Achieve Whole Recovery
1115 Elkton Drive, Suite 300
Colorado Springs, CO 80907
Office: 719-373-9703 Fax: 877-588-3465

Adult Intake Form:

Name: ______________________________ **Birthdate:** ________________________

Address: ____

Email: ____

Insurance Provider: ____

Member ID: ___________________________ **Group Number:** ____________________

Relationship to the Insured Subscriber: ____________________________________

***The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand I am financially responsible for any balance. I authorize the release of any information required to process claims.**

Signature: __________________________________ **Date:** _____________________

Best Phone to Contact you and leave a message: ______________________________

Is it OK to leave a message at this number? Circle YES or NO

Primary Care Name, Address, and Phone Number: ____________________________

____

Therapist Name, Address, and Phone Number: _______________________________

____

Emergency Contact: Name: _________________________ **Number:** _______________

May I share information with this person(s) about your mental health condition?

Circle YES or NO

Please bring all medication bottles including supplements to your first appointment. Also, if you have any lab work from the past 12 months, medical records you would like reviewed, Neuro-Psych Testing Results, ADHD Evaluations, MRI Results, etc. Please bring all of this with you to your intake appointment. Knowing the names and dosages of your current medications is very important.

Adult Intake/ Assessment Interview

Date:

Patient Name: ____________________________ **Birthdate:** __________________________

ALLERGIES:

Medications

Please list any medications and dosages you are currently taking (please include over the counter medications, herbals and any nutritional supplements)

1. ____
2. ____
3. ____
4. ____
5. ____

PLEASE USE THE BACK OF THIS PAGE IF YOU NEED MORE ROOM FOR MEDICATIONS

Primary Care Provider: ____

PCP Phone Number: ____

Do you see any specialist: Yes/ No

Specialist Name: ____

Specialty: Phone: ____

What do you consider to be the top three stresses in your life?

1. ____
2. ____
3. ____

Mood *(past 1-2* weeks): Calm Happy Sad Anxious Angry Frustrated Worried Hopeless Helpless Other: ______________________________

Behavioral Symptoms *(circle problems in the past month):*

Sleep Enjoying Life Motivation Fatigue Guilt Poor Concentration

Appetite Change Impulsiveness Loss of Sex Drive Racing Thoughts

Can't Stop Talking Poor Judgment Strange Thoughts or Behavior

Periods of Very High Energy Periods of Very Low Energy

Mental Health History

1. Have you been in counseling or mental health treatment before? (For example: Counselor, Psychiatrist, Psychologist, Marriage/Family Counselor): *Yes / No*
2. Have you ever been hospitalized for mental or emotional problems? (For example: nervous breakdown, depression, suicide, mania, schizophrenia, anxiety, drug or alcohol problems, etc): *Yes / No*
3. Has anyone in your family had mental or emotional problems? (For example: nervous breakdown, depression, suicide, mania, drug or alcohol problems, etc): *Yes / No*
4. Have you ever been referred to Social Services? *Yes / No*

RISK ASSESSMENT (Check appropriate boxes):	No	Yes	Recently	Today
1. Been so distressed you seriously wished to end your life?	____	____	____	____
2. Have you had or do you have:				
a. A specific plan how you would kill yourself?	____	____	____	____
b. Access to weapons/means of hurting self?	____	____	____	____
c. Made a serious suicide attempt?	____	____	____	____
d. Purposely done something to hurt yourself?	____	____	____	____
e. Heard voices telling you to hurt yourself?	____	____	____	____
3. Had relatives who attempted or committed suicide?	____	____	____	____
4. Had thoughts of killing or seriously hurting someone?	____	____	____	____
5. Heard voices telling you to hurt others?	____	____	____	____
6. Hurt someone or destroyed property on purpose?	____	____	____	____
7. Slapped, kicked, punched someone with intent to harm?	____	____	____	____
8. Been arrested or detained for violent behavior?	____	____	____	____
9. Been to jail for any reason?	____	____	____	____
10. Been on probation for any reason?	____	____	____	____

Physical Symptoms: Circle any that were a problem for you in the last month:

Headaches *Dizziness* *Heart Pounding* *Muscle Spasms*
Muscle Tension *Sexual Problems* *Diarrhea* *Vision Changes*
Numbness *Tics/Twitches* *Fatigue* *Fainting* *Blackouts*
Chest Pains *Skin Problems* *Nausea* *Chills/Hot Flashes*
Sweating *Rapid Heart Beat* *Choking Sensations* *Stomach Aches*
Shortness of Breath *Trembling/Shaking* *Mouth Muscle/Joint Pain*

If Female: Are you on any form of birth control? Yes / No
Are you, or is there a chance you might be, pregnant? Yes / No
When was your last menstrual period? ______________________________

Medical History: Check all that apply:	**Childhood**	**Adult**	**Recently**
Serious Illnesses	____________	_______	__________
Serious Injuries	____________	_______	__________
Serious Head trauma	____________	_______	__________

1. Are you allergic to any medications or foods? ______________If yes, please list: _________________
____

2. Do you currently have problems with pain? *Yes / No*
   If yes: Where is your pain located? ____
   How long have you had this pain problem? ____
   What things help your pain? ____
   How intense is your pain today? ***(none)*** *0 1 2 3 4 5 6 7 8 9 10* ***(worst)***
   Do you ever take more pain medication than prescribed? Yes / No
   Are you currently being treated by another doctor for your pain? Yes / No
   If yes, who? ____

Nutrition:
Do you purge, restrict, or overeat? *Yes / No*
Have you had any difficulties or concerns related to food intake? *Yes / No*

Social History
1. Are your parents divorced? *Yes / No* If yes, how old were you? _____________________
2. Briefly describe your childhood *(happy, chaotic, troubled):* _____________________________________
____
3. Are childhood events contributing to current problems? *Yes / No*
4. Current Marital Status: *Single* *Married* *Divorced* *Widowed* *Separated*
5. Number of Years Married: ____________________ Total Number of Marriages: __________________
6. Do you have any children? *Yes / No* Ages? ____
7. Have you experienced any abuse (physical, sexual, verbal) *Yes / No*
8. How satisfied are you with your current family life? (circle one)
Very Unsatisfied *Unsatisfied* *Satisfied* *Very Satisfied*

Social Support
How satisfied are you with the support you receive from your family/Friends?
Very Unsatisfied *Unsatisfied* *Satisfied* *Very Satisfied*
Have your current difficulties affected your family/friends/coworkers? *Yes / No*

Quality of Life: Are you satisfied with your quality of life?
Very Unsatisfied *Unsatisfied* *Satisfied* *Very Satisfied*
What do you do for leisure? ____
Are you able to enjoy leisure/recreational activities? *Yes / No*
If no, why? ____

Education History: Years of education completed? ________ Degree(s) _________________________

Job History

1. How many jobs: Have you held? ______________________ Been fired from? ______________________
2. How satisfied are you with your current occupation?

Very Unsatisfied *Unsatisfied* *Satisfied* *Very Satisfied*

3. Do you have performance problems or difficulties with your boss? *Yes / No*

Alcohol Use: Do you or did you:	**In the Past**	**Recently**
1. Regularly use alcohol (more than twice per month)?	*Yes / No*	*Yes / No*
2. Had trouble (legal, work, family) because of alcohol?	*Yes / No*	*Yes / No*
3. Felt you should cut down on your drinking?	*Yes / No*	*Yes / No*
4. Been annoyed by people criticizing your drinking?	*Yes / No*	*Yes / No*
5. Felt bad or guilty about your drinking?	*Yes / No*	*Yes / No*
6. Ever had a drink first thing in the morning?	*Yes / No*	*Yes / No*

Other Substance Use/Abuse Do you or did you?	**In the Past**	**Recently**
1. Use medications (other than over the counter) that were not prescribed to you?	*Yes / No*	*Yes / No*
2. Taken more than the recommended daily dose of an over the counter medication?	*Yes / No*	*Yes / No*
3. Taken more than the prescribed dose of your prescription medication?	*Yes / No*	*Yes / No*
4. Taken or used any illegal substance?	*Yes / No*	*Yes / No*
5. Used any product or other means to get "high"?	*Yes / No*	*Yes / No*

Habits:	**In the Past**	**Recently**
1. Do you smoke or chew tobacco regularly?	*Yes / No*	*Yes / No*

2. How many caffeinated drinks do you have per

day (coffee, tea, sodas)? ____

3. How often do you exercise per week? ____

Preferred Exercise: ____

4. Do you have problems with gambling?____

5. Do you have other potentially harmful habits you want to change? _____________________

If so, what? ____

Goals for Treatment:

What are your goals for treatment? In other words, what things would you like to see change or be different about yourself? ____

____

____

Legal History:

Have you ever been arrested? ____

Do you have any pending legal problems? ____

Spiritual Life:

Do you belong to a particular religion or spiritual group? (Yes) (No)

If yes, what is the level of your involvement? ____

Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ( ) more helpful ( ) stressful

Is there anything else that you would like us to know?

____
____
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____

Signature: ________________________________ Date: ________________

Guardian Signature(if under 18):________________________ Date: ________________

Emergency Contact: ________________________ Date: ________________

Please review the following medications. Circle or check any of the medications you have ever taken, even if only once. I have tried to use the Brand name as well as the generic. I underlined some of the more commonly used mediations. If you do not see a medication you have taken, please write it in the margins. If you remember when you took these medications, the doses you used, and how well they worked, that would be helpful as well. Sometimes you can get a list from your previous provider or from the pharmacy where you filled the prescriptions.

Antipsychotics/neuroleptics/major tranquilizers/anti-Parkinsonians

Thorazine/
Mellaril/thioridazine
Trilafon/perphenazine
Stelazine/trifluoperazine
Prolixin/fluphenazine
Compazine/
Haldol/haloperidol
Orap/pimozide

Navane/thiothixene
Loxitane/loxapine

Newer Antipsychotics
Invega/paliperidone
Risperdal/risperidone
Clozaril/clozapine
Zyprexa/olanzapine

Seroquel/quetiapine
Geodon/ziprasidone
Abilify/aripiprazole
Vraylar/cariprazine

Artane/trihexyphenidyl
Cogentin/benztropine
Symmetrel/amantadine

Antidepressants/mood elevators

Elavil/amitriptyline
Pamelor/nortriptyline
Sinequan/doxepin
Tofranil/imipramine
Norpramin/desipramine
Limbitrol Symbyax
Anafranil/clomipramine
Desyrel/trazodone
Serzone/nefazodone

Newer Antidepressants
Prozac/fluoxetine
Zoloft/sertraline
Paxil/Pexeva/paroxetine
Luvox/fluvoxamine
Celexa/citalopram
Lexapro/escitalopram
Effexor/venlafaxine

Cymbalta/duloxetine
Wellbutrin//bupropion
Remeron/mirtazapine
Trintellix/vortioxetine

MAOIs
Nardil/phenelzine
Parnate/tranylcypromine
Emsam/selegiline

Mood stabilizers and anticonvulsants

Lithium/Eskalith/Lithobid
Depakote/valproic acid
Lamictal/lamotrigine

Tegretol/carbamazepine
Trileptal/oxcarbazepine
Neurontin/gabapentin

Lyrica/pregabalin
Topamax/topiramate

Anxiolytics/minor tranquilizers/sleeping pills

BuSpar/buspirone

Valium/diazepam
Librium/chlordiazepoxide
Tranxene/clorazepate
Serax/oxazepam
Ativan/lorazepam

Xanax/alprazolam
Klonopin/clonazepam
Dalmane/flurazepam
Restoril/temazepam
Halcion/triazolam
ProSom/estazolam

Ambien/zolpidem
Sonata/zaleplon
Lunesta/eszopiclone
Rozerem/ramelteon
Trazodone
Vistaril/hydroxyzine

Please review the following medications. Circle or check any of the medications you have ever taken, even if only once. I have tried to use the Brand name as well as the generic. I underlined some of the more commonly used mediations. If you do not see a medication you have taken, please write it in the margins. If you remember when you took these medications, the doses you used, and how well they worked, that would be helpful as well. Sometimes you can get a list from your previous provider or from the pharmacy where you filled the prescriptions.

Stimulants or medications for ADHD

Adderall/Adderall XR
Vyvanse
Strattera/atomoxetine
Ritalin/Concerta
Daytrana/
Focalin
Provigil/modafinil

Other psychoactive substances – prescription and nonprescription

Tobacco/nicotine products

Alcohol

Marijuana/grass/weed
Ecstasy/MDMA
LSD
Mescaline
Peyote
Psilocybin/mushrooms

DMT
STP
PCP
Amphetamines /speed/diet pills
Glue/other volatile inhalants
Heroin/other opiates
Quaaludes
Barbiturates
Other downers

Suboxone/ buprenorphine
Antabuse/disulfiram
Campral/acamprosate
Revia/Vivitrol/naltrexone

Aricept/donepezil
Exelon/rivastigmine
Namenda/memantine

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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 in some way	0	1	2	3

FOR OFFICE CODING __0__ + ______ + ______ + ______

=Total Score: ______

If you 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**
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

ACHIEVE WHOLE RECOVERY INFORMED CONSENT FORM

ACHIEVE WHOLE RECOVERY
1115 Elkton Drive, suite 300
Colorado Springs, CO 80907

Patient Last Name: ____________________ First: ___________ DOB: _______ Date: __________

Fees: All payments for services are due at the time of service.
Cash pay rates are as follows:

- First general psychiatry appointment-$350
- 15 minute follow-up Psychiatry Medication Management: $125
- **Phone calls:** Brief phone calls (usually less than 5 minutes) to cover issues such as scheduling appointments, reactions to new medications, returning my phone call to you, etc., will not be billed. Extended phone calls or multiple phone calls may be billed an average of $300/hour, and this will be discussed with the patient on a case by case basis.
- **Reports, Consultations, and Other Special Documentation:** In the rare circumstance that my services are needed to prepare specific reports or documentation beyond a routine office appointment, the rate will be $300/hour. These services, if needed, will be fully discussed with the patient prior to the service being provided.
- **Cancelled appointments with less than 24 hour notice and no-shows will be billed to you at the full rate of the scheduled visit. This includes the first appointment and you may be asked to provide credit information to hold your first appointment.**

Cancellation policy: Appointments must be cancelled with at least a 24 hour notice. Cancellations made less than 24 hours or missed appointments without notice ("no-shows") will be billed at the full rate of the scheduled visit. Late arrivals will be billed at the full rate without extending the scheduled appointment, and another appointment may be required to complete the service.

Past Due Accounts: Payment is due at time of service. Accepted methods of payment include cash, check, credit card, and debit card. There will be a $25 additional charge on all returned checks added to the full service fee plus any bank charges. Failure to make payment will result in late fees and possible suspension or termination of treatment. Accounts receivable more than 90 days will be assessed a $25 billing fee per month starting with the first month. Past due accounts may be referred to collections and will include the amount owed plus reasonable attorney fees and court costs.

Collaboration of Care with Other Providers: Communication with other care providers, including your family doctor, therapist, or other clinicians is strongly recommended for the best possible treatment outcome. Please provide their contact information and your consent to communicate with them. Only essential and pertinent medical will be shared with your providers in accordance with privacy laws. Please talk to me about any concerns.

Important health information for females – Pregnancy: All medications pose some danger to the fetus or breast-feeding child. If you are pregnant, feel you may be pregnant, decide to become pregnant, or no longer practice regular birth control, you must notify me as soon as possible so that we can discuss this in advance of a pregnancy. Waiting until you are pregnant may unnecessarily expose the fetus to dangerous medication. Sometimes, the risks of not treating mental illness are greater than the risks of the medication, but treatment will still only be with the consent of the patient, and you will be asked to sign a written consent stating that you understand the risks before treatment is given.

Expectation of Treatment Compliance: Repeated cancelled appointments, at least 2 no-shows/cancellations under 24 hours, or not adhering to the treatment plan such as not taking medication as prescribed or not following through with therapeutic recommendations will disrupt the plan for treatment. If it becomes evident that there is a recurrent pattern of these issues, the first step will be to discuss solutions to see if this is something that can be

worked through. If the issues persist after this step, it will be recommended that you seek care with another provider.

Abuse of Prescription Medications: Abuse or misuse of medication prescribed by Achieve Whole Recovery to you will not be tolerated. This not only includes taking more medication than prescribed or recommended, but also selling your medication to others, obtaining duplicate prescriptions for controlled substances without our consent, using Narcotics while taking your prescribed medication with our knowledge, or buying prescription medication "off the street." At a minimum, if this occurs you will be requested to seek care with another provider, but there may also be risk of legal consequences. Controlled substances will be monitored the Prescription Drug Monitoring Program.

Photo Copies and Electronic Signatures: A photo copy of any signed form will be considered as an original copy. An electronic signature will be considered the same as a signature by hand.

Doctor's Absences and After-Hours Calls: Our administrative assistant will list any upcoming vacations or other absences to help you in planning follow-up appointments or medication refills. Phone calls will be returned within 24 hours except when the office is closed. As noted above, brief telephone calls are not charged, however repeated phone calls and extended calls may result in fees. After-hours calls are managed by a call-service, and messages left by patients forwarded the next business day, and our staff will respond to all messages by phone call with that business day. If your call is of an emergent nature ANYTIME, please go to your nearest emergency room or call emergency services (911). **Please do not delay medical care by waiting for our return call - delays in response can be beyond our control.**

Medication and Refills: If you are taking medication, you agree to take medication only as prescribed and not to ingest any alcohol or illicit drugs. Medication refills should be called into your pharmacy at least five days before running out. Refill requests made on weekends or holidays might not be accommodated until the office reopens during the normal business week. You are responsible for monitoring your supply.

Privacy, Confidentiality and Safety: Personal information shared with us during our sessions is confidential and not shared with anyone without a signed release of information, except under specific legal and safety concerns as defined by laws. If there is an indication of child abuse, risk of danger to self, or risk of danger to others, we are legally bound to report the concerns to the appropriate authorities. As noted above, communication with your other care providers including your family doctor, therapist, or other clinicians is strongly recommended for the best possible treatment outcome. Please provide their contact information and your consent to communicate with them. Only essential and pertinent medical will be shared with your providers in accordance with privacy laws. Your signed consent is necessary for us to be able to communicate with them.

Consent for Treatment

I consent to and authorize the attending physician, physician's assistant, and/or nurse practitioner to perform healthcare examinations, treatment, and diagnostic testing as deemed medically necessary in their professional judgment.

1. I have read and understand my responsibilities as outlined by the policies of Achieve Whole Recovery's office as outlined on www.achievewholerecovery.com.
2. I acknowledge receipt of the HIPAA Notice of Privacy Practices.
3. I have read and understand the above information.
4. I agree to the terms of the office payment and cancellation policies

____

PATIENT SIGNATURE/ DATE

PATIENT NAME: ____________________________ DOB: ______________________________

APPOINTMENT REMINDER AUTHORIZATION FORM

Please indicate below which way you would like to be reminded:

EMAIL

I, ____, authorize Achieve Whole Recovery to send Appointment Reminders electronically via Email to the following email address.

EMAIL ADDRESS (please print clearly): ____

TEXT MESSAGE

I, ____, authorize Achieve Whole Recovery to send Appointment Reminders electronically via text message to my mobile phone. I understand that this service is offered free of charge. However, standard text messaging rates from my mobile carrier may apply. Please activate text message reminders for the patient/mobile phone number:

MOBILE #: __________________________________ MOBILE CARRIER: _________________________

VOICE MESSAGE

I, ____, authorize Achieve Whole Recovery to contact me for Appointment Reminders via voice messaging. If I am unavailable to answer the telephone, I give Achieve Whole Recovery permission to leave a message on my answering machine or with the person answering the telephone.

TELEPHONE #: ________________________________

(Circle One) YES or NO Achieve Whole Recovery may contact me at work to reschedule appointments or confirm existing appointments.

WORK TELEPHONE#: _________________________________

Patient Signature: ____ Date: _________________ OR
Parent/Legal Guardian Signature: ______________________________ Date: _________________