Chesapeake Behavioral Health Center, LLC

♦ Intake Screening Form ♦

Intake Date: _____ **Time:** _____

1st Appointment scheduled: Date: _____ **Time**: _____ **Provider**: _____

Part 1 ☐ **New Patient or** ☐ **Returning Patient - Last Visit:** _____

Patient's Legal Name - First: _____ **Middle:** _____ **Last:**_____

Preferred Name, if different: _____

Date of Birth: _____ **Social Security #:** _____-_____-_____

Gender: ☐ **M** ☐ **F** **Transgender:** ☐ **M to F** ☐ **F to M** ☐ **Non-Binary** ☐ **Other:** _____

Race: ☐ **White** ☐ **African American** ☐ **Hispanic** ☐ **Asian** ☐ **American Indian** ☐ **Other:** _____

Sexual Orientation: ☐ **Heterosexual** ☐ **Homosexual** ☐ **Bisexual** ☐ **Prefer not to answer** ☐ **Other** _____

Marital Status: ☐ **Single** ☐ **Partnered** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

Name of ☐**Spouse or** ☐**Significant Other:** _____ **Phone Number:** _____

Home Address: _____

_____

E-mail: _____

Cell Number: _____ **Home Number:** _____

Part 2

Primary Insurance Company: _____

Phone #: _____ **Fax #:** _____

Subscriber Name: _____ **DOB:** _____

Relationship to insured: ☐ **Self** ☐ **Spouse** ☐ **Mother** ☐ **Father** **Other:** _____

ID#: _____ **Group#:** _____ **Effective Date:** _____

Co-Pay: $_____ **Deductible: $** _____

Employer Name: _____

Secondary Insurance Company (if any): _____

Phone #: _____ **Fax #:** _____

Subscriber Name: _____ **DOB:** _____

Relationship to insured: ☐ **Self** ☐ **Spouse** ☐ **Mother** ☐ **Father** **Other:** _____

ID#: _____ **Group#:** _____ **Effective Date:** _____

Co-Pay: $_____ **Deductible: $** _____

Employer Name: _____

Tertiary Insurance Company (if any): _____

Phone #: _____ **Fax #:** _____

Subscriber Name: _____ **DOB:** _____

Relationship to insured: ☐ **Self** ☐ **Spouse** ☐ **Mother** ☐ **Father** **Other:** _____

ID#: _____ **Group#:** _____ **Effective Date:** _____

Co-Pay: $_____ **Deductible: $** _____

Employer Name: _____

Part 3 Emergency Contacts (or Responsible Parties if patient is under 18 or unable to provide information on their own)

Contact Name: _____ **Relation to Patient:** _____
Cell #: _____ **Home #:** _____
Work #: _____ **E-Mail:** _____
Mailing Address : _____
_____

Contact Name: _____ **Relation to Patient:** _____
Cell #: _____ **Home #:** _____
Work #: _____ **E-Mail:** _____
Mailing Address: _____
_____

Part 4 Only complete, if Prior Psychiatric Hospitalization (s)

Most Recent Psych Hospitalization: _____ **Discharge Date:** _____
Mental Health Treatment History: _____
_____
_____

PLEASE BRING ANY PSYCHIATRIC DISCHARGE OR MEDICATION RECORDS PERTINENT TO TREATMENT.

History of Drug or Alcohol Abuse: ☐ **Yes or** ☐ **No If yes Please Explain:** _____
_____

Part 5 CHILDRENS SERVICES ONLY

Custody Status (if applicable): ☐ **N/A Intact Family** ☐ **Mother** ☐ **Father** ☐ **Foster Care:** _____
Custody Papers Requested? ☐ **Yes** ☐ **No**

AUTHORIZATION

I, _____, authorize Chesapeake Behavioral Health Center (CBHC), LLC to leave text and voice messages, including automated appointment reminders generated by our Electronic Records System, at the phone number(s) listed above.

I, _____, authorize CBHC, LLC to use and disclose the protected mental health information described below to the individuals listed:

1. _____
2. _____
3. _____

x_____ _____ _____
Patient's Signature **Patient Name (Printed)** **Date**

x_____ _____ _____
Guardian's Signature if Client is Disabled or a Minor Guardian Name (Printed) Date

Chesapeake Behavioral Health Center, LLC

217 Main Street, Suite B
Reisterstown, MD 21136
Tel: (410) 833-0581
Fax: (410) 833-8604

PLACE LABEL HERE

♦ Consent for Mental Health Treatment ♦

Last Name	First Name	Middle Name

I, _____(Patient's Name) have reviewed all of the policies and procedures regarding the Mental Health treatment I am requesting to receive from Chesapeake Behavioral Health Center (CBHC), LLC and its qualified Physicians, Nurse Practitioners, Mental Health Providers, Employees and Agents (Collectively known as CBHC, LLC) to provide outpatient mental health services deemed medically necessary, appropriate, usual and customary. It is further understood, I may revoke my Consent for Treatment in writing at any time.

I understand that all information concerning participation in mental health treatment is privileged and confidential, and *except where specifically required by Law,* will not be provided to any source without my specific written consent.

I agree that I have been fully oriented to the services offered by CBHC, LLC and the treatment which is being proposed for me. I have reviewed my Health Insurance Portability and Accountability Act (HIPAA Privacy Form), Financial Responsibilities Form, Consent for Release of Information, Consumer Discharge Policy.

I also understand it is my responsibility as a consumer to make the staff at CBHC, LLC fully aware of any problems or issues that may arise due to treatment, therapy, changes in my contact or insurance information, and billing issues or balances, in a timely manner.

x_____	_____
Client's Signature	**Date**
_____	_____
Guardian's Signature if Client is Disabled or a Minor	Date
_____	_____
Staff Representative	Date

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PLACE LABEL HERE

♦ Financial Responsibility Form ♦

SIGNING THIS DOCUMENT MAY ALTER YOUR LEGAL RIGHT UNDER Maryland Law. Please review and read carefully ask if you have any questions. *Do not sign unless you understand this document*.

THE COST OF TREATMENT COVERED BY INSURANCE

_____(Initials) I will be responsible for providing ALL current insurance information, (including a copy of the insurance card) or any changes in coverage. If the information I provide is incorrect, out of date or my insurance denies services rendered, I understand that I am responsible for all charges incurred for services received at Chesapeake Behavioral Health Center (CBHC), LLC and I may have to pay out of pocket.

_____(Initials) CBHC, LLC **DOES NOT** Participate with any Health Maintenance Organizations (HMO's). If services are provided, I will be billed, and I are responsible for full payment of the statement.

PAYMENTS, CO-PAYMENTS, DEDUCTIBLES- METHOD OF PAYMENTS

_____(initials) I understand I am responsible for co-payments, deductibles, and outstanding balances that are due when services are rendered. If any questions or discrepancies arise, I will contact the billing department before I come in for my next appointment or service may be denied.

_____(Initials) I am solely responsible for administrative fees associated with the completion of forms, letters, applications, assessments or other administrative documents requested of CBHC, LLC on the patients behalf; I am aware that administrative fees range from **$25.00 to $250.00** and are assessed in accordance with the time required of the Clinician and/or Clinical staff at CBHC, LLC.

_____ (Initials) I understand that payments for services, co-pays, and deductibles may be made via Cash, Check, Visa, MasterCard, Discover, American Express and Money Orders**.** If checks are returned due to insufficient funds a returned check fee of **$35.00** will be assessed. **This must be paid in full before the patient can be seen again.**

CANCELLATIONS / LATE CANCELLATIONS/ NO SHOWS

_____(Initials) I understand that I must keep scheduled appointments in order to have the best care possible. I agree to schedule appointments at the frequency recommended by the treating physician or therapist.

_____(Initials) I am aware that if I have 3 cancellations or no shows from either the Psychiatrist, Nurse Practitioner or Therapist I will be discharged from **any** Psychiatric or Psychotherapeutic services at CBHC, LLC.

_____(Initials) I understand that I must give at least **48 hours** advance notice to cancel a scheduled appointment. **A late cancellation** or **no-show** fee of **$30.00** will be charged to my credit card on file at CBHC, LLC. These fees are my responsibility and will **not** be paid by my insurance company.

Credit Card #: _____ **Exp Date:** _____ **CVV#:**_____ **Zip Code:** _____

_____(Initials) I understand that if I do not have a credit card or one on file, I am responsible, and I agree that I will pay for the missed appointment fee **$30.00** before I am seen again.

FINANCIAL AGREEMENT – PATIENT OR RESONSIBLE PARTY

I have reviewed the above conditions and financial responsibilities. I agree to my financial responsibility for Behavioral Health Services, as stated above.

_____ _____ _____

Client's or Guardian's Signature (if Client is Disabled or a Minor) | **Printed Name** | **Date**

Chesapeake Behavioral Health Center, LLC

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PLACE LABEL HERE

♦ HIPAA Privacy Rights Form ♦

(Federal Health Insurance Portability and Accountability Act)
45 C.F.R. Parts 160 and 164

1. 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. If you have any questions about this Notice or want additional information, please contact, Chesapeake Behavioral Health Center, LLC, (Privacy Contact - Lucy Cashdollar, R.N.) at 410-833-0581

2. Purpose. We are required by law to maintain the confidentiality and privacy of your protected health information. "Protected health information" is information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information.

We are required to abide by the terms of this Notice, which is effective April 14, 2003. We reserve the right to change the terms of our Notice at any time as permitted by law. The new Notice will be effective for all protected health information that we maintain at that time and for information we receive in the future. We will post a current copy of the policy and will have copies of our current policy available each time you are here for health care services. We will also provide you with any revised Notice of Privacy Practices upon a request made by you via phone or in person.

3. Uses and Disclosures of Protected Health Information for Treatment, Payment and/or Operations. The following categories describe different ways that we may use and disclose health information for treatment, payment and operations. At least one example is given for each category. Please be aware that not every possible use or disclosure is listed.

A. Treatment: We may use and disclose your protected health information to provide you with treatment and services and to coordinate your care. For example, we may disclose your protected health information to other agency clinical staff that are involved in your care as well as different departments of the agency in order to coordinate the various services you might need, such as prescriptions.

B. Payment: Your protected health information may be used to obtain approval for and payment for services you receive. For example, we may confirm your eligibility with insurance plans, governmental agencies, or Medicaid in order to obtain approval and/or payment of services.

C. Operations: We may use or disclose your protected health information as necessary for our regular business activities such as health oversight, accreditation, licensing, and quality assurance. For example, members of the quality assurance team may use information in your health record to assess the care in your case to continually improve the quality and effectiveness of the healthcare services we provide. As part of operations, we may contact you to provide appointment reminders.

We may share your protected health information with third party "business associates" that perform various activities for us involving protected health information (e.g., auditors, attorneys), but only when we have a written contract with the business associate that fully protects the privacy of your protected health information.

4. Other Permitted and/or Required Uses and Disclosures: According to Federal Privacy Regulations, we may make the following uses and disclosures without obtaining consent or written authorization from you.

A. Unless you object, under federal law we may disclose health information about you to a member of your family, a relative, a close friend or any other person you identify as involved in your care.

B. We may use or disclose your protected health information in an emergency when use and disclosure of the protected health information is necessary to prevent serious risk of bodily harm or death.

C. We may use or disclose your protected health information if and to the extent we are required by federal or state law. You will be notified, if required by law, of any such uses or disclosures.

D. We may disclose to a court when ordered by the court.

E. We **must** disclose to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, if we believe that you have been a victim of abuse, neglect or domestic violence, we **must** disclose your protected health information to the governmental entity or agency authorized to receive such information. Any disclosure of suspected abuse will be made consistent with the requirements of any applicable state law.

F. We may disclose to governmental agencies or private entities responsible for overseeing health care activities through audits, investigations, inspections and licensure. Oversight agencies include government and/or private agencies that oversee the health care system, government benefit programs, government regulatory programs and civil rights laws.

G. Required Uses and Disclosures**:** Under federal law, we must make disclosures when required by the Secretary of the United States Department of Health and Human Services to investigate or determine our compliance with the requirements of 45 C.F.R. Part 164.308 et. seq. We may disclose for public health purposes such as notifying public health authorities regarding specific communicable diseases, but only to the extent allowed by state law. We may disclose to federal, state or local agencies engaged in disaster relief to the extent that such information is required to enable them to carry out their responsibilities in specific disaster situations.

5. Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization: Other uses and disclosures of your protected health information not covered by this Notice or by laws that apply to us will be made only with your written authorization. You may revoke this authorization, at any time, in writing. If you revoke this authorization, we will no longer use or disclose your protected health information for the reasons covered by the authorization. However, we cannot undo any disclosures we have already made with the authorization and are required to retain our records of the care that we provided to you.

6. Your Rights Regarding Your Protected Health Information.
You have the following rights with respect to your protected health information:

A. **You Have the Right to Request Restrictions:** You have the right to request a limitation or a restriction on the protected health information we use or disclose about you for treatment, payment or healthcare operations. We are not required to agree to a restriction that you may request. If we agree to the requested restriction, we may not use or disclose your protected health information in violation of the restriction unless it is needed to provide emergency treatment. You must make this request in writing to our Privacy Contact at the address listed below.

B. **Right to Request Confidential Communication:** You have the right to request to receive confidential communications from us in a certain way or at an alternative location. For example, you can ask that we only contact you at home or by mail. We will accommodate reasonable requests. We may also condition this accommodation by asking you for specification of an alternative address or other method of contact. The request must be made in writing to our Privacy Contact at the address listed below specifying how or where you wish to be contacted.

C. **Right to Inspect and Copy:** You have the right to inspect and obtain a copy of protected health information about you that we maintain. To inspect and/or obtain a copy of protected health information, you must submit your request in writing to our Privacy Contact. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other related costs. We may deny your request to inspect and copy in certain limited circumstances. Under federal law, for example, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding. We are also permitted to deny your request to inspect and copy if the protected health information was obtained from someone under a promise of confidentiality. Please contact our Privacy Contact if you have questions about access to your records.

D. **Right to Amend:** If you believe that health Information, we have about you is incorrect or incomplete, you may request that we amend it. Your request must be in writing, submitted to the address listed below, and must state the reason you are seeking an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us which will be made a part of your record. We may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal. Please contact our Privacy Contact if you have questions about amending your record.

E. **Right to Receive an Accounting of Disclosures:** You have the right to an accounting of disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You must submit your request in writing to the address listed at the end of this Notice. The right to receive this information is subject to certain exceptions, restrictions and limitations. If you believe we have violated your privacy rights, you may complain to us or to the Secretary of Health and Human Services. You may file a complaint with us by notifying our Privacy Contact. We will not retaliate against you for filing a complaint.

F. **Right to Receive a Copy:** You have a right to receive a paper copy of the Notice of Privacy Practices upon request.

Copy offered to consumer ☐ Yes ☐ No

7. Contacting Privacy Officer: Lucy Cashdollar, R.N. Chesapeake Behavioral Health Center, LLC, (Privacy Contact) at 410-833-0581, 217 Main Street, Suite B, Reisterstown, MD 21136-1213

X_____ _____

Patient's Signature **Date**

X_____ _____

Guardian's Signature if Client is Disabled or a Minor Date

Chesapeake Behavioral Health Center, LLC

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PLACE LABEL HERE

♦ CONSUMER DISCHARGE POLICY ♦

A consumer may be discharged from the rolls of Chesapeake Behavioral Health Center (CBHC), LLC for any or all the following reasons:

1. **PLANNED DISCHARGE**, consumer or consumer and legal guardian *with* the approval of the CBHC, LLC Treatment Team.

    a. The consumer, or the consumer and/or their legal guardian have determined, in conjunction with their Treatment Team, discharge is now appropriate and viable by a specified date and time everyone has agreed upon. This discharge is considered normal, appropriate and routine.

2. **UNPLANNED DISCHARGE**, Consumer or Consumer and Legal Guardian, *without* the approval of the CBHC, LLC Treatment Team.

    a. Treatment Compliance: The consumer, or the consumer and their legal guardian have been unable or unwilling to follow the Treatment Plan agreed upon by the consumer, or the consumer and their legal guardian and the CBHC, LLC Treatment Team.

    b. Failed to Keep Appointments: The consumer, or the consumer and their legal guardian have been unable or unwilling to keep appointments reserved for them by the CBHC, LLC Treatment Team, without providing *at least 48 hours prior notice.*

    c. The consumer or the consumer and their legal guardian have been unable or unwilling to attend appointments with the regularity agreed upon by the consumer, or the consumer and their legal guardian, and CBHC, LLC Treatment Team.

At the time of Discharge, the following information will be provided to the consumer, or to the consumer and their Family or legal guardians:

A letter will be mailed informing you of a list of providers to the consumer or the consumer and their legal guardian advising them of their discharge from Medical Treatment at CBHC, LLC specifying the reason for the consumer's discharge from CBHC, LLC and continuing service recommendations and summary of the anticipated transition process will also be included.

I, as the consumer, have reviewed all the Policies and Procedures regarding the Consumer Discharge Policy from CBHC, LLC and its qualified Physicians, Nurse Practitioners, Mental Health Providers, Employees and Agents (Collectively known as CBHC, LLC). I agree to the terms and provisions of consumer discharge policy from medical treatment. It is further understood, I may at any time, acting on my own behalf, terminate medical treatment resulting in discharge from CBHC, LLC.

---

x_____ _____

Client's Signature **Date**

_____ _____

Guardian's Signature if Client is Disabled or a Minor Date

_____ _____

Staff Representative Date

Chesapeake Behavioral Health Center, LLC

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♦ Client Medical Self-Report ♦

Name: _____ Date of Birth: _____ Date Completed: _____

Primary Care Physician: _____ PCP Phone Number: _____

Date of last physical: _____ Comments: _____

How would you describe your current state of health?
☐ Very good ☐ Good ☐ Fair ☐ Poor ☐ Very poor explain: _____

Please indicate which medical conditions you have experienced in the past or are currently experiencing.

Have had in past	Have now		Have had in past	Have now	
		General Health			**Glands**
☐ Y ☐ N	☐ Y ☐ N	Tuberculosis	☐ Y ☐ N	☐ Y ☐ N	Swollen Glands
☐ Y ☐ N	☐ Y ☐ N	Flu	☐ Y ☐ N	☐ Y ☐ N	Thyroid Problems
☐ Y ☐ N	☐ Y ☐ N	Hepatitis	☐ Y ☐ N	☐ Y ☐ N	Diabetes
☐ Y ☐ N	☐ Y ☐ N	Cancer	☐ Y ☐ N	☐ Y ☐ N	Low energy level
☐ Y ☐ N	☐ Y ☐ N	Frequent Colds	☐ Y ☐ N	☐ Y ☐ N	High energy level
☐ Y ☐ N	☐ Y ☐ N	Pneumonia			**Genito-Urinary**
☐ Y ☐ N	☐ Y ☐ N	Heart Problems	☐ Y ☐ N	☐ Y ☐ N	Venereal Disease
☐ Y ☐ N	☐ Y ☐ N	Stroke	☐ Y ☐ N	☐ Y ☐ N	Kidney Problems
☐ Y ☐ N	☐ Y ☐ N	Mononucleosis	☐ Y ☐ N	☐ Y ☐ N	Bedwetting
☐ Y ☐ N	☐ Y ☐ N	Surgery, Specify	☐ Y ☐ N	☐ Y ☐ N	Blood in urine
		Gastro-intestinal	☐ Y ☐ N	☐ Y ☐ N	Difficulty urinating
☐ Y ☐ N	☐ Y ☐ N	Stomach trouble			**Nervous System**
☐ Y ☐ N	☐ Y ☐ N	Ulcers	☐ Y ☐ N	☐ Y ☐ N	Frequent Nightmares
☐ Y ☐ N	☐ Y ☐ N	Liver trouble	☐ Y ☐ N	☐ Y ☐ N	Shakiness/tremors
☐ Y ☐ N	☐ Y ☐ N	Weight loss	☐ Y ☐ N	☐ Y ☐ N	Frequent headaches
☐ Y ☐ N	☐ Y ☐ N	Weight gain	☐ Y ☐ N	☐ Y ☐ N	Sleep problems
☐ Y ☐ N	☐ Y ☐ N	Loss of appetite	☐ Y ☐ N	☐ Y ☐ N	Nervousness
☐ Y ☐ N	☐ Y ☐ N	Pancreatitis	☐ Y ☐ N	☐ Y ☐ N	Depression
		Circulation	☐ Y ☐ N	☐ Y ☐ N	Mental Illness
☐ Y ☐ N	☐ Y ☐ N	Cold hands/feet	☐ Y ☐ N	☐ Y ☐ N	Attempted Suicide
☐ Y ☐ N	☐ Y ☐ N	High blood pressure	☐ Y ☐ N	☐ Y ☐ N	Memory Problems
☐ Y ☐ N	☐ Y ☐ N	Low blood pressure	☐ Y ☐ N	☐ Y ☐ N	Head Injury
☐ Y ☐ N	☐ Y ☐ N	Bleed Easily	☐ Y ☐ N	☐ Y ☐ N	Paralysis/loss of mobility
		Respiration	☐ Y ☐ N	☐ Y ☐ N	Loss of Coordination
☐ Y ☐ N	☐ Y ☐ N	Difficulty breathing	☐ Y ☐ N	☐ Y ☐ N	Persistent Pain
☐ Y ☐ N	☐ Y ☐ N	Frequent coughing			**Females Only**
☐ Y ☐ N	☐ Y ☐ N	Pain/pressure in chest	☐ Y ☐ N	☐ Y ☐ N	Pregnant
☐ Y ☐ N	☐ Y ☐ N	Coughing Blood	☐ Y ☐ N	☐ Y ☐ N	Abortion
☐ Y ☐ N	☐ Y ☐ N	Night Sweats	☐ Y ☐ N	☐ Y ☐ N	Miscarriage/still birth
☐ Y ☐ N	☐ Y ☐ N	Asthma	☐ Y ☐ N	☐ Y ☐ N	Decreased sex drive
		Males Only	☐ Y ☐ N	☐ Y ☐ N	Female Disorders
☐ Y ☐ N	☐ Y ☐ N	Prostate Problems			**Other**
☐ Y ☐ N	☐ Y ☐ N	Decreased Sex Drive			
☐ Y ☐ N	☐ Y ☐ N	Impotence			

Food Allergies: _____

Drug Allergies: _____

Environmental Allergies: _____

a) Do you experience chronic pain? ☐ No ☐ Yes If yes, describe the location / context of the pain:

_____

Are you receiving treatment? ☐ No ☐ Yes By Whom: _____

b) Height: _____ ft. _____ in. Weight: _____ lb.

Do you consider yourself: ☐ average weight ☐ overweight ☐ underweight?

In the past **month**, have you: ☐ gained weight ☐ lost weight? How much? _____ lbs.

Was this gain/loss intentional? ☐ yes ☐ no Explain: _____

For children, is your child making the appropriate height & weight gains?

☐ yes ☐ no Explain: _____

c) In a typical **week**, how often do you eat: ☐ Breakfast: _____ ☐ Lunch: _____ ☐ Dinner: _____

Do you believe that you have balanced meals? ☐ yes ☐ no, why not? _____

Have you ever: ☐ binged ☐ purged ☐ restricted calorie intake

How recent? _____ How frequently? _____

d) Please list prescribed medications and dosages currently taken:

Medication: _____ Dosage: _____ Start Date: _____
Medication: _____ Dosage: _____ Start Date: _____
Medication: _____ Dosage: _____ Start Date: _____
Medication: _____ Dosage: _____ Start Date: _____
Medication: _____ Dosage: _____ Start Date: _____
Medication: _____ Dosage: _____ Start Date: _____

Please list any street drugs or alcohol used, amounts and frequency:

_____

_____

e) Family: Please comment on the physical health and mental health history of key family members:

Relationship	Age	Living with you?	Past or Present Medical / Mental Health Conditions?	If deceased, cause of death and age at death
Father		☐ Y ☐ N		
Mother		☐ Y ☐ N		
Stepfather		☐ Y ☐ N		
Stepmother		☐ Y ☐ N		
Spouse		☐ Y ☐ N		
Brothers /Sisters		☐ Y ☐ N		
		☐ Y ☐ N		
		☐ Y ☐ N		
		☐ Y ☐ N		
Children		☐ Y ☐ N		
		☐ Y ☐ N		
		☐ Y ☐ N		
Extended Family		☐ Y ☐ N		
		☐ Y ☐ N		
		☐ Y ☐ N		

Client's Signature: _____ **Date**: _____/_____/_____

Physician's Signature: _____ **Date**: _____/_____/_____