# Washington Behavioral Health, PC

1954 Opitz Blvd #007 Woodbridge, VA 22191 (703) 492-2924

**All information on this form is strictly confidential**

## PATIENT INFORMATION

| | | | | |
|---|---|---|---|---|
| Patient's last name: | | | First: | M: |
| Social Security no.: | Birth date: | Sex: M ☐ F ☐ | Marital status : S ☐ Marr☐ Div☐ Wid☐<br>Non-married committed relationship ☐ | |
| Street address:<br>May we contact you through this method: | | | City: | State: ZIP: |
| Home phone no.: ( ) | Y ☐ N☐ | | Occupation: | |
| Cell phone no: ( ) | Y ☐ N☐ | | Employer: | |
| Email Address: | Y ☐ N☐ | | Work phone no: ( ) ☐ May we call/leave a message on this phone: Y ☐ N☐ | |
| **PCP:** | | | **Referral Source:** | |

## IN CASE OF EMERGENCY

| | | |
|---|---|---|
| Name of local friend or relative: | Relationship to patient: | Contact phone no.:<br>( ) |

## FINANCIAL RESPONSIBLE PARTY

| | | |
|---|---|---|
| Name of Financial Responsible Party: | Relationship to patient: | Contact phone no.:<br>( ) |

## INSURANCE INFORMATION

**PRIMARY** Insurance Company Information

| | | | | |
|---|---|---|---|---|
| Primary Insurance Company Name: | | Identification No: | | Group No: |
| Patient's relationship to subscriber: | ☐ Self | ☐ ***Spouse*** | ☐ ***Child*** | ☐ ***Other*** |

***IF SUBSCRIBER IS OTHER THAN PATIENT:***

| | | | | |
|---|---|---|---|---|
| Subscriber Name: | Subscriber's S.S. no.: | Birth date: | Sex: | Relationship: |

**Assignment of Benefits.** I authorize my insurance benefits be paid directly to Washington Behavioral Health, PC. I understand that I am financially responsible for any balance.

**Release of Information.** I also authorize Washington Behavioral Health, PC to release any information required to process my claims as allowed by Law.

The above information is true to the best of my knowledge.

*Patient/Guardian signature* *Date*

# Washington Behavioral Health, PC

1954 Opitz Blvd #007 Woodbridge, VA 22191 (703) 492-2924

**PATIENT NAME:** **DOB**

| List the problems for which you wish to be seen today: | What are your goals for treatment? |
|---|---|
| • | • |
| • | • |
| • | • |

## PSYCHIATRIC HISTORY

*Do you have a history of mental health problems or hospitalizations?* Y ☐ N☐ (If no, skip to the next question)

| Diagnosis: | Dates Treated: | By Whom: |
|---|---|---|
| Diagnosis: | Dates Treated: | By Whom: |
| Diagnosis: | Dates Treated: | By Whom: |

*Are you currently receiving professional counseling or any kind of psychotherapy?* Y ☐ N☐ (If no, skip to the next question)

If yes, by whom: Phone:

**Trauma History:** *Do you have a history of trauma from childhood abuse, military combat, workplace trauma, domestic violence, rape, or medical trauma?* Y ☐ N☐

If yes, please explain:

**Suicide Risk Assessment** *Have you ever had feelings so bad that you have had thoughts that you didn't want to go on, or that you might want to kill yourself?* **Y ☐ N☐ (If no, please skip to next section)**

*Is this unhappy feeling so strong you ever wish you were dead?* Y ☐ N☐ *Have you planned a time for this?* Y ☐ N☐

*Have you ever thought about how you would kill yourself ?* Y ☐ N☐ *Is the method you would use readily available?* Y ☐ N☐

*Have you ever tried to kill or harm yourself before?* Y ☐ N☐ *Did things change because of these attempts?* Y ☐ N☐

| Has anything happened recently to make you feel like this? | How often have you had these thoughts? |
|---|---|
| On a scale of 1 to 10, how strong is your desire to kill yourself? | What would it take to move you one point down the scale? |
| Is there anything that would stop you from killing yourself? | If you could look into the future, what do you feel you could look forward to? |

**Family History:** *Has any one in your family been diagnosed with or treated for: check all that apply):*

| | | | |
|---|---|---|---|
| ☐ Anxiety | If so, which family member: | ☐ Post-traumatic stress | If so, which family member: |
| ☐ Alcohol abuse | If so, which family member: | ☐ Schizophrenia | If so, which family member: |
| ☐ Bipolar disorder | If so, which family member: | ☐ Suicide | If so, which family member: |
| ☐ Depression | If so, which family member: | ☐ Substance abuse | If so, which family member: |

*Has any family member been treated with a psychiatric medication?* Y ☐ N☐

If yes, what medications? How effective were they?

# Washington Behavioral Health, PC

1954 Opitz Blvd #007 Woodbridge, VA 22191 (703) 492-2924

**PATIENT NAME:** **DOB:**

## Substance Use:

*Have you ever been treated for alcohol or drug use or abuse?* Y ☐ N☐ (If no, skip to the next question)

What Substances:

| Where were you treated? | When? |
|---|---|
| *How many alcoholic drinks do you consume each week?* | *In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day?* |
| *Have you used any street drugs in the past 3 months?* Y ☐ N☐ (If no, skip to the next question) | Which ones? |

| | |
|---|---|
| *Have you ever felt you ought to cut down on your drinking or drug use?* | Y ☐ N☐ |
| *Have people annoyed you by criticizing your drinking or drug use?* | Y ☐ N☐ |
| *Have you ever felt bad or guilty about your drinking or drug use?* | Y ☐ N☐ |
| *Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?* | Y ☐ N☐ |
| *Do you think you may have a problem with alcohol or drug use?* | Y ☐ N☐ |

***Check if you have ever tried the following:***

| | | | | | |
|---|---|---|---|---|---|
| ☐ Methamphetamine | Last use: | ☐ Methadone | Last use: | ☐ Marijuana | Last use: |
| ☐ Pain killers (not prescribed) | Last use: | ☐ Cocaine | Last use: | ☐ Alcohol | Last use: |
| ☐ LSD /Hallucinogens | Last use: | ☐ Ecstasy | Last use: | ☐ Stimulants (pills) | Last use: |
| ☐Tranquilizer/sleeping pills | Last use: | Other: | | Date of Last use: | |

## MEDICAL HISTORY

*Allergies:*

*Do you wear? (check all that apply):*

☐ *Glasses* ☐ *Contact Lenses* ☐ *Hearing Aid(s)*

*Are you ? (check all that apply):*

☐ *Blind* ☐ *Deaf* ☐ *Hard of Hearing*

***Name of your Primary Care Provider:*** ***Phone No:***

| | |
|---|---|
| *Date of Last Physical Exam:* | *Have you ever had an EKG?* N☐ Y ☐ Date: |
| *Current prescription medications and how often you take them:* ***(if none, write none)*** | *Current over-the-counter medications or supplements* |
| | |
| | |
| | |

*Current medical issues/concerns:*

*Do you have any significant ambulatory or sensory issues? (If so, please describe)*

# Washington Behavioral Health, PC

1954 Opitz Blvd #007 Woodbridge, VA 22191 (703) 492-2924

**PATIENT NAME:** **DOB:**

***Past medical hospitalizations/surgeries:***

| Dates: | Hospital: | Reason: |
|---|---|---|
| Dates: | Hospital: | Reason: |
| Dates: | Hospital: | Reason: |

**Advanced Directive** *Do you have an Advanced Directive?*

☐ **Yes.** ***Please provide a copy for your chart*** ☐ **No** ***If you are interested in completing an Advanced Directive, please request a form from the Front Office.***

**Tobacco History**

*Do you Smoke Cigarettes:* Y ☐ N☐ How many per day on average? For how many years?

*In the Past: :* Y ☐ N☐ *When did you quit?*

*Pipe, cigars, or chewing tobacco?* Y ☐ N☐ How many per day on average? *In the Past: :* Y ☐ N☐

**For Women Only:**

Date of Last Period: Birth control method

Are you currently pregnant or do you think you might be pregnant? Y ☐ N☐ Are you planning to get pregnant in the near future? Y ☐ N☐

**SOCIAL HISTORY**

**Education**

Indicate highest grade completed: College: ☐ Yes: _____years ☐ No

Occupational training, technical or vocational school: ☐ Yes ☐ No

**Marital History and Current Family:**

How would you identify your sexual orientation: straight/heterosexual ☐ lesbian/gay/homosexual ☐ bisexual ☐ transexual ☐

Do you have concerns related to your sexual orientation? Y ☐ N☐

| *Are you currently dating, sexually active, or in a relationship(s)?* Y ☐ N☐ | *What is your significant other's occupation?* |
|---|---|

*Describe your relationship with your spouse or significant other:*

| *Have you had any prior marriages?* Y ☐ N☐ | *If so, how many?* | *For how long?* |
|---|---|---|

| *Do you have any children?* Y ☐ N☐ | *Ages:* |
|---|---|

*Describe your relationship with your children:*