WALSTON HEALTH SERVICES

6164 Fuller Court, Alexandria, VA 22310
(703) 924-9810 Fax: (703) 924-7044 whsphonecalls@gmail.com

Child & Adolescent Psychiatry Intake Form

Dear Parents/Guardian, the information you provide by completing this form will help your provider in identifying your child's needs. Please use the back of these forms if more room is needed.

Child's Name:_____Date: _____Age:_____

Child's Address: _____

This form was completed by: _____Date: _____
Who has legal custody of this patient? (i.e. who can legally make medical decisions about the child's care)

_____

Who referred you to our office? _____

Family Demographics

Father or Male Caretaker's Information

Name: _____Age: _____Occupation:_____

Living in home? Yes☐ No☐ If not, address: _____

Relationship: Biological Father☐ Adoptive Father☐ Stepfather☐ Other☐

Marital Status:_____Date Married:_____

(Optional) Cultural background:_____Religion:_____

Telephone (home):_____(work):_____(cell): _____

Email_____

Mother or Female Caretaker's Information

Name: _____Age: _____Occupation:_____

Living in home? Yes☐ No☐ If not, address: _____

Relationship: Biological Mother ☐ Adoptive Mother ☐ Stepmother ☐ Other☐

Marital Status:_____Date Married:_____

(Optional) Cultural background:_____Religion:_____

Telephone (home):_____(work):_____(cell): _____

Email_____

Main Concerns / Reason for Referral

A. Please list the primary concerns you have about your child: _____

_____

_____

B. How long have you had these concerns? _____

_____

C. What are your goals of treatment for your child? _____

_____

_____

D. Does your child have problems with activities of daily living (dressing, feeding, grooming, bathing)? _____

_____

_____

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E. Please indicate ☒ if child has exhibited any of the following behaviors:

		Yes	No
1.	Has trouble hearing	❑	❑
2.	Is overly sensitive to sounds	❑	❑
3.	Has visual problems	❑	❑
4.	Tilts his/her head to look at items	❑	❑
5.	Has daytime toilet accidents	❑	❑
6.	Repetitive flapping or spinning	❑	❑
7.	Has poor eye contact	❑	❑
8.	Doesn't play with other children	❑	❑
9.	Is preoccupied with interest	❑	❑
10.	Can't tolerate a change in routine	❑	❑
11.	Is extremely sensitive to textures	❑	❑
12.	Stares into space as if in a trance	❑	❑
13.	Is easily frustrated	❑	❑
14.	Has frequent tantrums	❑	❑
15.	Rarely smiles, giggles, laughs	❑	❑
16.	Has problems sleeping	❑	❑
17.	Has unusual fears/nightmares	❑	❑
18.	Sleepwalks	❑	❑
19.	Eats things that are not food	❑	❑
20.	Goes on diets	❑	❑
21.	Is aggressive to others	❑	❑
22.	Is cruel to animals	❑	❑
23.	Running away from home	❑	❑
24.	Shoplifting / Stealing	❑	❑
25.	Frequent lying	❑	❑
26.	Depression / Sadness	❑	❑
27.	Isolation / withdrawal	❑	❑
28.	Irritability / anger	❑	❑
29.	Rapid / intense mood swings	❑	❑
30.	Explosive outbursts	❑	❑
31.	Significant weight change	❑	❑
32.	Appetite change	❑	❑
33.	Excessive worries / anxiety	❑	❑
34.	Declining school grades	❑	❑
35.	Refusal to attend school	❑	❑
36.	Paranoid thinking	❑	❑
37.	Sudden recurrent motor movements (blinking, shoulder shrugging, head jerking)	❑	❑
38.	Sudden recurrent vocalizations (chirping, sniffing, coughing)	❑	❑
39.	Sexually Inappropriate behavior	❑	❑
40.	Has "melt downs"	❑	❑
41.	Has lost interest in doing fun activities	❑	❑

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Child's Past Psychiatric History

A. Please list your child's past psychiatric or psychological evaluations and/or therapy or counseling provided by school, physicians, clinics, counselors, or psychologist (include phone number if possible).
-Please note the **Date, Location, and Results** of the testing and/or therapy.
-**Please Bring Evaluations to First Appointment**

B. Has your child ever been hospitalized for psychiatric reasons? ❑Yes ❑No. If yes, please explain _____

C. Has your child ever attempted suicide? ❑Yes ❑No. If yes, please explain_____

D. Has your child ever engaged in self-injurious behavior? ❑Yes ❑No. Please explain_____

E. Has your child ever been abused? ❑None ❑Physical ❑Sexual ❑Emotional
Has Child Protective Services and/or Family Advocacy Program ever been involved? ❑Yes ❑No.
If yes, please explain_____

F. Has your child ever drunk alcohol, used marijuana, abused prescription pain killers, or used other recreational drugs? ❑Yes ❑No. Please explain_____

G. Has your child ever misused or taken more medication than prescribed? ❑Yes ❑No. Please explain _____

H. Are there any substances you fear that your child may be using abusing? ❑Yes ❑No. Please explain _____

I. Has your child ever used medication that was prescribed for someone else? ❑Yes ❑No. Please explain ____

J. Has your child ever received counseling for substance abuse? ❑Yes ❑No. Please explain _____

K. Please list any past psychiatric medications your child has taken:

Medication	For how long?	Reason for taking medication

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L. What psychiatric medication is your child currently taking? _____

M. Are there any side effects from the medication/s that your child is experiencing? _____

Child's Medical History

A. Child's physician's name: _____
Date of last comprehensive physical exam: _____
Has child seen any medical specialists such as cardiologist or neurologists? ❑Yes ❑No. Please explain _____

B. Has your child been hospitalized for medical reasons? ❑Yes ❑No. Please explain _____

C. Has your child had any surgeries? ❑Yes ❑No. If so, why, when, where? _____

D. List any seizures, head injury, loss of consciousness/concussion, or neurological evaluations _____

E. Has your child ever experienced a physical trauma or injuries? ❑Yes ❑No. If yes, please explain _____

F. Does your child have drug, food, or environmental allergies? ❑Yes ❑No. If so, please describe. _____

G. Please indicate the child's current level of pain:

No Pain ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Extreme Pain

Comments: _____

H. Please indicate ☒ if your child has had any of the following medical illnesses or problems.

Frequent ear infections	❑	Shortness of breath	❑
Hearing problems	❑	Fainting	❑
Eye problems	❑	Heart defect	❑
Swallowing problems	❑	Prior EKG	❑
Thyroid disease	❑	Encephalitis	❑
Headaches	❑	Meningitis	❑
Ear Tubes	❑	Low blood count/anemia	❑
Cardiac arrhythmias	❑	Accidents	❑
Heart murmurs	❑	Broken bones	❑

Other: _____

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I. List any medication(s) your child is currently taking? Include over-the-counter medication, herbal supplements, and diet pills:

Medication	For how long?	Reason for taking medication

J. To the best of your knowledge is your child sexually active? ❑Yes ❑No. Please explain _____

_____

If child is a female, has menstrual cycle begun? ❑Yes ❑No. If yes, age of onset? _____

K. Nutritional History _____

- Any problems with chewing, swallowing, chocking, feeding? ❑Yes ❑No _____
- Any food allergies/intolerance? ❑Yes ❑No _____
- Any weight gain or weight loss of 10 lbs. in the past 6 months? ❑Yes ❑No _____
- Any concerns that your child may have an eating disorder? Vomiting? Excessive dieting? Excessive exercising? Low caloric intake? ❑Yes ❑No _____
- Would you like to discuss nutritional issues with a dietician? ❑Yes ❑No_____

Pregnancy and Birth History

A. Prenatal History – (*Questions refer to the pregnancy of the child who is being evaluated.*)
Please recall the following the best you can:

	Yes	No	Comment
Was this child a planned pregnancy?	❑	❑	_____
Did mother			
Take any medication during pregnancy?	❑	❑	_____
Smoke cigarettes during the pregnancy?	❑	❑	_____
Drink alcohol during the pregnancy?	❑	❑	_____
Use any other drugs during pregnancy?	❑	❑	_____

Were there any complications during the pregnancy? _____

_____

_____

B. Labor History:
Was the baby full term? ❑Yes ❑No. If not, how many weeks old at birth? _____
Were there any problems with delivery? ❑Yes ❑No _____
Was delivery induced or spontaneous? _____
Were forceps used? _____
Nuchal cord? ❑Yes ❑No _____
Meconium staining? ❑Yes ❑No _____
What was the birth weight of the child? _____
Length of stay in the hospital: Mother:_____days Child: _____days

C. Infant's Condition at Birth: _____
Any problems shortly after birth? _____

_____

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Developmental and Skill Profile

A. Between the ages of 0 and 2-years-old, was your child:
- Extremely sensitive to slight changes in touch, sound level, lighting, etc? ❑Yes ❑No
- Unable to develop a regular sleeping pattern? ❑Yes ❑No
- Impossible or very difficult to soothe or calm self when distressed/upset? ❑Yes ❑No
- Unable to separate from parents without extreme distress? ❑Yes ❑No
- Unable to show affection? ❑Yes ❑No

B. Check the boxes as appropriate to describe developmental milestones

Milestone	Age achieved (If known)	Early	On time	Late	Don't Know
Walked alone		❑	❑	❑	❑
Said first words		❑	❑	❑	❑
Daytime toileting		❑	❑	❑	❑
Bladder training		❑	❑	❑	❑
Bowel training		❑	❑	❑	❑
Tied shoelace		❑	❑	❑	❑
Wrote name		❑	❑	❑	❑

C. What are your child's strengths? _____

D. Please list your child's leisure time activities (i.e. sports, clubs, internet use, social networking sites) : _____

E. Please list any problems with use of TV, internet, or cell phone: _____

F. What is your family's religious or spiritual affiliation? _____
Does your child have religious, spiritual, or cultural practices your provider needs to be aware of during treatment? _____

Educational History

A. Name of current school: _____ Location: _____
Teacher or Counselor's name: _____ Grade: _____ Phone: _____

B. How many schools has your child attended? _____

C. What are the average grades your child receives? _____
- Has child repeated a grade or subject? ❑Yes ❑No What grade or subject? _____
- Please list any subjects your child is currently failing, if any: _____

D. Has child been suspended or expelled? ❑Yes ❑No If "Yes," please explain: _____

E. Has your child received any special education services (IEP) or other academic support like 504 plan? ❑Yes ❑No _____
If so, PLEASE BRING THE IEP TO YOUR FIRST APPOINTMENT and briefly describe below.
Any history of Occupational Therapy, Speech Therapy, or Counseling in the school setting? _____

F. Please indicate any problems your child has in school:

Reading	❑	Spelling	❑
Writing	❑	Math	❑
Does not get along with teacher	❑	Does not get along with students	❑

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Family Social & Medical History

A. Does this child have other parent(s) and/or stepparent(s)? ❑Yes ❑No
If yes, please provide the following information:

Name	Relationship to this child	Location (city, state)

B. Please list everyone living in household:

Names (last, first)	Age	Relationship

C. If the patient has any other siblings not living with him/her, please list them below.

Name (last, first)	Age	Relationship

D. Who is the child's primary care giver? Name: _____

E. How many hours per day is your child in a child-care setting? _____

F. If child is not living with biological parents list why: _____

_____

G. Please indicate ☒ on the chart below anyone in child's biological family who has a history of any of the problems listed below. (If child is not living with biological parent, please include health information on biological parents if known):

	Child's Father	Father's Family	Child's Mother	Mother's Family	Child's Siblings
Attention Difficulties and/or Hyperactivity	❑	❑	❑	❑	❑
Learning Difficulties	❑	❑	❑	❑	❑
Mental retardation	❑	❑	❑	❑	❑
Autism	❑	❑	❑	❑	❑
Problems with alcohol and/or drugs	❑	❑	❑	❑	❑
Seizures/convulsions	❑	❑	❑	❑	❑
Cardiac defects/arrhythmias	❑	❑	❑	❑	❑
Tourette's syndrome	❑	❑	❑	❑	❑
Eating Disorder	❑	❑	❑	❑	❑
Nervousness or anxiety	❑	❑	❑	❑	❑
Schizophrenia	❑	❑	❑	❑	❑
Bipolar (Manic/Depressive) Disorder	❑	❑	❑	❑	❑
Nervous Breakdown	❑	❑	❑	❑	❑
Mental Health Hospitalization	❑	❑	❑	❑	❑
Depression/Other mental health problems	❑	❑	❑	❑	❑
Self-mutilation	❑	❑	❑	❑	❑
Suicide	❑	❑	❑	❑	❑
Sudden Death	❑	❑	❑	❑	❑
Legal Problems (Incarceration)	❑	❑	❑	❑	❑

Other: _____

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H. Please tell us of any significant stressors your family had experienced in the past year.

Death	❑	Deployment	❑
Divorce or separation	❑	Work stressors	❑
Child or Spouse abuse	❑	Legal problems	❑

Other stressors: _____

I. To what extent do you and your spouse generally agree on how to discipline your child?

Never agree ① ② ③ ④ ⑤ *Always agree*

J. What methods of discipline do you typically use?

Time-out	❑	Ground	❑
Take privileges (TV, games, allowance)	❑	Yell	❑
Give rewards for doing well	❑	Spank	❑
"1-2-3 Magic" or other behavior course	❑		

Other methods used: _____

Risk Assessment

A.	Are there any firearms in any homes where your child resides?	❑Yes	❑No
B.	Is there any history of domestic violence in the home?	❑Yes	❑No
	If yes, has family ever been referred to CPS or FAP?	❑Yes	❑No
C.	Does your child have a history of homicidal (harm to others) thoughts or behaviors?	❑Yes	❑No
D.	Does your child have current homicidal (harm to others) thoughts or behaviors?	❑Yes	❑No
E.	Does your child wear a seat belt?	❑Yes	❑No
F.	Does your child have history of suicidal thoughts or behaviors?	❑Yes	❑No
G.	Does your child have current suicidal thoughts or behaviors?	❑Yes	❑No
H.	Do you have other safety concerns at this time?	❑Yes	❑No

If yes, please explain: _____

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Walston Health Services Office Rules

Appointments

Your appointment time is reserved for you. Each appointment requires advanced preperation on our behalf to ensure a high level of attention and care specific to your needs. Therefore, if you are unable to keep your appointment, our practice requires a minimum of 24 hours notice to cancel or reschedule. This will ensure that those patients on the waiting list will have access to any available apointments. We will make an attempt to contact you to confirm your appointment. This call is a courtesy and our failure to reach you will not relieve you of your responsibility for any missed appointment charges. **Failure to provide a 24-hour notice will result in a charge of $50, which is not covered by your insurance.**

Prescriptions and Refills

Please request prescription refills at the time of your appointment. You will be provided enough refills to last until your next expected appointment, according to your insurance specifications. **If you miss your appointment and require a refill prescription, you will need to let our office know one week prior to when the medication runs out.** Please be aware that refills take valuable staff and physician time to address. **All patients who request prescription refills at any time other than an office visit are subject to a $15 service fee.**

Contracted Insurance

If you have health insurance, it is extremely beneficial and to your advatage to be aware of the coverage and details of your insurance benefit coverage. Your health insurance coverage is an agreement between you and your insurance company to pay certain amounts for your care and treatment. Your Physician's bill, on the other hand, is an agreement between you and your physician. **Your are responsible for the payment of your doctor's bill(s).**

This practice directly contracts with carriers to provide behavioral health services for some insurances companies. As a convenience to you, our practice will verify your benefits and coverage eligibility. If you are enrolled with one of theese companies, you are financially responsible for any co-pays, or deductible fees, which are predetermined by your insurance group or employer. **You will be asked to pay any co-pays, deductibles, and co-insurance at the time of service.**

Billing

Balances are due within thirty (30) days of the billing settlement date. **Any delinquent balances will incur a 1.5% late payment charge per month.** If an unsual financial circumstance exists, please call our practice to discuss payment options. This will avoid any misunderstanding and enable you to keep your account in good standing.

Collections

Except when previous payment arrangements warrant otherwise, accounts ninety (90) days past due are referred to a collecton agency. **Any collection cost or attorney fees necessary for the collection of any outstanding debt of this practice will be charged and paid by the debtor.**

Discharge from Care

We reserve the right to discharge any patient from this practice at any time for failure to comply with treatment recommendations or office policy responsiblities. We will suggest referral options in this event.

I hereby certify that I have read, understand, and will follow the Office Rules.

Signature: _____ **Date:** _____

Ph: (703) 924-9810 Fax: (703) 924-7044

Patient's Bill of Rights

As a person receiving mental health services, you have the right to:

- •Be treated with dignity and respect.
- •Choose the services or programs in which you participate based upon information about rules, treatment procedures, costs, risks, rights, and responsibilities.
- •Ask questions and get answers about services.
- •Participate fully in all decisions about treatment or services.
- •Request changes in treatment or services.
- •Receive treatment in the least restrictive setting - one that provides the most freedom appropriate to your treatment needs.
- •Refuse treatment or service unless ordered by the Court to participate.
- •Be informed about the rules that will result in discharge from a program if violated.
- •Participate fully in decisions regarding your discharge from a program and receive advance notice regarding the proposed discharge unless your behavior threatens the wellbeing of another person.
- •Know the name of the medication you are taking, why you are taking it, and what its possible side effects might be.
- •Refuse to take medication if you choose. (Note: You should not discontinue taking medication suddenly without first discussing the possible dangers with a psychiatrist.)
- •Have your family involved in your treatment.
- •Refuse family participation in your treatment if you choose.
- •Not be subjected to verbal, physical, sexual, emotional, or financial abuse, harsh or unfair treatment.
- •Make complaints, have them heard, get a prompt response, and not receive any threats or mistreatments as a result.
- •File a grievance if you are not satisfied with the response to a complaint.
- •Be assisted by an advocate of your choice, (i.e. family, friend, case manager, member of a consumer advocacy committee or organization, etc.)
- •Review your record, with two exceptions. Limited portions of your records can be withheld from you if your treatment team leader has written that seeing specific information would, ◦be harmful to your treatment, or reveal the identity or break the trust of someone who has provided information in confidence.
- •Decide who else can see your records, with several exceptions. Those who do not need to ask your permission are: people involved in your mental health treatment or to whom you are referred for treatment, people providing emergency medical care, an attorney representing you at a commitment hearing, a court, people conducting program or utilization reviews, or third-party payers (those who pay for your treatment). These people may only see as much information as they need for the specific purpose requested.
- •Not be discriminated against on the basis of race, age, sex, religion, national origin, sexual orientation, disability, or marital status.

I hereby certify that I have read and understand the Patient's Bill of Rights.

Signature: _____ **Date:** _____

HIPAA Patient Consent Form

The federal government requires all medical offices to make patients aware that they have rights regarding the use of their personal health information. Our notice of privacy practices is available online through WalstonHealthServices.org or at our front office.
By signing this form, you consent to our use and disclosure of protected health information according to the Notice of Privacy Practices available on our website or in office.
I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
- The day to day healthcare operations of your practice.
- I have also been informed of, and given the rights to review and secure a copy of your Notice of Privacy Practices which contains a more complete description of the use and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.
- I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these request restrictions.
- However, if you do agree, you are bound to comply with this restriction. I understand that I may revoke this consent at any time, in writing, signed by you.

The Client understands that:

- We will not release information to any future doctor, attorney, life insurance company, or workman's company without your written consent.
- Protected health information may be used for treatment through one of your current doctors (such as your primary care physician or a specialist referral), payment with your insurance company, or healthcare operations within our office.
- Walston Health Services reserves the right to change the notice of privacy practices.
- The patient has the right to restrict the use of their information, but Walston Health Services does not have to agree to these restrictions if, for example, it interferes with payment, daily operations, or providing quality health care.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.

I hereby certify that I have read and understand my rights regarding my personal health information.

Signature: _____ **Date:** _____

Cancellation Policy

Your appointment time is reserved exclusively for you. Each appointment requires advance preparation on your behalf to ensure a high level of attention and care specific to your needs. Therefore, if you are unable to keep your appointment, our practice requires a minimum of **24 hours'** notice to cancel or reschedule. Same day rescheduling will follow the same protocol. This protocol has been put in place in order to ensure that those patients on the waiting list will have access to those appointments.

We will try to contact you to confirm each appointment. This is a courtesy and our failure to reach you will not relieve you of your responsibility for any missed appointment charges. **Failure to provide 24-hour notice will result in a charge of $50.00 per appointment which is not covered by your insurance.**

Please note that we do have a "Three Strike" Policy. After two missed appointments you will be given a reminder of our cancellation policy. After a third missed appointment with any provider Walston Health Services retains the right to terminate the patient – provider relationship.

I hereby certify that I have read, understand, and will follow the Cancellation Policy.

Signature: _____ **Date:** _____

Limits to Privacy and Confidentiality
Informed Consent to Participate in Treatment

It is important for you to know the limits to privacy and confidentiality regarding your appointments within Walston Health Services. This notice is written in accordance with departmental policy, military guidelines, and regulations under Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the final Privacy Rule of 2000. Clinics within WHS are committed to compliance with HIPAA privacy regulations.

When you speak with a mental health provider, the notes and results of your initial evaluation and subsequent visits are entered into your electronic medical record (Practice Fusion) as maintained by Walston Health Services under your social security number and will be designed as "sensitive", which offers the highest level of privacy available for this information. Access to portions of your electronic record by third parties is only allowed when required by law, regulations or judicial proceedings. This is consent with the Privacy Act Statement and the HIPAA Notice of Privacy Practice.

As a rule, your mental health provider will disclose no information obtained from your contacts with them, or the fact you are receiving care in this clinic, except with your written consent. However, there are some important exceptions to this confidentiality rule as described by the following or as otherwise specified by law.

- As general practice, we will use and disclose your protected health information to provide, coordinate, or manage your health care and related services as described in the HIPAA Notice of Privacy Practices.
- Contents of your record may also be reviewed by other health care providers for supervision, consultation, and quality assurance.
- If you reveal information about child neglect, abuse, or physical abuse of elders or dependent adults, we are required to report it to civil authorities.
- If you report spousal/partner abuse or drug abuse, we are required to report it to the authorities.
- If you are judged to be suicidal or a threat to yourself, we are required to warn the intended victim and the appropriate law enforcement agencies.
- If a court of law issues a legitimate subpoena, we are required to provide the information specifically described in the subpoena.
- If you report a violation of civil law, we may be required to report it to the appropriate authorities.

Statement of Understanding and Informed Consent

I have been advised that all information obtained as herein described will be used in confidence and in conformity with Health Insurance Portability and Accountability Act (HIPAA) and/or other restrictions and protections required by law(s). As a result of Behavioral Health evaluation, I have been informed of and recommended to participate in specified appropriate level of treatment to include, but not limited to : individual counselling or therapy, group therapy , pharmacotherapy , psychological testing, biofeedback treatment, and assessment using laboratory and/or radiological testing. I have been informed that I may refuse any or all aspects of treatment at any time, but by refusing help may result in worsening of my mental health conditions. This consent will be maintained in my medical record.

I understand that I may revoke this consent at any time, and that if I do so, by signed/dated revocation, it shall be made part of my medical record.

____ I consent to mental health treatment ____ I do NOT consent to treatment at this time

Signature: _____ Date: _____

Telepsychiatry Informed Consent

Introduction
Telepsychiatry is a form psychiatric care using audio-video conferencing tools in which the psychiatrist and patient are not at the same location.
Electronic systems used will incorporate network and software security protocols to protect the confidentiality of health information and will include measures to safeguard the data to ensure its integrity and privacy against intentional or unintentional corruption and unauthorized access.

Expected Benefits
Benefits of telepsychiatry include improved access to psychiatry care by enabling a client to remain in his/her home or office and efficient psychiatric evaluation and management.

Possible Risks
Potential risks associated with the use of this technology include interruptions, unauthorized access, and technical difficulties.
By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of health information also apply to telepsychiatry, and that no information obtained in the use of telepsychiatry which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that my telepsychiatry session will not be recorded by me or my psychiatrist without both of us giving consent.
3. I understand that I have the right to withhold or withdraw my consent to the use of telepsychiatry during my care at any time, without affecting my right to future care or treatment
4. I understand that I have the right to inspect all information obtained during a telepsychiatry interaction and may receive copies of this information for a reasonable fee.
5. I understand that it is my duty to inform my psychiatrist of any other healthcare providers involved in my medical/psychiatric care.
6. I understand that I may expect the anticipated benefits from the use of telepsychiatry in my care, but that no results can be guaranteed or assured.

Client consent to the use of telepsychiatry

I have read and understand the information provided above regarding the benefits and the risks of telepsychiatry. I have discussed the contents of this form with my psychiatrist, nurse, case manager, or another as may be my designated, and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telepsychiatry in my health care.

I hereby authorize the providers at Walston Health Services to use telepsychiatry during my diagnosis and treatment.

I hereby certify that I have read and understand this Telepsychiatry Consent.

Signature: _____ **Date:** _____

CONTROLLED MEDICATON POLICY

1. I understand I will only get controlled medication from one provider.
2. I understand that Controlled medications must be handled with care.
3. I understand that any controlled medication that is prescribed to me for my diagnosis and treatment should not be shared with friends and/or family members.
4. I understand that controlled medications should be taken according to the instructions. Dosage increasing or sudden discontinuation without the knowledge and approval of my physician is strictly forbidden.
5. I understand that early request for controlled medicine is not allowed.
6. I understand that excuses of misplaced medications such as: medications were stolen, spoiled, or somebody flushed them down the toilet are not acceptable and in such instances medication **Will Not BE REPLACED.**
7. I understand that Dr. Walston will monitor the proper use of my controlled medication using Virginia Prescription drug Monitoring system. Walston Health Services will also receive a report from my insurance company or pharmacy regarding prescription drug history or suspected prescription drug abuse. Based on this report, we may decide not to prescribe the controlled medication. We may also decide to terminate the patient-physician relationship in the interest of your safety and best interest of the medical practice.
8. I understand that I will make Walston Health Services office staff aware at least three to five days prior to running out of my controlled medication to avoid sudden discontinuation. I understand that in order to be prescribed a controlled medication or a medication refill I may be required to schedule an appointment.
9. If I claim to be actively on treatment with suboxone with a provider and want to establish care with this practice, I will need to bring medical records from the previous provider and latest pill bottles.

By signing this controlled substance policy, I have read, understand, and will abide by the latest terms of this contract as long as I am an active patient here at Walston Health Services.

Signature: _____ **Date:** _____

Walston Health Services

6165 Fuller Court, Suite 2 Alexandria, VA 22310
(703) 924-9810 Fax: (703) 924-7044 walstonhealthservices@gmail.com

Mental Health Intake Questionnaire

Please answer the following questions to the best of your ability. Your answers will help us to better understand what concerns you may be having now. This will also help us focus on specific issues and more effectively use your time with us.

Today's Date:_____

Name:_____ SSN#:____-____-____
Last, First, M.I.

Age:____ Sex:____ Ethnicity/Nationality:_____ DOB:_____

Marital Status: ❑ Single ❑ Engaged ❑ Married ❑Divorced ❑Remarried ❑Widowed

Home Address:_____
Street

_____
City State Zip

Cell phone number:_____ Home phone number:_____

Who referred you to this clinic?_____

What is your reason for being seen? _____

_____

What are your expectations?_____

_____

_____

_____

Have you had any of these symptoms or experiences recently: If yes, length of time

Depressed mood	❑ Yes	❑ No	_____
Big change in appetite or weight (up or down)	❑Yes	❑ No	_____
Changes in sleep patterns or quality of sleep	❑Yes	❑ No	_____
Constant feeling of fatigue, tiredness or low energy	❑Yes	❑ No	_____
Feeling of worthlessness or excessive guilt	❑Yes	❑ No	_____
Decreased ability to think or concentrate	❑Yes	❑ No	_____

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Name: _____

Decreased interest in enjoyable activities	❑Yes	❑ No	_____
Constant anxiety or excessive worry	❑Yes	❑ No	_____
Avoidance of a specific object or situation	❑Yes	❑ No	_____
Intense memories of any previous traumatic events	❑Yes	❑ No	_____
Unusual experiences that cause distress	❑Yes	❑ No	_____
Constantly on guard, watchful or easily startled	❑Yes	❑ No	_____
Feelings of being numb or detached from others	❑Yes	❑ No	_____
Unpredictable mood swings	❑Yes	❑ No	_____
Thoughts of hurting yourself or someone else	❑Yes	❑ No	_____
Changes in the use of alcohol or other substances	❑Yes	❑ No	_____
Recent or past incidents of family violence (Domestic violence or child abuse)	❑ Yes	❑ No	_____
Legal or disciplinary issues	❑Yes	❑ No	_____

Mental Health History

Have you participated in any previous counseling or group therapy? If yes, please describe:_____

_____

_____

Have you ever taken medication for mental health symptoms? If yes, please list the medications:_____

_____

_____

Have you ever been hospitalized for mental health reasons? If yes, please describe:_____

_____

_____

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Name:_____

Is there any family history of mental health problems (nervous breakdown, suicide, substance abuse problems, ect)? If yes, please describe:_____

_____

_____

Medical History

Do you have any current medical conditions? If yes, please list:_____

_____

_____

List all allergies:_____

_____

Are you currently taking any medication (including herbal, supplements, and over the counter)? If yes, please lists:____

_____

_____

_____

Do you have any current pain? If yes, please rate on a scale from 0 (no pain) to 10 (intense pain) and describe the location:
Pain level_____Location of pain:_____

Substance Use History

How often do you have a drink containing alcohol?
- ❑ Never
- ❑Monthly or less
- ❑2-4 times a week
- ❑2-3 times a week
- ❑4 or more times a week

How often during the past year have you needed a first drink in the morning to get yourself going after drinking the night before?
- ❑Never
- ❑Less than a month
- ❑Monthly
- ❑Weekly
- ❑Daily or almost daily

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Name:_____

How many drinks containing alcohol do you have on a typical day when are drinking?
❑1-2
❑3-4
❑5-6
❑7-9
❑10 or more

How often during the past year have you had a feeling of guilt or remorse after drinking?
❑Never
❑Less than monthly
❑Monthly
❑Weekly
❑Daily or almost daily

How often do you have six or more beers or Drinks on one occasion?
❑Never
❑Less than monthly
❑Monthly
❑Weekly
❑Daily or almost daily

How often in the past year have you been unable to remember what happened the night before because you had been drinking?
❑Never
❑Less than monthly
❑Monthly
❑Weekly
❑Daily or almost daily

How often during the past year have you found that you were unable to stop drinking once you had started?
❑ Never
❑Less than a month
❑Monthly
❑Weekly
❑Daily or almost daily

Have you or someone else been injured as a result of your drinking?
❑No
❑Yes, but not in the last year
❑Yes, during the past year

How often during the past year have you failed to do what was normally expected of you, because of your drinking?
❑Never
❑Less than a month
❑Monthly
❑Weekly
❑Daily or almost daily

Has a friend, relative, doctor, or other health worker been concerned about your drinking or suggested you cut down?
❑No
❑Yes, not in this last year
❑Yes, during the last year

Have you ever used any illegal or illicit drugs? If yes, please list the drugs, frequency of use, and date of last use:_____

_____

_____

Have you ever attended alcohol and/or drug treatment? If yes, please list the dates and type of treatment:_____

_____

_____

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Name: _____

What is your current caffeine/ energy drink/ supplement use? Please describe amount and types: _____

_____

Do you use tobacco? ❑YES ❑ NO How much?____

Personal History/ Background

I mainly grew up in the city of or rural area near?

My family's financial situation when I was growing up was? ❑Upper ❑Upper Middle ❑Middle ❑Lower Middle ❑ Lower income

I have_____ brothers and _____ sisters. I was born 1st, 2nd, 3rd, 4th, or other_____

Father's job:_____

How did you get along with your father?_____

Mother's job: _____

How did you get along with your mother?_____

My parents were? ❑Never Married ❑Married ❑Divorced ❑Widowed.

If divorced, how old were you?____

Did anyone else live with you? ❑Yes ❑No

Discipline in my family consisted of:_____

As a child, I had: ❑No ❑Few ❑Many friends. Now I have ❑ No ❑Few ❑Many friends.

Number of school years you completed?____ Age when completed:_____

How were your grade in school? ❑Excellent ❑Good ❑Fair ❑Failing

Were you in any special classes? If yes, what types:_____

With my teachers I got along: ❑Very Well ❑Okay ❑Did Not

With other students I got along: ❑Very Well ❑Okay ❑Did Not

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Name: _____

List school activities/ sports/ favorite subjects:_____

_____

Were you ever placed on probation, suspended, or expelled from school? If yes, please explain when, why and number of times:_____

_____

Did you ever have problems with law enforcement agencies prior to enlistment? If yes, please explain when and why:

What kind of jobs did you have prior to joining the military?_____

_____

Please place a check by any of the following that you may have experienced and not your age at the time:

Yes	Age		Yes	Age		Yes	Age	
❑	_____	Nail biting	❑	_____	Anger control	❑	_____	Physical abuse
❑	_____	Sleep Walking	❑	_____	Cruelty to animals	❑	_____	Verbal abuse
❑	_____	Bed Wetting	❑	_____	Stealing	❑	_____	Sexual abuse
❑	_____	Bad Nightmares/ Night terrors	❑	_____	Reckless driving	❑	_____	Running away
❑	_____	Hyperactivity	❑	_____	Fire setting	❑	_____	Over/Under eating

If married, how long?_____Spouse's age:_____Is this the first marriage for both? ❑Yes ❑No
If not, please describe:_____

Length of dating before marriage?_____

Do you have any children? ❑Yes ❑No If yes, how many?_____ What are their ages?_____Do they live with you? ❑Yes ❑No

How would you describe your strengths and weaknesses?_____

_____

_____

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Name: _____

Has religion, faith, or spiritual beliefs been an important part of your life in the past? ❑Yes ❑ No
Currently? ❑Yes ❑ No

If yes, please list your particular denomination or religious preference:_____

_____

Patient's Signature:_____

Date:_____

By signing this, you agree that you have read and understood all documents on these forms. You also agree that to the best of your knowledge, all personal answers and statements on these form are correct and true.

WALSTON HEALTH SERVICES

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Consent for Release of Client Information

Name: _____ DOB: _____ S.S.: _____-_____-_____

I hereby authorize **Walston Health Services to.....** ☐ **Release** ☐ **Obtain**

Specified information in my medical/client/education record for the purpose of continued mental health care.

_____

(Individual, Facility, or Organization)

_____

(Address)

_____ _____

(Phone Number) (Fax Number)

This data shall include the available items checked below:

- ☐ Telephone Communication Only
- ☐ Admission Summary
- ☐ Progress/ Treatment Notes
- ☐ Initial Evaluation
- ☐ Medication Log
- ☐ Guest Portal
- ☐ Discharge
- ☐ Laboratory Results
- ☐ Psychological Test
- ☐ Educational Test
- ☐ Other _____

Dates of Treatment: From: _____ To: _____

Disclosure and/or exchange of the protected health and account information as authorized above may include communication by phone, fax, or email. This disclosure and/or exchange may include information regarding drug, alcohol, sexual abuse, psychological or psychiatric impairments, HIV and/or AIDS or other physical conditions. If the authorized individual or entity that receives or releases this information is not a health insurance plan or health care provider covered by federal privacy regulations (HIPAA), the released information may be re-disclosed at will by recipient or sender without the consent of the patient or guarantor and may no longer be protected by federal or state law. *If refuse to sign this form, I understand that I will not adversely affect my ability to receive health care services, reimbursement for service, enrollment in a health plan or eligibility for health for benefits.* Note: This consent does not expire; however, it may be revoked anytime IN WRITING, except to the extent that any action has already been taken prior to revocation.

I have read and understood the above statements and I consent to the release of the protected health and account information as indicated above. I also understand that there may be cost incurred with request. Any such cost will be compliance with State copying laws.

_____ _____ _____

Client (or Guardian's) Signature Witness Date

WALSTON HEALTH SERVICES

6164 Fuller Court Alexandria, VA 22310
Ph: (703) 924-9810 Fax: (703) 924-7044

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Card Type (circle): Visa MasterCard Discover American Express

Cardholder Name (as shown on card): _____

Credit Card Number: _____

Expiration Date: _____ CVV (security code): _____

Cardholder ZIP code (from billing address): _____

Patient Name (if different from card): _____

I _____ authorize _____ to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Signature Date

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ❍ Yes ❍ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ❍ Yes ❍ No
3. **In the past week, have you been having thoughts about killing yourself?** ❍ Yes ❍ No
4. **Have you ever tried to kill yourself?** ❍ Yes ❍ No

   If yes, how? _____

   _____

   _____

   When? _____

   _____

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ❍ Yes ❍ No

   If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (**Note: Clinical judgment can always override a negative screen*).
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ **"Yes"** to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1. 0 I do not feel sad.
   1 I feel sad
   2 I am sad all the time and I cannot snap out of it.
   3 I am so sad and unhappy that I cannot stand it.

2. 0 I am not particularly discouraged about the future.
   1 I feel discouraged about the future.
   2 I feel I have nothing to look forward to.
   3 I feel the future is hopeless and that things cannot improve.

3. 0 I do not feel like a failure.
   1 I feel I have failed more than the average person.
   2 As I look back on my life, all I can see is a lot of failures.
   3 I feel I am a complete failure as a person.

4. 0 I get as much satisfaction out of things as I used to.
   1 I do not enjoy things the way I used to.
   2 I do not get real satisfaction out of anything anymore.
   3 I am dissatisfied or bored with everything.

5. 0 I do not feel particularly guilty
   1 I feel guilty a good part of the time.
   2 I feel quite guilty most of the time.
   3 I feel guilty all of the time.

6. 0 I do not feel I am being punished.
   1 I feel I may be punished.
   2 I expect to be punished.
   3 I feel I am being punished.

7. 0 I do not feel disappointed in myself.
   1 I am disappointed in myself.
   2 I am disgusted with myself.
   3 I hate myself.

8. 0 I do not feel I am any worse than anybody else.
   1 I am critical of myself for my weaknesses or mistakes.
   2 I blame myself all the time for my faults.
   3 I blame myself for everything bad that happens.

9. 0 I do not have any thoughts of killing myself.
   1 I have thoughts of killing myself, but I would not carry them out.
   2 I would like to kill myself.
   3 I would kill myself if I had the chance.

10. 0 I do not cry any more than usual.
    1 I cry more now than I used to.
    2 I cry all the time now.
    3 I used to be able to cry, but now I cannot cry even though I want to.

11. 0 I am no more irritated by things than I ever was.
    1 I am slightly more irritated now than usual.
    2 I am quite annoyed or irritated a good deal of the time.
    3 I feel irritated all the time.

12. 0 I have not lost interest in other people.
    1 I am less interested in other people than I used to be.
    2 I have lost most of my interest in other people.
    3 I have lost all of my interest in other people.

13. 0 I make decisions about as well as I ever could.
    1 I put off making decisions more than I used to.
    2 I have greater difficulty in making decisions more than I used to.
    3 I cannot make decisions at all anymore.

14. 0 I do not feel that I look any worse than I used to.
    1 I am worried that I am looking old or unattractive.
    2 I feel there are permanent changes in my appearance that make me look unattractive
    3 I believe that I look ugly.

15. 0 I can work about as well as before.
    1 It takes an extra effort to get started at doing something.
    2 I have to push myself extremely hard to do anything.
    3 I cannot do any work at all.

16. 0 I can sleep as well as usual.
    1 I do not sleep as well as I used to.
    2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
    3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 I do not get more tired than usual.
    1 I get tired more easily than I used to.
    2 I get tired from doing almost anything.
    3 I am too tired to do anything.

18. 0 My appetite is no worse than usual.
    1 My appetite is not as good as it used to be.
    2 My appetite is much worse now.
    3 I have no appetite at all anymore.

19. 0 I have not lost much weight, if any, lately.
    1 I have lost more than five pounds.
    2 I have lost more than ten pounds.
    3 I have lost more than fifteen pounds.

20. 0 I am no more worried about my health than usual.
    1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
    2 I am very worried about physical problems and it's hard to think of much else.
    3 I am so worried about my physical problems that I cannot think of anything else.

21. 0 I have not noticed any recent change in my interest in sex.
    1 I am less interested in sex than I used to be.
    2 I have almost no interest in sex.
    3 I have lost interest in sex completely.

RCADS

NHS ID: .....

Child/ Young Person's NAME:

.....

Date: ☐☐/☐☐/ 20☐☐ **Time:** ☐☐ h ☐☐ m

Please put a circle around the word that shows how often each of these things happens to you. There are no right or wrong answers.

1	I worry about things	Never	Sometimes	Often	Always
2	I feel sad or empty	Never	Sometimes	Often	Always
3	When I have a problem, I get a funny feeling in my stomach	Never	Sometimes	Often	Always
4	I worry when I think I have done poorly at something	Never	Sometimes	Often	Always
5	I would feel afraid of being on my own at home	Never	Sometimes	Often	Always
6	Nothing is much fun anymore	Never	Sometimes	Often	Always
7	I feel scared when I have to take a test	Never	Sometimes	Often	Always
8	I feel worried when I think someone is angry with me	Never	Sometimes	Often	Always
9	I worry about being away from my parent	Never	Sometimes	Often	Always
10	I am bothered by bad or silly thoughts or pictures in my mind	Never	Sometimes	Often	Always
11	I have trouble sleeping	Never	Sometimes	Often	Always
12	I worry that I will do badly at my school work	Never	Sometimes	Often	Always
13	I worry that something awful will happen to someone in my family	Never	Sometimes	Often	Always
14	I suddenly feel as if I can't breathe when there is no reason for this	Never	Sometimes	Often	Always
15	I have problems with my appetite	Never	Sometimes	Often	Always
16	I have to keep checking that I have done things right (like the switch is off, or the door is locked)	Never	Sometimes	Often	Always
17	I feel scared if I have to sleep on my own	Never	Sometimes	Often	Always
18	I have trouble going to school in the mornings because I feel nervous or afraid	Never	Sometimes	Often	Always
19	I have no energy for things	Never	Sometimes	Often	Always
20	I worry I might look foolish	Never	Sometimes	Often	Always

21	I am tired a lot	Never	Sometimes	Often	Always
22	I worry that bad things will happen to me	Never	Sometimes	Often	Always
23	I can't seem to get bad or silly thoughts out of my head	Never	Sometimes	Often	Always
24	When I have a problem, my heart beats really fast	Never	Sometimes	Often	Always
25	I cannot think clearly	Never	Sometimes	Often	Always

26	I suddenly start to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
27	I worry that something bad will happen to me	Never	Sometimes	Often	Always
28	When I have a problem, I feel shaky	Never	Sometimes	Often	Always
29	I feel worthless	Never	Sometimes	Often	Always
30	I worry about making mistakes	Never	Sometimes	Often	Always

31	I have to think of special thoughts (like numbers or words) to stop bad things from happening	Never	Sometimes	Often	Always
32	I worry what other people think of me	Never	Sometimes	Often	Always
33	I am afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
34	All of a sudden I feel really scared for no reason at all	Never	Sometimes	Often	Always
35	I worry about what is going to happen	Never	Sometimes	Often	Always

36	I suddenly become dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
37	I think about death	Never	Sometimes	Often	Always
38	I feel afraid if I have to talk in front of my class	Never	Sometimes	Often	Always
39	My heart suddenly starts to beat too quickly for no reason	Never	Sometimes	Often	Always
40	I feel like I don't want to move	Never	Sometimes	Often	Always

41	I worry that I will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always
42	I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order)	Never	Sometimes	Often	Always
43	I feel afraid that I will make a fool of myself in front of people	Never	Sometimes	Often	Always
44	I have to do some things in just the right way to stop bad things from happening	Never	Sometimes	Often	Always
45	I worry when I go to bed at night	Never	Sometimes	Often	Always
46	I would feel scared if I had to stay away from home overnight	Never	Sometimes	Often	Always
47	I feel restless	Never	Sometimes	Often	Always