

## FAMILY THERAPY & RECOVERY, PS ROBYN BENNETTS, ARNP, PMHNP

This packet of additional information is intended to assist your Practitioner in providing you with the best service possible. We ask that you answer carefully and completely. All information on these forms is considered to be confidential and will be handled according to the PHI (Protected Health Information) HIPAA requirements.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Referred By: \_\_\_\_\_

Phone: \_\_\_\_\_

**\*\* Please note some of the questions are not relevant to children, you may mark out the sections that do not apply\*\***

Is there any additional information you would like to provide about what brings you here today?

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**Please list any medications not listed on the initial registration form:**

**CURRENT / RECENT MEDICATIONS:**

NAME of Medication	Dose:	Frequency	Start	Stop

Adverse / Allergic Drug Reactions: \_\_\_\_\_

Alternative Supplements/Vitamins: \_\_\_\_\_

Highest Weight: \_\_\_\_\_ Current Weight: \_\_\_\_\_ Height: \_\_\_\_\_

**Women:** Are you currently pregnant?     Yes     No

Number of Pregnancies: \_\_\_\_\_      Regular menstrual periods?     Yes     No

Are you currently taking birth control?     Yes     No

Have you ever been diagnosed or treated for any of the following? Regardless of whether they are current or past problems.

Current	Past		Current	Past	
		Abdominal pain			Increased thirst/ urination
		Alcohol Abuse			Infection(s)
		Anemia			Jaundice/ Hepatitis
		Arthritis			Joint/ Back problems
		Asthma			Kidney Disease/ stones
		Bleeding mole			Liver disease
		Cancer (within last 5 years)			Motor coordination/ paralysis
		Chest Pain/ Palbitation			Night sweats/ fevers
		COPD/ Emphysema			Nutrition problems
		Convulsions/ Seizures			Pain in back or extremities
		Coughing up blood			Sexually transmitted disease
		Diabetes			Shortness of Breath
		Dizziness/ fainting spells			Skin problems
		Drug Abuse			Smoking
		Eating Disorder(s)			Stroke
		Epilepsy			Sudden Loss of Smell, Taste, Vision,
		Frequent lingering cough			Sudden Loss of Hearing, Sensation
		Frequent severe headaches			Swelling of the Feet/Ankles/Hands
		Heart Disease			Thyroid/ Gland Problems
		Hemophilia			Tuberculosis/ TB Exposure
		High Blood Pressure			Ulcers
		Hormone Replacement Therapy			Unintentional weight loss/ gain
		Hyper/ Hypoglycemia			Other:
					Surgeries/ injuries:

Have you ever received any prior Psychiatric, Psychological or Substance Use Disorder Services?

Name of treatment facility: i.e. outpatient/inpatient	Practitioners Seen:	Dates of Service	Were services helpful?

**SUBSTANCE USE HISTORY: (if applicable)**

Have you ever felt you should cut down on your drinking/drug use? \_\_\_\_\_

Have people annoyed you by criticizing your drinking/drug use? \_\_\_\_\_

Have you ever felt bad or guilty about your drinking/drug use? \_\_\_\_\_

Have you ever drank/used drugs in the morning to steady your nerves or relieve a hangover? \_\_\_\_\_

**FAMILY MEDICAL, PSYCHIATRIC AND SUBSTANCE USE HISTORY**

Please note with a "X" in the appropriate box if these conditions are current or have occurred in relatives

	Children	Siblings	Mother	Father	Uncles/ Aunts	Grandparents	Others
Nervous Problems (anxiety)							
Depression							
Substance Abuse							
Other							

**Family Data:**

**Place of Birth:** \_\_\_\_\_

**Father:** Living or deceased? \_\_\_\_\_ Age if living: \_\_\_\_\_

Occupation: \_\_\_\_\_

Health Status: \_\_\_\_\_

If deceased, cause of death: \_\_\_\_\_

Frequency and nature of contact: \_\_\_\_\_

**Mother:** Living or deceased? \_\_\_\_\_ Age if living: \_\_\_\_\_

Occupation: \_\_\_\_\_

Health Status: \_\_\_\_\_

If deceased, cause of death: \_\_\_\_\_

Frequency and nature of contact: \_\_\_\_\_

**Brothers/ Sisters:**

Name	Sex	Age	Resides where?

Did you live with anyone other than your natural parents for any significant time during your childhood years?

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**RELATIONSHIP HISTORY**

**Marital Status:** Single:\_\_\_\_\_ Married:\_\_\_\_\_ Divorced:\_\_\_\_\_ Widowed:\_\_\_\_\_ Partnered:\_\_\_\_\_

If married, remarried or partnered, for how long? \_\_\_\_\_

If divorced, separated, or widowed, for how long? \_\_\_\_\_

If previously married or in a long-term relationship, when? \_\_\_\_\_ how long? \_\_\_\_\_

Spouse/ Partner's age: \_\_\_\_\_ Spouse/ Partner's occupation: \_\_\_\_\_

Spouse/ Partner's prior marriages: \_\_\_\_\_ When? \_\_\_\_\_ How long? \_\_\_\_\_

**Children/ Step-children:** *(if additional space needed write on the back)*

Name	Sex	Age	Resides where?

**LIVING ARRANGEMENTS / HOME ENVIRONMENT**

With whom do you currently live? \_\_\_\_\_

Are there any concerns about living arrangements? \_\_\_\_\_

**EDUCATIONAL HISTORY**

Highest level of education completed? \_\_\_\_\_

Did you receive any special educational services? \_\_\_\_\_

**OCCUPATIONAL HISTORY**

Occupation: \_\_\_\_\_ Current position: \_\_\_\_\_

If not currently working, date you last worked: \_\_\_\_\_

List names of employers in past 10 years: \_\_\_\_\_

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## Confidentiality

**Mental Health:** We respect your right to confidentiality. With the exception of the specific special circumstances noted below, most issues that are discussed in the course of psychiatric or mental health evaluations and treatments are confidential. However, under the HIPAA Policies and Patients' Rights Agreement, which is made available to you, there are exceptions to this rule, which you may read about in that document. Under the Health Care Information Access and Disclosure Law of Washington State, I am allowed to confer with any current, prior, or future health care providers for purposes of continuity of care, without written Authorization, unless you instructed me otherwise. Substance Abuse (Chemical Dependency) and Domestic Violence information cannot be disclosure except as noted below.

**Furthermore, there are specific exceptions to confidentiality that are mandated by law. These include:**

1. If you are a specific danger to yourself or others
2. Information regarding the abuse or neglect of a child, a developmentally disabled person, or a dependent adult.
3. Information required by court proceeding.
4. If you are gravely disabled.

**Alcohol/Substance Use:** Alcohol and/or Substance Use treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, Parts 160 and 164.

**Domestic Violence:** Domestic Violence records are protected under the Federal and State Confidentiality Regulations and cannot be disclosed without written consent unless otherwise provided for in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, Parts 160 and 164 and State (RCW 71.05.390 - WAC 275-56-240).

Generally for Drug and Alcohol Abuse or Domestic Violence, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as a client unless:

1. The patient consents in writing; OR
2. The disclosure is allowed by a court order; OR
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation; OR
4. The patient commits or threatens to commit a crime either at the program or against any person who works for the program.

**Please ask your health care provider if you have any questions about the information found within this consent.**

**FAMILY THERAPY & RECOVERY, PS**  
**ROBYN BENNETTS, ARNP, PMHNP**  
**INFORMED CONSENT FOR TREATMENT, APPOINTMENTS, FEES AND MEDICATION REFILLS**

**Your Right and Responsibilities**

As a patient, you have the right to ask questions about any aspect of your treatment, and deserve information regarding any risks, benefits, or side effects of any proposed treatments as well as treatment alternatives. You have the right to refuse or end treatment at any time without any legal or financial obligations except to pay for evaluation and treatment already received. Similarly, we reserve the right to decline or terminate treatment at our discretion if we feel that a positive or effective treatment relationship is not possible, and in that case, we would assist you in finding an alternate provider if that became necessary.

**Coverage:** We believe the decision to start and maintain medications for psychiatric and substance use disorders is a shared responsibility. You and your family are expected to manage more routine and less urgent issues with your medications primarily during your appointments, or at least during weekday business hours. Currently we do not have after-hour or weekend coverage. If a truly urgent issue arises, **PLEASE CALL 911 or go to the nearest Emergency Room or Call the Crisis Line @ 866.427.4747 or 211 on your cell phone.** For non-emergent issues, you may call 253.220.9452 and leave a message that will be forward to your practitioner the next business day.

**Regarding prescription refills:** At each appointment we will provide enough medication to last until your next appointment. Please schedule that appointment accordingly so that you do not run out of medication. Generally, **we will not refill medications if you do not have a return appointment scheduled.** If you have that appointment, then contact your pharmacy for a refill request. Please see controlled drug expectations below. Please allow 3 business days for us to process refill requests – this means notifying us before you run out of your medications. **Any refill request made outside of this policy will be charged a \$25.00 prescription request fee.**

**Patient Initials:** \_\_\_\_\_

**Scheduled Appointment Policy**

Entering into psychiatric-mental health services is effectively a contract. We agree to be available to you as scheduled to treat you ethically and to the best of our ability. We are able to provide these services because you are agreeing to make your appointments and pay for your services (usually, in part, through your insurance). If you miss an appointment or cancel with little notice, this prevents us from providing service to other patients as well as it affects the viability of our practice. We expect you to show us the courtesy of cancelling appointments with sufficient notice to be able to use that time productively.

**Missed Appointment or Late Cancellation Fees:** It is your responsibility to attend regularly scheduled appointments. Our usual practice is to contact you by either phone, email or send a letter if an appointment is missed either due to late cancellation or not coming. **Late cancellations and missed appointments will be charged \$100 per occurrence.** These charges must be paid by you and cannot be billed to your insurance.

Any cancellation or reschedule request must be done **48 hours prior** to your appointment to avoid late cancellation fees. Cancellations are accepted via email ([admin@familytherapyrecovery](mailto:admin@familytherapyrecovery)) or by phone (**253.220.9452**), they are to be done Mon - Sat during business hours. Any cancellations or reschedule requests done after or before business hours will be processed the following business day.

If there have been **3 no shows or late cancellations** for appointments, we will need to close your mental health services with Family Therapy & Recovery, PS. At that time, you would have 30 days to request refills or referrals to other health care providers prior to final closure of your care. Clearly, we want to avoid this if at all possible, but are unable to accommodate multiple missed appointments.

**Patient Initials:** \_\_\_\_\_

# CONSENT FOR TREATMENT, ACKNOWLEDGEMENT AND SIGNATURE FORM

Please sign and return this page as a permanent inclusion in your client file after you have read the policies on Informed Consent for Treatment, Appointments, Cancellations / Rescheduling and Medication Refills

- My signature below indicates that I have read, understand, and agree to the policies as stated on the form, "Informed Consent for Treatment, Appointments, Fees and Medication Refills.
- I understand and accept responsibility for payment of fees in accordance with these terms and conditions, including the late cancellation and missed appointment fees.
- I understand my rights and responsibilities as a client, and the responsibility of the medical staff member to me. I authorize FT&R and Staff to provide behavioral health services to me. I consent to the use of a diagnosis in billing and to release of that information and other information necessary to complete the billing process.
- I understand that under the Health Care Information Access and Disclosure Law of Washington State, your provider is allowed to confer with my current, prior, or future health care providers for purposes of continuing care, without my written Authorization, unless I have instructed my provider otherwise.
- I know I can end treatment at any time that I wish and that I can refuse any treatment recommendations made by my provider.

**This authorization constitutes informed consent to treatment without any exception.**

\_\_\_\_\_  
Patient Signature:

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Parent/ Guardian Signature:

\_\_\_\_\_  
Date:

Name: \_\_\_\_\_ Date: \_\_\_\_\_

## ANXIETY SCALE

**INSTRUCTIONS:** This scale includes questions about the symptoms of anxiety. For each item please indicate how well it describes you during the PAST WEEK, INCLUDING TODAY. Circle the number in the columns next to the item that best describes you.

0=not at all true    1=rarely true    2=sometimes true    3=often true    4=almost always true

### During the PAST WEEK, INCLUDING TODAY....

- |  |   |   |   |   |   |
|--|---|---|---|---|---|
| 1. I felt nervous or anxious .....                       | 0 | 1 | 2 | 3 | 4 |
| 2. I worried a lot that something bad might happen ..... | 0 | 1 | 2 | 3 | 4 |
| 3. I worried too much about things .....                 | 0 | 1 | 2 | 3 | 4 |
| 4. I was jumpy and easily startled by noises.....        | 0 | 1 | 2 | 3 | 4 |
| 5. I felt "keyed up" or "on edge" .....                  | 0 | 1 | 2 | 3 | 4 |
| 6. I felt scared.....                                    | 0 | 1 | 2 | 3 | 4 |
| 7. I had muscle tension or muscle aches .....            | 0 | 1 | 2 | 3 | 4 |
| 8. I felt jittery .....                                  | 0 | 1 | 2 | 3 | 4 |
| 9. I was short of breath.....                            | 0 | 1 | 2 | 3 | 4 |
| 10. My heart was pounding or racing .....                | 0 | 1 | 2 | 3 | 4 |
| 11. I had cold, clammy hands.....                        | 0 | 1 | 2 | 3 | 4 |
| 12. I had a dry mouth.....                               | 0 | 1 | 2 | 3 | 4 |
| 13. I was dizzy or lightheaded .....                     | 0 | 1 | 2 | 3 | 4 |
| 14. I felt sick to my stomach (nauseated).....           | 0 | 1 | 2 | 3 | 4 |
| 15. I had diarrhea .....                                 | 0 | 1 | 2 | 3 | 4 |
| 16. I had hot flashes or chills.....                     | 0 | 1 | 2 | 3 | 4 |
| 17. I urinated frequently.....                           | 0 | 1 | 2 | 3 | 4 |
| 18. I felt a lump in my throat.....                      | 0 | 1 | 2 | 3 | 4 |
| 19. I was sweating .....                                 | 0 | 1 | 2 | 3 | 4 |
| 20. I had tingling feelings in my fingers or feet.....   | 0 | 1 | 2 | 3 | 4 |



## PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

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	0	1	2	3

add columns  +  +

(Healthcare professional: For interpretation of TOTAL, TOTAL:  please refer to accompanying scoring card).

10. If you checked off <i>any problems</i> , 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	_____

## MoodCheck

**Part A.** Please place a check after the statements below that *accurately describe you*.

<b>During times when I am not using drugs or alcohol:</b>	
I notice that my mood and/or energy levels shift drastically from time to time.	
At times, I am moody and/or energy level is very low, and at other times, and very high.	
During my "low" phases, I often feel a lack of energy, a need to stay in bed or get extra sleep, and little or no motivation to do things I need to do.	
I often put on weight during these periods.	
During my low phases, I often feel "blue," sad all the time, or depressed.	
Sometimes, during the low phases, I feel helpless or even suicidal.	
During the low phases, my ability to function at work or socially is impaired.	
Typically, the low phases last for a few weeks, but sometimes they last only a few days.	
I also experience a period of "normal" mood in between mood swings, during which my mood and energy level feels "right" and my ability to function is not disturbed.	
I then notice a marked shift or "switch" in the way I feel.	
My energy increases above what is normal for me, and I often get many things done I would not ordinarily be able to do.	
Sometimes during those "high" periods, I feel as if I have too much energy or feel "hyper".	
During these high periods, I may feel irritable, "on edge," or aggressive.	
During the high periods, I may take on too many activities at once.	
During the high periods, I may spend money in ways that cause me trouble.	
I may be more talkative, outgoing or sexual during these periods.	
Sometimes, my behavior during the high periods seems strange or annoying to others.	
Sometimes, I get into difficulty with co-workers or police during these high periods.	
Sometimes, I increase my alcohol or nonprescription drug use during the high periods.	
Total	<input type="text"/>

**Part B.** The statements in Part A (not just those checked) describe me (circle one of the answers below):

Not at all (0)	A little (2)	Fairly well (4)	Very well (6)
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Add the number in parentheses in Part B to your checkmark total from Part A. \_\_\_\_\_

### Part C.

Please indicate whether any of your (blood) relatives have had any of these concerns:						
	Grandparents	Parents	Aunts/Uncles	Brothers/Sisters	Children	
Suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol/Drug Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Depression Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Manic or Bipolar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?					Yes	No
Have you ever attempted suicide?					Yes	No

(please continue with part D, over)

# MoodCheck

## Part D.

How old were you when you first were depressed? (circle one)	As long as I can remember	Grade school	Middle school	High school	18-24	> 24
How many episodes of depression have you had?	One	2-4	5-6	>10		
Have antidepressants ever caused: (circle all that apply)	Excessive energy	Severe insomnia	Agitation	Irritability	Racing thoughts	Talking a lot
How many antidepressants have you tried, if any?	None	1	2	3	>3	
Has an antidepressant you took worked at first, then stopped working?	No			Yes		
Do your episodes start gradually, or suddenly?	Gradually	Can't say	Suddenly			
Do your episodes stop gradually, or suddenly?	Gradually	Can't say	Suddenly			
Did you have an episode after giving birth?	No	Within 6 months	Within 2 months	Within 2 weeks		
Are your moods much different at different times of year?	No effect of time of year			Yes, seasonal shifts		
When you are depressed, do you sleep differently?	No	Sleep less			Sleep more	
When you are depressed, do you eat differently?	No	Eat less			Eat more	
When you are depressed, what happens to your energy?	Nothing	It varies a lot	Very low	Extremely low, can hardly move		
In episodes, have you lost contact with reality? (delusions, voices, people thought you were odd)	No			Yes		

If your total score from Parts A and B is **greater than 16**; or if you have **lots of circles** in shaded boxes on this page, you may need to learn more about "mood swings without mania". See [www.PsychEducation.org](http://www.PsychEducation.org) . This is something to learn about, not necessarily about *you*.

If your total score from Parts A and B is **less than 10**, and you have **few circles** in shaded boxes on this page, antidepressants are probably okay, if you and your doctor choose to use them. They can occasionally cause: unusual thoughts, including violent and suicidal ones; irritability; too much energy; and severe sleep problems. Contact your doctor if you think any of these might be happening to you.

Your Name \_\_\_\_\_

Date \_\_\_\_\_

MoodCheck is a public document but may not be used for profit. To download, see the Primary Care Providers' Resource Center at [www.PsychEducation.org](http://www.PsychEducation.org) .