation growing up:

Mother's occupation growing up:

How many siblings do you have?



Did you have any early development problems as a child?

Are you/were you a victim of any form of physical/sexual/emotional abuse?

Highest Level of Education:

Please list the last three jobs you have had below:

Current employment:

Are you currently in a romantic relationship? **YES** **NO** Duration: _____

Describe your relationship:

Spouse or partner's current occupation:



Do you have any children? YES NO How many? _____

What are your children's names and ages?

What activities do you enjoy doing?

Have you ever been convicted of any crimes, served time, or been on probation? YES NO

Details:

Please list any additional notes that you think would be helpful for treatment below:



CONSENT TO TREATMENT

First Name

Last Name

You are about to take a very important step in your mental health treatment, and you are seeing a mental health professional. As your mental health provider, we will be entering into a protected relationship. Treatment might involve a multidimensional family approach. Due to this consent is needed for all those attending sessions.

We are treating you and we will do our best to accurately diagnose you and design a comprehensive treatment plan that will enable you to continue with a normal emotional development. This may include recommendations of therapy, or medications. This is all part of the service of a mental health professional. We will also work with your primary care physician to assure coordination of care.

_____ (Initial)

You are our patient and have confidentiality rights. Confidentiality does not apply under certain situations: We are obligated by law to report any suspicion of child abuse. This includes physical or sexual abuse. Also, we have a duty to protect if we suspect anyone is in danger of killing themselves or has made threats to hurt someone else. Except in these rare situations, your child has the right to keep particular topics confidential from even his/her guardian. Please respect this confidentiality. Again, if there is any concern of harm, suicide or other dangerous behavior, we will inform you.

If I require or think it is in your best interest to communicate with an outside source, I will request a release of information. To assure good therapeutic care, frequent appointments are required. Unless arranged otherwise, patients that have not been seen in 6 months may be considered inactive. A new evaluation will be required for any inactive patient to be seen.

_____ (Initial)

I, _____ (patient), do hereby seek and consent to take part in the treatment provided by North Country Behavioral Medicine PLLC. If I am attending group services I also understand and consent that confidentiality still applies and that North Country Behavioral Medicine PLLC is not liable for group members breaking confidentiality. I understand that developing a treatment plan with this provider and regularly reviewing our work toward the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this mental health professional.

_____ (Initial)



I am aware that I may stop treatment with this mental health professional at any time. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

_____ (Initial)

I am aware that if I attempt to contact my provider through phone, email, text, or any other form of communication over the Internet, my information may not be completely secure. In the event that my information is intercepted, North Country Behavioral Medicine is not responsible for the breach of patient privacy. Below are the approved contact means to leave messages on or respond to if contacted:

Phone

Email

_____ (Initial)

Patient Name (please print)

Patient Signature

Date



LIFETIME INSURANCE AUTHORIZATION AND RELEASE OF INFORMATION

First Name

Last Name

Release of Information: I, the subscriber named below, authorize North Country Behavioral Medicine PLLC and any providers working under North Country Behavioral Medicine PLLC examining or treating me to release any and all information pertaining to my treatment to any third party payer (such as my insurance company or a government agency) as needed to determine a claim for payment for such treatment and or diagnosis.

Physician Insurance Assignment: I, the below named subscriber, hereby authorize payment directly to North Country Behavioral Medicine PLLC for my treatment at this office that is otherwise payable to me for their services as described.

Medicare/Medicaid – Patient’s certification authorization to release information and payment request, I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN’S OFFICE. This assignment will remain in effect until revoked by me writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. I understand it’s my responsibility to pay any deductible amount co-insurance, or any other balance not paid for by my insurance or third payer within a reasonable period of time not to exceed 90 days.

Patient Name (please print)

Patient/Guardian Signature

Date

Insurance Company



HIPPA NOTICE/PRIVACY PRACTICES

First Name

Last Name

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

North Country Behavioral Medicine PLLC 8 Broad Street, Plattsburgh, NY 12901, (518) 825-1555

We understand the importance of privacy and are committed to maintaining the confidentiality of your information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this notice please contact our office.

See front office for "HIPPA Detail" forms.

Patient Name (please print)

Patient/Guardian Signature

Date



AUTHORIZATION FOR RELEASE OF INFORMATION

First Name

Last Name

Date of Birth (mm/dd/yyyy)

We respect your personal information and want you to know your rights as a patient of North Country Behavioral Medicine. Please read the information below.

PATIENT RIGHTS

- You may end this authorization (permission to use or disclose information) any time by contacting our office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

PATIENT AUTHORIZATION

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, legal/court records, educational records, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the above identified patient. I authorize these agencies to share information by mail, phone, in person, fax and/or email contact. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

I hereby authorize North Country Behavioral Medicine PLLC to **RELEASE** my protected health information (PHI) to:

I hereby authorize North Country Behavioral Medicine PLLC to **OBTAIN** my protected health information (PHI) from:



DISCLOSURE SCOPE FOR PHI RELEASE:

Disclosure may include the following verbal or written information: (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Face sheet | <input type="checkbox"/> History & physical |
| <input type="checkbox"/> Laboratory/diagnostic testing results | <input type="checkbox"/> School information |
| <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Medication records |
| <input type="checkbox"/> Behavioral health/psychological consult | <input type="checkbox"/> Psychosocial assessment/Family history |
| <input type="checkbox"/> ER record report | <input type="checkbox"/> Psychiatric evaluation |
| <input type="checkbox"/> Substance abuse treatment records | <input type="checkbox"/> HIV/AIDS lab results & treatment history |
| <input type="checkbox"/> Progress & Case Notes | <input type="checkbox"/> Summary of treatment records & contact dated |
| <input type="checkbox"/> Psychological evaluation/testing results | <input type="checkbox"/> Tense/unable to relax |
| <input type="checkbox"/> Afraid to leave home | <input type="checkbox"/> Excessive worry |
| <input type="checkbox"/> Inflated self esteem | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Feel guilty or worthless | <input type="checkbox"/> Thoughts of death or suicide |

Other: _____

Information necessary to identify, diagnose, prognosis, or treatment for mental health, substance abuse (alcohol/drug use), and any other relevant information for the purpose of treatment.

All information I hereby authorize to be obtained from the above identified source will be held strictly confidential and cannot be released by North Country Behavioral Medicine PLLC without my written consent. I understand that this authorization will remain in effect for:

- The period necessary to complete all transactions on accounts related to services provided to me.
- One (1) year
- Other: _____

I understand that unless otherwise limited by state or federal regulation and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time. If patient is a minor child, I verify that I am the legal guardian/custodian of this child.

Signature of Patient/Legal Guardian or Legally Authorized Representative Date

Witness Date



APPOINTMENT CANCELLATION AGREEMENT

First Name

Last Name

Each meeting is another opportunity to help you confidently take charge and start living the life that's important to you. We understand things come up and you may need to miss your appointment. If you need to reschedule or cancel any appointments, the office of North Country Behavioral Medicine requires **24 business hours notification (Monday through Friday 8:00 am to 5:00 pm)**. Please understand that we set aside this time for you, and if you are unable to make it, we will have missed an opportunity to meet with another valuable patient. This policy is in place to give the office enough time to schedule another patient in that time slot. If you fail to cancel 24 hours business hours prior to your appointment a **\$50 fee will be charged (\$100 for an initial assessment) to the card below** or the credit card on file. ***If you are a Medicaid patient (including Fidelis, UHC Community Plan, Medicare/Medicaid, etc.) you are not subject to the \$50 fee, however after 2 violations of this agreement (1 for a new assessment), services at this office may be terminated.***

While we do remind you of your appointment, it is your responsibility to call the office at (518) 825-1555, to cancel.

I authorize the following card to be used for co-pays and fees incurred during the time I am a patient with North Country Behavioral Medicine PLLC.

Card Number

Expires

CVV

Printed Name

Signature

Date

I understand that the office of North Country Behavioral Medicine PLLC will attempt to bill my insurance, however **if my insurance does not pay, for whatever reason, I am responsible for any remaining balance.** This may include deductibles, copays, or out of pocket expenses.

My signature acknowledges:

- In the case of a Psychiatric Emergency I will call 911 or go to the nearest hospital
- 72 business hours is required for any prescription renewals.
- I will adhere to the guidelines above to the best of my ability.

Patient Name (please print)

Patient/Guardian Signature

Date



Statement of Non-Discrimination

This Practice does not differentiate or discriminate in the treatment of Persons on the basis of to include, but not limited to: veteran status, race, ethnicity, mental or physical disability or medical condition, sexual orientation, claims experience, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, color, sex, age, religion, national origin, place of residence, health history, health status, handicap, source of payment or status as a Person.

Signature

Printed Name

Date

North Country Behavioral Medicine, PLLC

Patient Review of Systems Questionnaire

NAME: _____ DATE: _____

Please check if you've had any of these symptoms within the last three weeks:

<p>Constitutional</p> <ul style="list-style-type: none"><input type="checkbox"/> Coldness<input type="checkbox"/> Sweating<input type="checkbox"/> Dry mouth<input type="checkbox"/> Fatigue<input type="checkbox"/> Fever <p>Eye, Ear, Nose, Mouth/Throat</p> <ul style="list-style-type: none"><input type="checkbox"/> Blurred vision<input type="checkbox"/> Corrective lenses: _____<input type="checkbox"/> Double vision<input type="checkbox"/> Ringing in ears<input type="checkbox"/> Hearing loss<input type="checkbox"/> Frequent colds<input type="checkbox"/> Frequent sore throats<input type="checkbox"/> Difficulty swallowing <p>Cardiovascular</p> <ul style="list-style-type: none"><input type="checkbox"/> Chest pain<input type="checkbox"/> Leg/Arm swelling<input type="checkbox"/> High blood pressure<input type="checkbox"/> Low blood pressure<input type="checkbox"/> Palpitations/skipped beats<input type="checkbox"/> Fast heart beat <p>Respiratory</p> <ul style="list-style-type: none"><input type="checkbox"/> Coughing<input type="checkbox"/> Shortness of breath<input type="checkbox"/> Wheezing <p>GI System</p> <ul style="list-style-type: none"><input type="checkbox"/> Abdominal pain<input type="checkbox"/> Anal problems<input type="checkbox"/> Blood in stools/black stools<input type="checkbox"/> Constipation/hard stools<input type="checkbox"/> Diarrhea/unformed stools<input type="checkbox"/> Heartburn<input type="checkbox"/> Nausea<input type="checkbox"/> Vomiting	<p>Genitourinary</p> <p>Women:</p> <ul style="list-style-type: none"><input type="checkbox"/> Vaginal discharge<input type="checkbox"/> Menstrual cramps/pain<input type="checkbox"/> Irregular periods<input type="checkbox"/> STD <p>Men:</p> <ul style="list-style-type: none"><input type="checkbox"/> STD<input type="checkbox"/> Penile discharge<input type="checkbox"/> Testicular swelling<input type="checkbox"/> Testicular tenderness <p>Urinary</p> <ul style="list-style-type: none"><input type="checkbox"/> Frequency<input type="checkbox"/> Incontinence<input type="checkbox"/> Recurrent infections<input type="checkbox"/> Urgency<input type="checkbox"/> Urethral discharge <p>Musculoskeletal</p> <ul style="list-style-type: none"><input type="checkbox"/> Use of assistive device: _____<input type="checkbox"/> Back pain<input type="checkbox"/> Joint pain<input type="checkbox"/> Stiffness<input type="checkbox"/> Swelling<input type="checkbox"/> Weakness <p>Skin/Hair/Nails</p> <ul style="list-style-type: none"><input type="checkbox"/> Dry skin<input type="checkbox"/> Hair loss<input type="checkbox"/> Lacerations (cuts)<input type="checkbox"/> Rashes<input type="checkbox"/> Scars <p>Breast/Chest</p> <ul style="list-style-type: none"><input type="checkbox"/> Breast feeding<input type="checkbox"/> Nipple discharge<input type="checkbox"/> Pain<input type="checkbox"/> Swelling	<p>Neurological</p> <ul style="list-style-type: none"><input type="checkbox"/> Confusion<input type="checkbox"/> Dizziness<input type="checkbox"/> Headaches<input type="checkbox"/> Head injury<input type="checkbox"/> Memory problems<input type="checkbox"/> Migraines<input type="checkbox"/> Numbness<input type="checkbox"/> Seizures<input type="checkbox"/> Fainting<input type="checkbox"/> Tingling<input type="checkbox"/> Tremors <p>Endocrine</p> <ul style="list-style-type: none"><input type="checkbox"/> Cold intolerance<input type="checkbox"/> Excessive hunger<input type="checkbox"/> Excessive thirst<input type="checkbox"/> Excess urination<input type="checkbox"/> Heat intolerance<input type="checkbox"/> Weight gain<input type="checkbox"/> Weight loss <p>Hematological</p> <ul style="list-style-type: none"><input type="checkbox"/> Bruising<input type="checkbox"/> Excessive bleeding<input type="checkbox"/> Lumps/swelling <p>Allergies</p> <ul style="list-style-type: none"><input type="checkbox"/> Drug<input type="checkbox"/> Environment<input type="checkbox"/> Seasonal<input type="checkbox"/> Food <p>OTHER:</p>
--	---	---

Patient Signature: _____

Vital Signs (provider to enter):

BP: _____ (Sitting)

PR: _____ **RR:** _____

O2: _____ **Temp:** _____

Height: _____ **Weight:** _____

Mood Disorder Questionnaire

Patient Name _____ Date of Visit _____

Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and...	YES	NO
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	<input type="checkbox"/>	<input type="checkbox"/>
...you were so irritable that you shouted at people or started fights or arguments?	<input type="checkbox"/>	<input type="checkbox"/>
...you felt much more self-confident than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you got much less sleep than usual and found that you didn't really miss it?	<input type="checkbox"/>	<input type="checkbox"/>
...you were more talkative or spoke much faster than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...thoughts raced through your head or you couldn't slow your mind down?	<input type="checkbox"/>	<input type="checkbox"/>
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	<input type="checkbox"/>	<input type="checkbox"/>
...you had more energy than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you were much more active or did many more things than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	<input type="checkbox"/>	<input type="checkbox"/>
...you were much more interested in sex than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	<input type="checkbox"/>	<input type="checkbox"/>
...spending money got you or your family in trouble?	<input type="checkbox"/>	<input type="checkbox"/>

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? YES NO

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?

No problems Minor problem Moderate problem Serious problem

CAGE-AID Questionnaire

Patient Name _____ Date of Visit _____

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Questions:	YES	NO
1. Have you ever felt that you ought to cut down on your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have people annoyed you by criticizing your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever felt bad or guilty about your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
4. 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?	<input type="checkbox"/>	<input type="checkbox"/>

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

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

FOR OFFICE CODING 0 + + +
=Total Score:

If you 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

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?

(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T_____ = _____ + _____ + _____)

Trauma Screening Questionnaire

Question 1

Have you ever experienced events in your life, or have you ever witnessed events that were really frightening, life-threatening, overwhelming or shocking?

(Check the appropriate answer)

No *(Thank you for your participation, you have now completed this questionnaire)*
 Yes *(Please continue to question 2)*

Question 2

What kind of shocking experience(s) have you experienced?

(Check what is applicable to you; you may check more than one answer)

	<i>Yes, one traumatic experience</i>	<i>Yes, more than one traumatic experience</i>	<i>No, no traumatic experiences</i>
<i>Sexual activities against your will</i>			
<i>Physical abuse</i>			
<i>Emotional or psychological abuse</i>			
<i>Severe neglect</i>			
<i>Accident/disaster/war</i>			
<i>An episode of psychosis</i>			

Question 3

Your own reactions now to the traumatic event

Please consider the following reactions which sometimes occur after a traumatic event. This questionnaire is concerned with your personal reactions to the traumatic event which happened to you. Please indicate (Yes/No) whether or not you have experienced any of the following at least twice in the past week.

		At least twice in the past week?	
		YES	NO
1	Upsetting thoughts or memories about the event that have come into your mind against your will		
2	Upsetting dreams about the event		
3	Acting or feeling as though the event were happening again		
4	Feeling upset by reminders of the event		
5	Bodily reactions (such as fast heartbeat, stomach churning, sweatiness, dizziness) when reminded of the event		
6	Difficulty falling or staying asleep		
7	Irritability or outbursts of anger		
8	Difficulty concentrating		
9	Heightened awareness of potential dangers to yourself and others		
10	Being jumpy or being startled at something unexpected		

MacLean Screening Instrument

1. Have any of your closest relationships been troubled by a lot of arguments or repeated breakups? Yes ___ No ___
2. Have you deliberately hurt yourself physically (e.g., punched yourself, cut yourself, burned yourself)? How about made a suicide attempt? Yes ___ No ___
3. Have you had at least two other problems with impulsivity (e.g., eating binges and spending sprees, drinking too much and verbal outbursts)? Yes ___ No ___
4. Have you been extremely moody? Yes ___ No ___
5. Have you felt very angry a lot of the time? How about often acted in an angry or sarcastic manner? Yes ___ No ___
6. Have you often been distrustful of other people? Yes ___ No ___
7. Have you frequently felt unreal or as if things around you were unreal? Yes ___ No ___
8. Have you chronically felt empty? Yes ___ No ___
9. Have you often felt that you had no idea of who you are or that you have no identity? Yes ___ No ___
10. Have you made desperate efforts to avoid feeling abandoned or being abandoned (e.g., repeatedly called someone to reassure yourself that he or she still cared, begged them not to leave you, clung to them physically)? Yes ___ No ___