Med Center Health®
Medical Center Psychiatry
A department of The Medical Center

Med Center Health®
at WKU Health Services

Patient Information

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____

Social Security Number: _____ Date of Birth: _____ Age: _____ Sex: F/M

Race: ❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacific
❑ Asian ❑ White
❑ Black or African American ❑ Other

Ethnicity: ❑ Hispanic or Latino ❑ Non Hispanic or Latino

Language: ❑ English ❑ Spanish ❑ Other ❑ Declined

Number of children (living or deceased): _____

Marital Status: _____ Previously widowed: ❑ Yes ❑ No Previously divorced: ❑ Yes ❑ No

Advanced Directive: ❑ None ❑ DNR ❑ Living Will ❑ Durable Power of Attorney ❑ HC Proxy

Date Reviewed: _____

Please check education completed:

❑ None ❑ Home Schooled ❑ Elementary School ❑ High School ❑ College Graduate
❑ GED ❑ Grad School ❑ Some College ❑ Trade School ❑ Technical School
❑ Medical School ❑ Law School

Degree obtained:

❑ Associate ❑ Bachelor ❑ Dental ❑ Doctorate ❑ Law ❑ Medical ❑ Nursing
❑ Pharmacy ❑ Veterinary

Were you a member of the military? ❑ Yes ❑ No Branch: _____

Emergency Contact:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Insurance:

Name of your insurance company: _____

Insurance ID Number: _____ Group Number: _____

Name and address of policyholder: _____

_____

Social Security Number of policyholder: _____

Employment Status: ❑ Full time ❑ Part time ❑ Retired ❑ Unemployed ❑ Other

Name and address of employer: _____

_____

Your occupation: _____

Prior psychiatric care: ❑ Yes ❑ No

If yes, when and with whom: _____

_____

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Are you allergic to any medications? _____ If yes, please list: _____

_____

List all medications you take, prescription and nonprescription and their dosage:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

List any surgeries you have had:

_____

_____

_____

Past Medical History: Explain

- ❑ Eyes _____
- ❑ Ears/nose/throat _____
- ❑ Intestinal _____
- ❑ Heart _____
- ❑ Lungs _____
- ❑ Genito-urinary _____
- ❑ Muscular/skeletal _____
- ❑ Vascular _____
- ❑ Skin _____
- ❑ Other (high blood pressure, diabetes, thyroid problems, seizures, head injuries, etc.)

_____

_____

Family History:

Please check any of the following that pertain to your immediate family (father, mother, grandparent, sibling, etc.) (past or present). If yes, please indicate the family member in the space provided

List Family Member

- ❑ Alcohol/substance abuse (illicit or prescribed) _____
- ❑ Alzheimer's _____
- ❑ Heart disease _____
- ❑ Heart disease before age 50 _____
- ❑ Depression _____
- ❑ Diabetes _____
- ❑ High cholesterol _____
- ❑ High blood pressure _____
- ❑ Mental Illness _____
- ❑ Obesity _____
- ❑ Stroke/CVA _____

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Social History:

Do you use tobacco: ❑ Yes ❑ No ❑ Former ❑ Never ❑ Unknown

Type of tobacco: ❑ Cigarettes ❑ Chewing ❑ Cigar ❑ Pipe ❑ Smokeless

Units per day: _____ Years used: _____

Ever tried to quit: ❑ Yes ❑ No Longest tobacco free: _____

Relapse reason: ❑ alcohol use ❑ craving ❑ end of pregnancy ❑ significant other smoking ❑ situational ❑ social pressure ❑ stress ❑ weight gain ❑ withdrawal symptoms

Passive smoke exposure: ❑ yes ❑ no

Do you use marijuana/other drugs: ❑ yes ❑ no former

Type: _____ How often: _____

Do you drink caffeine: ❑ yes ❑ no former

Type: _____ Amount daily: _____

Do you drink alcohol: ❑ yes ❑ no former

Type: _____ How often: _____

Amount: _____ Last drink: _____

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CONTROLLED MEDICATION USE AGREEMENT

This agreement is required by MCH at WKU Health Services for all patients prescribed controlled medication.

This agreement is between _____ (patient) and this Practice, MCH at WKU Health Services. The purpose of this agreement is to list the details and expectations of the medication therapy in order to have the best possible results and the least side effects. Failure to abide by this agreement will be the cause for Your provider to immediately stop prescribing controlled substance medications.

1. I agree to take this medication only as prescribed. This means I will take the directed amount prescribed at the directed time as told to me by the provider. I agree not to take more medication than directed without contacting my provider. If I use the medication up sooner than prescribed, I understand that the pharmacy will strictly monitor the use of my medications.

2. I agree to obtain this medication only from my provider at MCH at WKU Health Services, or another provider at this Practice covering for my provider. I will not request or accept controlled substance medications from any other health-care provider or from any individual while I am receiving prescriptions for such medications from this Practice. I understand that controlled substance medications will not be refilled though the Emergency Room or other clinics.

3. I agree not to sell or give my medication to another person.

4. I agree to keep the medication in a safe place so that it will not be damaged, lost or stolen. If the prescription is lost, misplaced, or stolen, I understand it will not be replaced. It is my responsibility to protect my medications.

5. I agree not to mix my medication with alcohol, pain medication or other depressants, such as sleep medications, benzodiazepines and other sedatives because of increased side effects.

6. I agree not to use any illegal drugs (such as marijuana, cocaine, speed, heroin, etc) while taking this medication.

7. I agree to provide urine samples at any time I am asked to confirm I am taking my medication and not using illegal drugs. I understand that unexpected results or uncooperative behavior may cause my provider NOT to order my medication.

8. I agree to bring my medication in whenever asked by my provider.

9. I agree not to drive or operate machinery if I feel drowsy or confused from this medication. I understand this medication may slow my reflexes and increase my risk of falls. I understand I could possibly be blamed for any accident I am involved in while taking this medication.

10. I agree not to stop this medication without contacting my provider.

11. I agree to seek treatment immediately if a problem with addiction is found.

12. I agree to keep my scheduled appointments. If I miss my appointment, I understand that my provider may require an immediate appointment before writing another prescription.

13. I understand that altering or forging a prescription is a felony that will be immediately reported to the authorities and may result in criminal prosecution.

14. I agree that I cannot request transfer to another provider because of this agreement.

15. I understand that the state of Kentucky tracks information provided by pharmacies regarding all controlled substance prescriptions and that my provider may access this data at any time.

16. I grant permission to MCH at WKU Health Services to discuss all diagnostic and treatment details with the dispensing pharmacist or other providers who provide your health care for purposes of maintaining accountability.

Treatment Goals: The goal of the medicine is to improve your quality of life. The amount of time you will be on the medicine depends on your illness and whether you follow the agreement. The dose may need to be adjusted over time. It may take days or weeks to find the right amount of medication. More or less medication rnaybe needed over time. You and your provider agree to work together to find the right amount of medicine.

Side Effects: Controlled substance medications may cause side effects. These side effects Usually decrease with time. These side effects are made worse by mixing the medications with alcohol or illegal drugs or taking the medication in a way other than prescribed. You agree to tell your provider of these side effects. This will allow treatment of the side effects and may require adjustment of the dose or a change in medication. Giving your medication to another person could lead to severe medical

PLEASE SIGN ON BACK →

problems for that person. Overdose by you, or other people who have access to these medications, may impair breathing and lead to coma or death.

Withdrawal: The body will become used to this medication, or dependent, with time. Because of this withdrawal can occur if the medication is stopped suddenly. Withdrawal symptoms may include runny nose, diarrhea, shakes, chills and a general bad feeling. More severe withdrawal symptoms may include rapid heart rate, irritability, confusion, memory problems, hallucinations, psychosis, seizures, insomnia, tremors, muscle twitching and sweating. At times these can be life threatening and it is important that you monitor your supply of medicine so that you do not abruptly run out. You agree not to stop the medication suddenly. If the medication needs to be stopped, the dose will be lowered slowly to minimize any withdrawal symptoms.

Refills: Most controlled substance medications do NOT have refills. You will need to keep Your appointments with your provider. If your provider will be away he or she will make arrangements for the prescription to be filled by another provider. It is your responsibility to monitor your medications and to request refills in a timely fashion. It is recognized, to allow for office work time, weekends, holidays or travel, that refills will need to be requested a few days before the refill date, but they may not actually be obtained before then.

Addiction/Abuse: Addiction to this medication is very unlikely to occur if it is used as directed. Addiction means that the patient is abusing the medicine, using too much of it, or is using it to get "high."

Warning signs of *addiction* include:

1. Buying medicines on the street.
2. Forging prescriptions or stealing medications.
3. Excessive alcohol or illegal drug use.
4. Taking more medicine than prescribed even after warnings.
5. Repeatedly 'losing" the medication.
6. Getting medications from other providers even after warnings.
7. Asking for medication early even after warnings.
8. Injecting medications.
9. Not wanting to adjust the medication even if it is causing problems.
10. Appearing drunk or high during office visits.

If addiction, abuse or the described inappropriate use of the medication occurs, the medication will be stopped. Drug rehab or other treatment will be recommended.

Selling or giving the medication to another person is illegal, dangerous and punishable by law. If this happens, the medication will be stopped and the authorities will be told.

I understand that if any of the conditions described above are violated the medication may be stopped. I understand failure to adhere to any provision of this agreement may be grounds for dismissing me, the patient, from this Practice.

I have read this entire agreement and understand it. I have received a copy of this agreement and the original will be maintained in the medical record.

I understand that this agreement continues until I no longer receive services from MCH at WKU Health Services and my patient file has been closed. The terms of this agreement apply to all controlled substance medications prescribed at the time of signing and to any and all subsequent controlled substances prescribed by this Practice during the term of this agreement.

_____ _____

Patient Signature or Person Authorized to Consent for Patient Date Time

_____ _____

Relationship to Patient Witness

PHQ-9

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Patient Health Questionnaire

Patient Name	Date

Over the last two 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 notice. 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 ____ + ____ + ____

total ____

10. If you have 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 _____

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Name _____ Date _____

THE MOOD DISORDER QUESTIONNAIRE

Instructions- Please answer each question as best you can. Upon completing this form, you will be able to print your completed form and take it to your healthcare practitioner.

1. Has there ever been a period of time when you were not your usual self and...		
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?	Yes	No
You were so irritable that you shouted at people or started fights or arguments?	Yes	No
You felt much more self-confident than usual?	Yes	No
You got much less sleep than usual and found you didn't really miss it?	Yes	No
You were much more talkative or spoke much faster than usual?	Yes	No
Thoughts raced through your head or you couldn't slow your mind down?	Yes	No
You were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	Yes	No
You were much more interested in sex than usual?	Yes	No
You did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	Yes	No
Spending money got you or your family into trouble?	Yes	No
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? Please select one response only. ❑ No Problem ❑ Minor Problem ❑ Moderate Problem ❑ Serious Problem		

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Pregnant, Nursing or Childbearing-Age Women

In general, during pregnancy, all medications (including psychotherapeutic medications) should be avoided where possible, and other methods of treatment should be tried.

A woman who is taking psychotherapeutic medication and plans to become pregnant should discuss her plans with her doctor. If she discovers she is pregnant, she should contact her doctor immediately. During early pregnancy, there is a possible risk of birth defects with some of these medications, and for this reason:

1. Lithium is not recommended during the first three months of pregnancy.
2. Benzodiazepines are not recommended during the first three months of pregnancy.

The decision to use a psychotherapeutic medication anytime during pregnancy should be made only after a careful discussion with the doctor concerning the risk and benefits to the woman and her baby.

Small amounts of medication pass into the breast milk. This is a consideration for mothers who are planning to breastfeed.

I, _____, have read and understood the above information. Any information that was unclear to me has been clarified by the clinical associate.

_____ _____
Patient Signature Date

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All prescriptions are called in by 4:30 pm.

We require at least five days notice if you need a prescription refill.

Pharmacy Prescription Release

I, _____, give my written permission for Med Center Health at WKU Health Services to fax my prescription to my pharmacy.

Pharmacy: _____

Pharmacy Phone Number: _____

Signed _____ Date _____

Witness _____

Prescription History

I, _____, give my written permission for my entire history to be obtained from my pharmacy.

Signed _____ Date _____

Witness _____